STATEMENT OF KIMBERLY RUOCCO
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TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS (TAPS)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

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Hearing: "VA Mental Health Care: Ensuring Timely Access to High-Quality Care"

EXECUTIVE SUMMARY

Introduction

Because of its role in caring for thousands of surviving families left behind by America's fallen military and recent veterans since 1994, the Tragedy Assistance Program for Survivors (TAPS) works extensively with bereaved military families, including those grieving a death by suicide. TAPS receives an average of at least two people per day seeking help and support in coping with the death by suicide of a service member, Guard member, activated Reserves member, or recent veteran.

In this testimony, Marine Corps widow Kim Ruocco, an expert in suicide postvention programs, shares critical information reported by surviving families of a suicide loss to TAPS and offers insights on improving the quality of mental health care within the VA system. The testimony discusses insights and observations gained from surviving families of recent veterans who died by suicide and examines the following:

(1) how extensive wait times and paperwork for initial mental health screenings, referrals to specialists, and complex disability ratings interfere with the mental health and well-being of our veterans;

(2) the value of peer-based support programs in filling gaps in mental health care; and

(3) how national non-governmental organizations link veterans to mental health services.

II. Recommendations for Improvement

(1) Provide continued funding for peer-based support programs to assist veterans through organizations such as Vet4Warriors and through the VA Vet Centers.

(2) Create incentive systems within the VA and the Vet Centers to encourage peer-support program managers and counseling staff, especially those who are veterans, to continue working at the VA and in the Vet Center.

(3) Assign an advocate at first contact, preferably a peer, to provide support to the veteran and help navigate the system while waiting for the first appointment.

(4) Decrease the amount of paperwork and "red tape" involved in getting veterans to their first mental health appointment.

(5) Create and implement a national public awareness campaign to support VA and Vet Center mental health staff recruitment focused on the rewards of working with veterans and issue a call to national service for mental health workers.

(6) Create and implement a national public awareness campaign that emphasizes the messages that veterans who are struggling can get help and that treatment can work. Suicide is not inevitable.

Mr. Chairman and Members of the Committee:

I am pleased to have the opportunity to submit this testimony on behalf of the Tragedy Assistance Program for Survivors (TAPS).

TAPS is the national organization providing compassionate care for the families of America's fallen military heroes. TAPS provides peer-based emotional support, grief and trauma resources, grief seminars and retreats for adults, 'Good Grief Camps' for children, case work assistance, connections to community-based care, and a 24/7 resource and information helpline for all who have been affected by a death in the Armed Forces. Services are provided to families at no cost to them. We do all of this without financial support from the Department of Defense. TAPS is funded by the generosity of the American people.

TAPS was founded in 1994 by Bonnie Carroll following the death of her husband in a military plane crash in Alaska in 1992. Since then, TAPS has offered comfort and care to more than 40,000 bereaved surviving family members. The journey through grief following a military or veteran death can be isolating and the long-term impact of grief is often not understood in our society today. On average, it takes a person experiencing a traumatic loss five to seven years to reach his or her "new normal."

TAPS has extensive contact with the surviving families of America's fallen military service members and recent veterans. TAPS receives an average of 13 newly bereaved survivors per day through our protocols with the Services' casualty officers and direct contact from those who are grieving the death of someone who died while serving the Armed Forces or in recent veteran status.

In 2012, 4,807 new survivors came to TAPS for comfort and care. This means that TAPS received in 2012, 13 new people each day seeking care and support in coping with the death of a service member or recent veteran. It should be noted that on average, TAPS received 7 new survivors on average per day in 2011. The number of grieving survivors turning to TAPS in 2012 seeking help and support increased by 46% over the previous year.

Thirty percent of the survivors coming to TAPS were grieving the death of a loved one in combat or in hostile action. Twelve percent were grieving the death of a loved one by sudden illness, and nine percent lost a loved one in an auto accident. Six percent lost a loved one in an accident and four percent were grieving someone who died in an aviation accident (typically a military training accident). Three percent were grieving the death of a loved one by homicide. One percent were grieving a death in a non-hostile incident, 0.7 percent lost a loved one in a noncombat incident, and 0.3 percent to friendly-fire.

