Statement for the Record

Submitted By

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Before the

Committee on Veterans Affairs

U.S. House of Representatives

"Overcoming PTSD: Assessing VA's Efforts to Promote Wellness and Healing"

June 7, 2017

Chairman Roe, Ranking Member Walz, and Distinguished Members of the House Veterans Affairs Committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on "Overcoming PTSD: Assessing VA's Efforts to Promote Wellness and Healing". We should also like to thank you for your overall concern about the mental health care of our troops and veterans.

There is an unprecedented demand VA for mental healthcare because many veterans suffer from depression, isolation, anxiety, and substance abuse disorders. While the VA has made strides in increasing access to mental healthcare, it alone cannot address this crisis. Solving the veterans' mental health crisis requires partnerships and a commitment with/from many sectors: public, private, non-profit, and local communities. Otherwise the crisis will only worsen.

Starting with this premise, not the least of issues with VA mental healthcare begins with recognition of our veterans' age, gender and race, as many of the VA's mental health programs remain "one size fits all". This does not allow for addressing the specific needs of individual veterans, particularly our women veterans, even with recognition of the need for more clinicians and financial resources.

VVA also understands that some of our veterans are calling for holistic PTSD treatments (i.e., complementary alternative medicines or CAMs) such as yoga/meditation, art therapy, music therapy, nature-based recreational therapy, and various pet therapies, Yet VVA is not aware of any science-based comparative clinical research studies of these therapies that demonstrate clinical efficacy outcomes **as stand-alone treatments for PTSD**. As such, VVA cannot support adding these additional treatment programs to VA's mental health programs without the comparative effectiveness studies that both psychological and pharmacological therapies must currently undergo, including the training and certification standards for such VA providers. Therefore, VVA strongly recommends that VA R&D monies be allocated for/directed to science-based comparative clinical research studies of these therapies before wholesale adoption by the VA (see *reference below).

Furthermore, VVA recognizes that veterans' peer support programs can be effectively utilized to link people living with a chronic condition or common illness who are able to share knowledge and experiences – including some that many health workers do not have. As such, the VA currently operates a peer support program in mental health, but it's relatively unknown, not well understood

within the veterans' community, and not well advertised. Thus, VVA calls for an independent evaluation of its peer support program for effectiveness.

In addition, in a May 29 *The Hill* op-ed piece by Maura C. Sullivan (former Assistant Secretary at the VA, former Assistant to the Secretary of Defense, and a U.S. Marine and Iraq Veteran), she notes "researchers have found that after U.S. forces began withdrawing from Afghanistan in 2011, death by suicide surpassed war-related deaths - making it the second leading cause of death, after accidents, among active service members in 2012 and 2013. Furthermore, the Department of Veterans Affairs (VA) estimates that up to 20 percent of U.S. military personnel who served in Iraq or Afghanistan, about 400,000 Veterans, have Post Traumatic Stress Disorder. To put this figure in perspective, that's nearly the equivalent of the population of Wyoming." Furthermore, the VA's own *2016 Suicide Report* concluded that approximately 65 percent of all Veterans who died from suicide in 2014 were 50 years of age or older – which is of the gravest concern to VVA. But despite the significance of these data, other problems with the VA's Veterans Crisis Line (VCL) also surfaced about the same time and were clearly noted in the GAO's report of June 2016 which stated "GAO found that the Department of Veterans Affairs (VA) did not meet its call response time goals for the Veterans Crisis Line" and "reports of dissatisfaction with VCL's service periodically appeared in the media". The GAO then recommended that VA and SAMHSA collect information on how often and why callers reach Lifeline (i.e., a back-up service) when intending to reach the VCL, review this information, and, if necessary, develop plans to address the causes. VA and HHS concurred with GAO's recommendations and described planned actions to address them.

Now fast forward to the VA's OIG report issued on May 18, 2017 entitled "Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities" wherein the purpose of the review was to evaluate facility compliance at 28 VHA facilities with selected VHA guidelines from October 1, 2015 through March 31, 2016. This report noted that most facilities had a process for responding to referrals from the Veterans Crisis Line and a process to follow up on high-risk patients who missed appointments. Additionally, when patients died from suicide, facilities generally created issue briefs and, when indicated, completed mortality reviews or behavioral autopsies and initiated root cause analyses. However, the report also identified six system weaknesses and made the following six recommendations:

- Suicide Prevention Coordinators provide at least five outreach activities per month.
- Clinicians complete Suicide Prevention Safety Plans for all high-risk patients, include in the plans the contact numbers of family or friends for support, and give the patient and/or caregiver a copy of the plan.
- When clinicians, in consultation with Suicide Prevention Coordinators, identify high-risk inpatients, they place Patient Record Flags in the patients' electronic health records and notify the Suicide Prevention Coordinator of each patient's admission.
- A Suicide Prevention Coordinator or mental health provider evaluates all high-risk inpatients at least four times during the first 30 days after discharge.
- When clinicians identify outpatients as high risk, they review the Patient Record Flags every 90 days and document the review and their justification for continuing or discontinuing the flags.
- Clinicians complete suicide risk management training within 90 days of hire.

