Statement for the Record of
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Committee on Veterans' Affairs
United States House of Representatives

Legislative Hearing on Veteran Suicide Prevention: Maximizing Effectiveness and Increasing Awareness

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Chairman Roe, Ranking Member Walz, and members of the Committee, on behalf of the men and women of American Veterans (AMVETS), thank you for allowing us this platform to address a serious problem in our country, veteran suicide, that has reached crisis proportions and now requires redoubled efforts in order to effectively confront it.

Past and recent Department of Veterans Affairs (VA) studies that explored the question of which veterans committed suicide, how they did it, and the number who chose this path only tell part of the story. The latest VA report provided an examination of more than 55 million records of veterans who served in the United States military from 1979 to 2015. The report is based on veteran suicide data that essentially echoes the findings of past research: approximately 20 veterans are choosing self-inflicted death over life in our country, each and every day, a trend that is going in the wrong direction despite collective efforts to curb veteran suicide. The question that persists is why.

Why are veterans, according to the data, 2.1 times more likely to die by suicide than non-veterans? Why has the suicide rate risen fastest among Post-9/11 veterans ages 18-24? Why do veterans over age 55 and those who served during peacetime still experience the overall highest numbers of suicide? These questions have remained unanswered throughout study after study, and it is imperative that any new research going forward gets to the heart of why so many of our nation's veterans die by suicide.

A key aspect of the recently released VA report is that it compares differences in suicide mortality between veterans who access VA healthcare to those who have not recently used VHA services. The report showed that, in 2016, veterans who had recently used VHA services had higher rates of suicide than veterans who did not. Conditions, such as mental health challenges, drug addiction, chronic pain and severely disabling conditions were associated with an increased risk for suicide. What efforts are being undertaken to reach these veterans and explore whether their contact with a VA hospital has a causal connection to suicide? The research data and their conclusions are only as good as the actions that have been taken in light of new information.

We also question the timelessness of the data used in the recently released VA report. AMVETS is concerned that we are nearing the end of 2018 and trying to develop current and relevant solutions by parsing data from over two years ago. The lag in being able to study recent data makes it difficult to be as proactive as stakeholders could be. Despite the less-than-optimal information related to veteran suicide, we will continue to work diligently and tirelessly to reverse the troubling trend that negatively affects all generations of veterans. However, steps must be taken to improve the relevance of national data on veteran suicide by using timelier collection and examination protocols, which may require tighter coordination with local and state-level authorities that are responsible for aggregating and reporting death-by-suicide data.

Accountability continues to concern AMVETS when veteran suicides occur. In August 2016, a 76-year-old shot himself in the parking lot of the Northport Veterans Affairs Medical Center in New York. In March 2018, a 62-year-old veteran shot himself in the John Cochran VA Medical Center waiting room in St. Louis. In June 2018, a 58-year-old Air Force veteran died after he set himself on fire near the Georgia State Capitol in Atlanta to protest the VA system.

While these isolated examples of veteran suicide on VA property and in protest of VA itself do not conclusively prove the existence of systemic problems across the agency, one cannot ignore the fact that these "statement" suicides are frequently disassociated from policies and/or actions on the part of VA clinical staff that played some role in these veterans' fateful narratives.

Another case in point, a recently released VA Office of Inspector General (OIG) report entitled, *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide Minneapolis VA Health Care System*. In this instance, the systems in place to address a veteran in crisis were not implemented. The Iraq War veteran in question was referred to inpatient care after he called the Veterans Crisis Line while in the midst of a suicidal crisis. He stayed in inpatient care for three days, and then he shot himself in the parking lot of the VA less than 24 hours after being discharged.

The OIG team determined that inpatient mental health staff failed to include the patient's outpatient treatment team in discharge planning; failed to identify an outpatient prescriber and schedule an outpatient medication management follow-up appointment; failed to adequately document assessment of firearms access and educate the patient on limiting access to firearms; and failed to document the patient's declination to engage family in treatment planning and discharge planning. Despite these failures, the inspectors arrived at the fruitless conclusion that "the OIG team was unable to determine that any one, or some combination, was a causal factor in the patient's death."