Nineteen percent of the survivors coming to TAPS in 2012 were grieving the death of a loved one who died by suicide or in a suspected suicide under investigation. At least two new survivors per day on average contact TAPS for support who are grieving the death by suicide of a service member or recent veteran. Fifteen percent of survivors reported a cause of death as "unknown" for their service member which often means a death is under investigation. Many of these "unknown" deaths are later ruled suicides, so the true number of families coming into TAPS grieving a death by suicide is actually closer to 30% or about four per day.

In 2012, approximately sixty-two percent of the family members coming to TAPS for support were grieving the death of a loved one who had served in the Army. Sixteen percent of the families were grieving a loved one who had served in the Marine Corps. Thirteen percent were grieving a loved one who had served in the Navy, six percent were grieving the death of someone who had served in the Air Force, and three percent were grieving the death of someone who served in the Coast Guard or another area.

TAPS also engages in suicide prevention programs for its survivors. As the *Wall Street* Journal reported in December 2012 in a front-page story, there have been a handful of suicides among surviving families of the fallen where a family has lost one family member to war, and then a second family member to suicide.

Nearly all of the bereaved who come to TAPS seeking care and support are grieving the traumatic, unexpected, and often violent death of a loved one who served in the military or recently left military service. Many of these families grieving a suicide have experienced the additional trauma of finding their loved ones body or being present when they died.

Suicide risk also goes up for the families left behind by our veterans and service members who die by suicide. While it is important to note that suicide is never inevitable, family members grieving a suicide loss are two to five times more likely to die by suicide themselves.

It's very important that organizations undertaking work with traumatized populations like TAPS does have in place good suicide prevention protocols that ensure safety and support help-seeking. On average, our 24/7 resource and information helpline receives at least one contact from a survivor in danger of imminent self-harm per week. Our online peer based support groups run 24/7 and are monitored by peer professionals in case a survivor posts something concerning. If a survivor is in crisis and appears to be in danger of self-harm, a TAPS staff member can immediately reach out to this survivor to assess risk and connect with support.

Additionally, the TAPS helpline occasionally receives calls from service members or recent veterans who are struggling and need care. We have built a comprehensive support network that we can warmly connect these service members and recent veterans to, including chaplains, Vet Centers and the National Veterans crisis line (NVCL).

My name is Kimberly Ruocco. I am the national director of suicide postvention and survivor support programs at TAPS. I am also the surviving widow of U.S. Marine Corps Major John Ruocco. My husband was a decorated Cobra helicopter pilot who proudly served his country in the Marine Corps for fifteen years. He died by suicide in 2005 while preparing for his second combat deployment to Iraq.

I first came to TAPS in 2005 with my 8 and 10-year-old boys, Billy and Joey. I was seeking help and support for my children and myself, in coping with the death of my husband. He was my best friend and we had been together for 23 years. My family was devastated and I did not know how to begin to heal. The challenges were overwhelming. How do you tell two young boys that their Dad, their coach, their hero made it home safely from combat and then took his own life? How would I keep my husband's death from defining his entire life? How would I keep my children from seeing suicide as an option? How would I keep my children from thinking that their Dad had chosen to leave them? These and other questions propelled me on a journey to heal my family and gather information and skills to help others and prevent suicide.

I have a master's degree in clinical social work from Boston University and I used my education and experience to come to help me understand how this could happen to my family. I read whatever I could find on the subject, I talked to experts in the field and spoke to survivors of suicide attempts. I reflected on our lives and worked to assemble a timeline of how my husband's struggles developed and what could have been done to save his life.