VVA asks how and when will the Secretary respond to these latest recommendations?

Finally, VVA eagerly awaits to hear the update from the VA on the implementation of the Clay Hunt SAV Act (PL 114-2), which requires (amongst other items) the VA to partner with non-profit mental health organizations on veteran suicide prevention and to arrange for an independent third-party evaluation of VA's mental healthcare and suicide prevention programs. VVA's Arizona State Council and chapters are participating partners in the state's pilot **Be Connected** program, working with all of the public and private sector key stakeholders, including the Arizona Coalition for Military Families, U.S. Department of Veterans Affairs, Office of Senator John McCain, Arizona Health Care Cost Containment System and Tri-West Healthcare Alliance among others. The program's goal is to increase access to, and use of, supportive resources and to decrease deaths by suicide within the Arizona veteran community.

VVA earnestly hopes that Congress can see there are many facets to addressing the issues that will be covered in today's hearing and we stand ready to assist in any way we can. Thank you for the opportunity to comment for the record.

***Reference --**

Jonas DE; Cusack K; Forneris CA; Wilkins TM; Sonis J; Middleton JC; Feltner C; Meredith D; Cavanaugh J; Brownley KA; Olmsted KR; Greenblatt A; Weil A; Gaynes BN. Psychological and pharmacological treatments for adults with Posttraumatic Stress Disorder (PTSD) Comparative Effectiveness Review No. 92. (Prepared by the RTI International-University of North Carolina Evidence-based Practice Center under Contract No. 290-2007-10056-I.) AHRQ Publication No. 13-EHC011-EF. Rockville, MD: Agency for Healthcare Research and Quality; April 2013. www.effectivehealthcare.ahrq.gov/reports/final.cfm

VIETNAM VETERANS OF AMERICA

Funding Statement

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The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

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Thomas J. Berger, Ph.D.

Dr. Tom Berger is a Life Member of Vietnam Veterans of America (VVA) and founding member of VVA Chapter 317 in Kansas City, Missouri. Dr. Berger served as a Navy Corpsman with the 3rd Marine Corps Division in Vietnam during 1966-68. Following his military service and upon the subsequent completion of his postdoctoral studies, he's held faculty, research and administrative appointments at the University of Kansas in Lawrence, the State University System of Florida in Tallahassee, and the University of Missouri-Columbia, as well as program administrator positions with the Illinois Easter Seal Society and United Cerebral Palsy.

After serving as chair of VVA's national PTSD and Substance Abuse Committee for almost a decade, he joined the staff of the VVA national office as "Senior Policy Analyst for Veterans' Benefits & Mental Health Issues" in 2008. Then in June 2009, he was appointed as "Executive Director of the VVA Veterans Health Council", whose primary mission is to improve the healthcare of America's veterans through education and information.

Dr. Berger has been involved in veterans' advocacy for over thirty years, and he is a member of VVA's national Health Care, Government Affairs, Agent Orange and Toxic Substances, and Women Veterans committees. In addition, he is a member (and the former Chair) of the Veterans Administration's (VA) Consumer Liaison Council for the Committee on Care of Veterans with Serious Mental Illness (SMI Committee) in Washington, D.C.; he is also a member of the VA's Mental Health Quality Enhancement Research Initiative Executive Committee (MHQUERI) based in Little Rock, Arkansas and the South Central Mental Illness Research and Education Clinical Center (SC MIRECC) based in Houston, Texas. Dr. Berger holds the distinction of being the first representative of a national veterans' service organization to hold membership on the VA's Executive Committee of the Substance Use Disorder Quality Enhancement Research Initiative (SUD QUERI) in Palo Alto, CA and serves as a committee member on the National Association of Alcohol and Drug Abuse Counselors (NAADAC) veterans' working group and member of the National Leadership Forum on Behavioral Health-Criminal Justice Services with the CMHS-funded national GAINS Center. He has also served as a reviewer of proposals for the Department of Defense (DOD) "Congressionally Directed Medical Research Programs". He is a current member of the Education Advisory Committee for the National Center for PTSD in White River Junction, Vermont, as well as a member of the Executive Committee of the National Action Alliance for Suicide Prevention.

Dr. Berger's varied academic interests have included published research, books and articles in the biological sciences, wildlife regulatory law, adolescent risk behaviors, domestic violence, substance abuse, suicide, and post-traumatic stress disorder. He currently resides in Silver Spring, Maryland.