Whether the actions on the part of VA personnel directly contributed to the veteran's suicide may never be known beyond a reasonable doubt. But that's not the evidentiary standard in this case. Was it possible that, but for those breakdowns in the system, the veteran may not have committed suicide? Why is more benefit of the doubt given to the institution that failed the veteran than the veteran who had turned to the system for help? The VA suicide report revealed that many younger veterans — specifically those of the Post-9/11 era — are slipping through the cracks despite the myriad efforts being made to address mental healthcare access and barriers to seamless transition after service. But if the system is not forced to correct itself through stronger accountability measures then nothing will change, and more lives will be lost.

We cannot speak of veteran suicide, and the tragic case at the Minneapolis VA, without mentioning Army Sgt. John Toombs, an Afghanistan veteran, who was wrongfully expelled from a regimented VA Residential Treatment Center after he arrived to the program later than his designated time to take his medications. He wanted to get back in the program, but was rejected, after which he hanged himself later that night. Besides telling his family he loved them, his last words on a video found on his phone were: "When I asked for help, they opened up a Pandora's box inside of me and just kicked me out the door…that's how they treat veterans 'round here."

There is currently a bill in the Senate, which passed the House, that seeks to honor his memory, H.R. 2634, *To designate the Mental Health Residential Rehabilitation Treatment Facility Expansion of the Department of Veterans Affairs Alvin C. York Medical Center in Murfreesboro, Tennessee, as the "Sergeant John Toombs Residential Rehabilitation Treatment Facility,"* which AMVETS wholeheartedly supports. AMVETS thanks the House of Representatives for passing this bill, which now sits with the Senate for consideration.

When the day comes that the treatment facility is named in his honor, it will serve as a powerful reminder that those who work in the mental health profession must take every measure possible to help and respect those who seek treatment.

Notwithstanding our criticisms, AMVETS does commend the VA for taking steps to improve its services and programs that target veteran suicide. In 2017, VA announced a Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) Initiative. REACH VET analyzes existing data from veterans' health records to identify those at a statistically elevated risk for suicide, hospitalization, illness or other adverse outcomes. This allows the VA to provide preemptive care and support for veterans, in some cases before a veteran even has suicidal thoughts.

Once a veteran is identified, his or her VA mental health or primary care provider reaches out to check on the veteran's well-being, and review conditions and treatment plans to determine if enhanced care is needed. It is clear this did not happen in the Minneapolis or Murfreesboro cases. That said, AMVETS does more than point out failures and breakdowns in the system. Earlier this year, AMVETS initiated a HEAL Program to ensure that veterans receive the healthcare they need, both physical and mental health services, so they may live longer, healthier lives. The AMVETS HEAL Program is staffed by a team of clinical experts with experience in eliminating the barriers veterans often face in accessing healthcare.

HEAL, stands for healthcare, evaluation, advocacy, legislation, and encompasses all necessary steps the team will take to intervene directly on behalf of veterans, service members, families, and caregivers to reduce veteran suicide, unemployment, homelessness, and hopelessness as it relates to mental and physical wellness. Since the Program's inception, we have been able to garner firsthand knowledge of specific issues that veterans are trying to manage through our town hall meetings, and through conversations with those that call the AMVETS HEAL help line at 1-833-VET-HEAL. Many of the issues we have addressed involved problems with timely access to mental healthcare, and proper management and monitoring of psychiatric symptoms once they begin treatment.

AMVETS has also partnered with the VA recently so that we could not only offer our recommendations for improvement, but also play an active role in implementing our recommendations. At our annual National Convention in August 2018, AMVETS and the Department of Veterans Affairs signed a Memorandum of Agreement (MOA) in furtherance of our mutual ongoing efforts to eliminate risk factors that contribute to veteran suicide and establish programs and practices that offer at-risk veterans the interventions necessary to avert potential suicide.