I came to understand that my husband was suffering from untreated post-traumatic stress injuries and depression. The military culture and his sense of who he was and who he was supposed to be conflicted with asking for help. On the day he died, he was having difficulty functioning in all areas of his life and he felt that this was all his fault. He had been resilient for years, fighting off his injuries and illness by exercising, praying, and giving back to his country, community and family. On the day he died, his resilience had been exhausted and he felt hopeless and helpless. He may have thought of the words he lived by, such as "death before

dishonor", "you are only as strong as your weakest link," and of course "Semper Fidelis." He saw himself as the weakest link and the problem. He was supposed to re-deploy in just a month and due to his struggles he was no longer able to fly his aircraft. He worried that he was letting everyone down, or worse, that he would get someone killed. As a Marine, he was used to making life and death decisions in a split second. He was a problem solver. He was fiercely loyal and cared for his Marines more than himself. I believe that in that moment of intense emotional pain and cognitive constriction he killed himself thinking that the world would be better off without him. How wrong he was.

With the support and assistance of TAPS and their trained mentors at the Good Grief Camp, my children and I began to heal and create a healthy new life. Over time, more families came to TAPS grieving deaths by suicide. I began to work with TAPS to create a program specifically focused on helping suicide survivors grieving the death of a service member or a recent veteran. We applied the best practices in peer-based emotional support and created a support program at TAPS to address the specific needs of military and recent veteran families grieving a death by suicide. By 2007, we were receiving two to three suicide survivors per week. By 2009, we were receiving, on average, one or two suicide survivors per day. Now, the average is more than two people per day who are grieving the death of a loved one by suicide. It should be noted that there may be multiple people grieving each death as TAPS provides care to parents, siblings, spouses, children and all others who are grieving a death in the Armed Forces, and multiple family members often come to TAPS hand-in-hand seeking help.

In 2012, TAPS sadly welcomed 931 people seeking care and support grieving the death by suicide of a loved one who served in the military. However, the true number is actually closer to thirty percent of our total caseload, or around 1,400 to 1,500 people, because so many families coming to TAPS tell us the cause of death was "unknown", either because they are in denial or feel shame to say that suicide is suspected, or because the death is under investigation and they are waiting for the outcome of that investigation. Many of these "unknown" deaths are later ruled suicides.

The war in Iraq is now over and the war in Afghanistan is drawing down, but the number of families coming to TAPS for bereavement support continues to increase. While these wars had some of the lowest casualty rates in our country's military combat history, there is no official count of the impact on families left. Nor is there an accurate accounting of the impact that many years at a high state of readiness has left on our troops. At TAPS we also see increasing numbers of bereaved military families and the families of recent veterans, who are grieving deaths by suicide or accidental deaths following high risk and self-destructive behavior. These "accidents" include high-speed head on vehicle or motorcycle collisions with no signs of braking. We are also beginning to see more families grieving deaths from sudden illnesses linked to toxic exposure while deployed.

Recently we have seen at TAPS increasing numbers of veterans who die by suicide within a couple of months or years of being discharged from active duty service in the military. It is this population that gives insights into the struggles that our veterans encounter in trying to reintegrate into their communities. It also highlights weaknesses and gaps in our system. While there are many veterans who receive outstanding care and thrive, TAPS sees those families who could not navigate the complex challenges of reintegration and lost hope. These families come to us heavily grieving and asking the question I asked myself...why?

One of the ways some families grieving a suicide cope with their loss is by sharing with each other what happened to their loved one. I have heard many families recount their narratives of what happened to their loved ones over the years. This desire and need to share is part of grieving and is part of the processing that many survivors do to cope with their grief. In many cases, I have seen surviving families gather voluminous amounts of information, interview people who were close to their loved ones, and work very hard to answer a simple question, "why?" It's a very legitimate question for our families to ask. They wonder how their loved ones reached the point of dying by suicide. Answering that question can take families years. Many of them do

not really begin addressing their grief until after they have completed this information-gathering and fact-finding process.

I wish to submit our testimony with information gathered by our surviving families in the wake of a suicide as part of their search for clues and inquiries made to understand what happened to their loved one. Families who come to TAPS, are traumatically bereaved after a death. Our testimony does not offer success stories of lives saved and deaths by suicide prevented, although many exist. Our families speak from a place of loss and often can point out lapses in care and areas for improvement so future deaths can be prevented and lives saved. Our testimony should be viewed with this perspective in mind.

The focus of this hearing is on timely access to high-quality mental health care. We believe that the experiences of our surviving families and the information that they have gathered about their loved ones and their treatment prior to their tragic deaths, can inform the Committee's discussions about prevention efforts.

In order to properly explain the challenges that these military families and their loved one faced, it is important to first discuss what this journey can look like for a veteran who dies by suicide. There are many variations to this story but there are common threads we hear within them. Many of the families who come to TAPS grieving the death by suicide of a recent veteran describe a similar scenario of a service member who is discharged with the hope of making it in civilian life, but instead face obstacles and frustrations that leave them feeling unappreciated and forgotten. They struggle to succeed in all areas of their lives – finding difficulty getting jobs, going back to school, connecting with civilian peers, and communicating with their significant others. If they suffer from illness or injury related to their service, then this complicates matters further. If they do manage to get a job, often concentration problems, sleep deprivation and anxiety can make it difficult to maintain employment. They may begin school to try to better themselves, but the combination of fighting for reimbursement for classes and struggling with emotional and physical challenges interferes with their ability to succeed.

At some point, the veteran may decide to go to the VA because he or she is struggling and needs help. Often this happens after a long battle and the service member's life is already falling apart and he or she is very sick. The service member then contacts the VA looking for help with his or her symptoms, whether it is addiction, anxiety, depression, uncontrollable outbursts of rage, etc. This is a critical time for the veteran. He or she may have shame about asking for help. He or she may feel disconnected from his or her unit and military peers. He or she has lost a sense of purpose and identity. He or she may have a relationship breakup and/or legal and financial issues due to their struggles. Very often the veteran's suffering is complicated with combinations of physical and emotional pain including issues like traumatic brain injury, post-traumatic stress, depression, moral injury, and survivor guilt. These issues become the veteran's own personal barriers to care. In this population we see avoidance, anxiety and trouble concentrating. Symptoms like panic attacks, flashbacks and hyper-vigilance among this population of veterans are often described to us by our surviving families.

These symptoms run counterintuitive to navigating a complex system of paperwork, crowded waiting rooms, extended wait times for appointments, referrals and disability ratings. The veteran enters this system tentatively with trepidation and some fear. The veteran is barely holding on. The veteran may feel like people do not understand him and that the public does not appreciate what he or she has sacrificed for this country. He or she may feel that his or her service did not matter or that they are now unprepared for the civilian world. He or she may feel as though he or she is losing everything that he or she has worked so hard for. When the veteran asks for help, he or she is desperate, and may be thinking of killing himself or herself because he or she is losing hope that things will get better. This is the composite profile of the veteran who dies by suicide, who initially approaches the VA for help.

At this point, the veteran and his or her family need immediate, comprehensive and quality care. One widow said to me "It was like finally making it to the people with the water after walking for days in the desert without it. I wanted them to wrap their arms around us and say "we've got you now" and give us water and clothes and instruction on how to proceed. Instead, while we could see them, we couldn't get to them, and when we finally got to them, they said "you can get water in two months" and turned us away to wonder in the wilderness once again.

In my testimony I will discuss: (1) how extensive wait time and bureaucracy for initial mental health screenings, referrals to specialists and complex disability ratings interfere with the mental health and well-being of our veterans; (2) discuss the value of peer based support in filling gaps; (3) highlight how national non-governmental organizations can link veterans to mental health services; and (4) offer recommendations for improvement.

It is important to state that our families are in every state of this country and therefore are seeking services in many different VA settings. I encountered many issues that were specific to only one clinic or location, but I attempted to gather those examples that demonstrated a common issue or struggle. The following stories were gathered for the purpose of understanding some of the contributing factors to the death by suicide of our veterans. These families are presently under the care of TAPS.