The agreement enhances cooperation between the AMVETS HEAL Program and the VA, through the VHA Office of Suicide Prevention. Together, AMVETS and the VA will work to identify and eliminate the barriers veterans face in accessing healthcare, enroll more at-risk veterans into the VA healthcare system, and provide training for those who work with veterans so that intervention begins once red flags are identified. The agreement also outlines terms under which the VA can refer veterans for services to the HEAL Program and vice versa.

VA Secretary Robert Wilkie noted at the MOA signing that suicide prevention remains VA's top clinical priority, and that it requires a focused, national approach to engage with all veterans whether or not they receive care in the VA. AMVETS could not agree more, and we are also encouraged by the January 2018 executive order signed by President Donald Trump that directed the VA, Department of Defense, and Department of Homeland Security to integrate efforts to provide seamless access to mental health care and suicide prevention resources for veterans who have recently separated from military service.

While there is much more work to be done, we are encouraged by the VA's willingness to partner with stakeholders in order to extend its reach to veterans who may be suffering silently in crisis. Preempting the crisis through immediate intervention, holistic assessment, and sustained support is key to giving at-risk veterans hope whenever they face problems such as mental issues related to post traumatic stress and/or traumatic brain injury, unemployment, homelessness, substance abuse, or other severe adjustment issues after service.

Americans should recognize that this problem is not just a VA problem. It is a problem for our entire country with very real and serious implications for the future of our military. We consider it a national emergency that requires immediate action. A better part of the last decade has been spent on efforts to improve the transitioning process for our veterans, but clearly it is failing in too many cases, and veterans are dying unnecessarily.

In order to address veteran suicide more effectively, Congress and the Department of Veterans Affairs must invest in research methods that produce timelier results, increase accountability among mental health providers employed at VA when the system fails, and conduct improved, targeted outreach to at-risk veteran populations through partnerships with organizations that have active and effective initiatives, such as the AMVETS HEAL Program, that are designed to intervene and avert crises that typically lead to suicide. No veteran should die by suicide in a country where saying "thank you for your service" is as common as saying "hello" and "goodbye," if such gratitude is sincere.

Chairman Roe, Ranking Member Walz, and members of the Committee, on behalf of the men and women of AMVETS and the nearly 20 million veterans in the United States whose interests are served by our mission, we thank you for the opportunity to contribute to this important discussion. AMVETS looks forward to working with this committee and the Department of Veterans Affairs to take every step necessary to end this crisis.

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Sherman Gillums Jr. served in the U.S. Marine Corps during the Persian Gulf War and Global War on Terror eras, starting in 1990 at age 17. During his 12-year military career, he was meritoriously promoted to the rank of staff sergeant in 1999 and was commissioned an officer in 2001. He was honorably discharged in 2002, after which he went on to pursue a new career in veteran advocacy.

In 2004, Sherman began his work as a VA benefits claims expert in San Diego, where he assisted veterans, families, and survivors with fighting for their entitlements. He later worked as an appellate representative at the Board of Veterans' Appeals in Washington, DC, and he became the executive director of Paralyzed Veterans of America in January 2016. He recently joined American Veterans, also known as AMVETS, as the organization's Chief Strategy Officer.

A well-respected commentator with an ability to move the needle on veterans issues, Sherman is a regular contributor to prominent publications such as Washington Times, Liberty Nation, NY Times, The Hill and Task & Purpose, where he ensures the voiceless have a voice in sociopolitical discourse on veterans' issues. He has testified before Congress as an expert witness on veterans' benefits and has appeared on CNN, Fox & Friends, CBS News, The Ingraham Angle, and C-SPAN. Today, he serves as Vice Chairman on the Federal Advisory Committee for Veterans' Family, Caregiver, and Survivor and a Consumer Reviewer for the Department of Defense Congressionally Directed Medical Research Program.

Sherman is a graduate of University of San Diego's School of Business Administration and completed his executive education at Harvard Business School.