A young Marine was discharged from active duty eighteen months before he died by suicide in August of 2011. He did not want to leave the Marine Corp but while deployed to Iraq he suffered from multiple physical and emotional issues that were so severe that he was sent home half-way through his deployment. Back in the states he continued to struggle and was eventually "medical boarded out." He had a young family with a fiancé and a little daughter. His fiancé and his parents tell us that he had a lot of difficulty "making it" when he got out. He had dizzy spells and anxiety attacks. He had difficulty sleeping and would wake up in a cold sweat with nightmares. His fiancé states that she tried to talk to him about his nightmares and all he would say is "I've never seen so much blood." She asked "in Iraq?" and he said "yes" but he would not elaborate.

She encouraged him to go to counseling and he would say "we don't do that, I need to suck it up." He also expressed fear about what would happen to him if he went for help. He worried, "What would they do?" He questioned why he needed to go while his peers didn't seem to need help and they had stayed for the whole deployment. He felt he was weak and should be able to handle it. In the meantime he couldn't get a job, his finances were suffering and his family was depending on him. He went to his parents for financial help because he was six months behind on his truck payment. He became more and more depressed and had angry outbursts.

His fiancé finally convinced him to call the VA. He called and asked for an appointment stating that his life was falling apart and he was depressed and anxious. The first appointment was two months away. He got a mental health evaluation and a referral to a psychiatrist. His fiancé states that "it took a long time to see him." He saw a psychiatrist approximately two months before his death. He was put on medications and according to his family was not offered counseling or peer-based support and he also did not have a follow up appointment. His fiancé states that he did not improve on the medication he was placed on. In fact, he complained a lot about how it made him feel. The night before he killed himself he called his Dad and said that the VA "put him on medications" and he just "felt worse". He stated that he just wanted to talk to someone else who had been through the same thing. His fiancé was six weeks pregnant when he died. She has been denied survivor benefits for his children because there is not enough proof that his death was connected to his military service.

The parents of another Marine veteran came to us for support after their son died by suicide in November of 2012. Their son served eight years in the Marine Corps and was honorably discharged. He had a one year deployment as a diesel mechanic. According to his parents he had a successful career in the Marines but had a lot of difficulty transitioning in to the community. His parents state that he was diagnosed with post-traumatic

stress and traumatic brain injury before he was discharged from the military. He was given a number and told to contact the VA. His Dad says that his son had a lot of trouble "getting on his feet" and said that his son had trouble concentrating, experienced difficulty sleeping, and had a lot of anxiety. He applied for a number of jobs but could not get one. He enrolled in school but the paperwork for the tuition was daunting and seemed impossible for him to complete. His classes were cancelled due to non-payment. His parents finally convinced him to go to the VA and ask for help. He was given an appointment for the next month. At his appointment he was given referrals for a specialist for the traumatic brain injury and depression but the specialist was located an hour and a half from where he lived and it was months before the first appointment could be scheduled. His parents feel that their son lost hope and felt disconnected from his Marines. They state that they wished they knew more about how to help him and could have been involved in his treatment.

A wife of an Army veteran came to us for support after her husband died by suicide in December of 2012. She stated that her husband had a one year deployment to Iraq and was "completely different when he returned." He separated from the Army in 2010 after the two of them decided it would be better for their family. One week after his discharge she went looking for him in the house and found him on their deck with a gun and "a crazy look in his eyes." She called his name but he would not respond. She became extremely frightened and called the police. The police responded and he was charged with "felony menacing." After meeting with the lawyer, the lawyer suggested that he may have post-traumatic stress and should go to the VA. His wife stated that they contacted the VA and were given an appointment for one month out. She claims that days before the appointment the VA called and rescheduled for another month away. She states that he attended the appointment and was offered medication which he refused to take. After several attempts, she was able to get him into counseling. She claims that the time and paperwork it took to get to the counseling was "overwhelming." For about a year her husband went to counseling and he seemed to be getting better. She states that she wishes the counseling were more often and included her and maybe a support group. She claims that due to the wait for appointments and cancellations and rescheduling he only went to five appointments in a year. Six months before his death his counselor left the VA. His wife says that the appointment was cancelled with no follow up. His wife claims that they were under a lot of stress at the time with financial, legal and relationship issues. She was worried about him and feared that things were going to get worse. She states that her husband was suffering with anxiety and depression. She claims that in the first week of December 2012 her husband called the VA and said he needed an appointment. He was told the first available appointment was January 18th. On December 29th this young widow says she and her husband had a good evening. They talked about their future and he moved the furniture out of the living room so that they could dance together. After dancing he went to bed first and she went to join him about an hour later. When she got into bed she saw that "crazy look in his eyes" and noticed that he had a gun. Before she could react he shot himself in the head and died instantly. This widow tells us that she wishes that the care was more consistent and focused more on why he was acting this way instead of treating his symptoms. She also wishes that they could have worked on his problems together as a couple in a consistent and comprehensive manner.

A surviving father who came to TAPS and was grieving the death of his veteran son by suicide, who is himself a veteran, and he talked with me about his and his son's experiences accessing care through the VA. I think this case illustrates some of the challenges in providing quality mental healthcare. The stressor of his son's suicide was so severe, that the father's own service-connected post-traumatic stress re-emerged. The father went to the VA seeking help and waited for four months to get a mental health evaluation. After the evaluation, he saw a counselor once a week and things seemed to stabilize for him. But every few months, the counselor would change and he would have to start all over again. The breaking of the bond with the counselor has hampered his healing. He became depressed. He requested to see a VA psychiatrist six months ago, and is still waiting for an appointment. He tells TAPS that he feels abandoned. This father's son had been medically discharged from the Army at Fort Hood after two combat deployments overseas where he saw two of his friends blown up. All that was left of one of his friends was his glove, which he photographed and carried on a photo in his wallet. The young soldier attempted suicide immediately after his discharge from the military. His veteran father and his

mother took him to the VA after the suicide attempt seeking care and help. He received inpatient care and outpatient treatment but there were wait times to get him appointments and into care. While the care for the young soldier addressed some of his mental health needs, his father felt the care never addressed the loss of his friends and the grief and pain he was carrying over their deaths in combat. The young veteran lost his job and a significant relationship, and then the young veteran died by suicide fourteen months ago. His father began to cry when he shared with us that he took in two neighborhood teens that had lost their parents. He mentored them and convinced them to join the military. One of them just returned to his home because he is getting divorced and is suffering from depression and lost his job. He is attempting to get him "in at the VA."

In the past five years, significant expansion of specific services to benefit returning Veterans has occurred at the VA. These services include: VA Vet Centers that are staffed by clinicians who are veterans themselves and Suicide Prevention Coordinators as well as the peer partners program and clinic specifically for issues such as post-traumatic stress.

After talking to these families and many more, it became clear that there are many promising programs and outstanding clinicians at the VA, but we must do something to ensure that our veterans can get the kind of comprehensive quality care they need in a timely fashion. We must also look at the kind of care we are giving for the type of injuries and illnesses they are suffering from. We must not only address the symptoms but provide care that helps heal the cause of the symptoms. I have spoken at many military bases to thousands of troops. I have never left one of those presentations without a Soldier, Marine, Airman or Sailor coming to me in tears and saying "I just want to talk to someone who has been there, who knows what this is like."

We have found at TAPS that peer-to-peer support plays a key role in helping traumatized families find healing and comfort. We also find that peer-to-peer contact opens up lines of communication and helps families better access the support and services they need. Similarly, veterans also benefit from peer-to-peer connections.

We believe that peer-based support can help maintain an umbrella of care for our veterans that is critically needed. We believe that peer-based support can provide a needed safety net for veterans who may be waiting for appointments or waiting on benefits.

VA Vet Center treatment can be successful when it is grounded in a veteran-connection that gets established between a veteran clinician and the veterans who use the service. TAPS is very familiar with the services offered by the VA's Vet Centers. Many of our survivors are eligible for bereavement counseling through the Vet Centers and find these services have proven to be a helpful part of their journey toward healing.

Peer support can play a powerful and transformative role when coupled with treatment. The VA has begun to implement many peer-based programs and veterans tell me that this has been invaluable in helping them "keep it together" especially while waiting or in between appointments. The "peer partners program" is one such program. I work closely with one of these peers who has made it his life's work to advocate and support veterans. He became a trained peer partner through the VA and is available whenever a veteran is in need.

He recently told me about a young veteran who was discharged from active duty and was suffering from severe post-traumatic stress and was self-medicating with alcohol. His life was spiraling out of control, he couldn't find a job, he lost his home, and his wife left him. His post-traumatic stress symptoms kept him from going to the VA because of the crowds and his avoidance and anxiety. He made one attempt to get care and became overwhelmed with the paperwork and the wait. The peer partner was called because another veteran thought this veteran was suicidal. The peer partner was able to escort him to the VA, help him fill out the paperwork and secure an appointment which was scheduled for a date in three months. The peer partner then took him to a home for homeless veterans and got him a room. While waiting for his VA appointment, the peer partner was able to get the veteran into free counseling at the Andrews center, a private mental health center that got a grant

from the State of Texas to provide free counseling to veterans. This veteran now had weekly counseling appointments, peer-based support groups and a place to live. Six months later this veteran was enrolled in a specialized post-traumatic stress clinic at the VA and was doing very well. What I love most about this story is the healing and sense of purpose the peer partner found in helping another vet.

There are limitations to the VA Vet Centers which can be addressed. Their capacity is stretched for staffing, and there are not enough centers, particularly in geographically challenging areas in the Mid-West and West. I know of a surviving sibling who drives over one hundred miles roundtrip to see her Vet Center counselor for bereavement counseling support and across a state line because that is the closest location to her home. In addition, the prioritization given to deployed or combat veterans limits the support available at the Vet Centers for the non-combat veterans in crisis who may also need access to care.

Unfortunately, staff turnovers at the Vet Centers have often impacted peer-based support programs, like veteran support groups and support groups for their families. A family of a veteran who died by suicide shared with TAPS that the veteran was in despair after his peer-based support group at the Vet Center stopped meeting because the Vet Center did not have anyone on staff to run it. “I miss going to my group,” is what the veteran said to his family. His family was also missing the peer support they found at the Vet Center in a support group that was structured for their needs. Sadly, the veteran died by suicide.

Because peer support can play such an important role in helping veterans we need to look at other ways it can be offered. Much synergy and better service could be provided by VA Vet Centers if there was a direct connection between the VA Vet Centers with a veteran peer support line such as Vets4Warriors where Vets4Warriors could bridge the gap in capacity (before and between appointments) and geographic access.

Vets4Warriors, funded by the Department of Defense as a 24/7 Veteran peer support help line, has fielded more than 55,000 incoming and outgoing calls, chats and emails since Dec 2011. The majority of callers, more than 63%, are routine callers who are looking to connect with another veteran and get information about VA benefits and entitlements or employment/financial/legal/counseling resources. They are not in crisis and can benefit from peer-based support. All callers receive follow up calls if they give permission. Vets4Warrriors has also made initial calls to the soldiers in the Individual Ready Reserve (IRR) with great success (70% of those contacted wanted follow up).

Vets4Warriors has an established, formal referral relationship with the National Veterans Crisis Line (NVCL) where warm transfers are made for the small (less than 2%) number of callers in crisis. The partnership between the NVCL and Vets4Warriors has yielded benefits for the veterans utilizing both call lines in that the NVCL transfers all non-crisis or non-emergent callers that just want to connect with a veteran peer. Additionally, Vets4Warriors has a unique capability, because of the follow up provided to callers to further support the NVCL with follow up calls to those veterans who only called the NVCL and were at risk.

Many other amazing non-profit organizations have also emerged to fill these gaps in service. One such organization is “Give an Hour.” This organization, founded by Dr. Barbara Van Dahlan, provides free mental health care services to US military personnel and families affected by the current conflicts in Iraq and Afghanistan.

II. Recommendations for Improvement

(1) Provide continued funding for peer-based support programs to assist veterans through organizations such as Vet4Warriors and through the VA Vet Centers.

(2) Create incentive systems within the VA and the Vet Centers to encourage peer-support program managers and counseling staff, especially those who are veterans, to continue working at the VA and in the Vet Center.

(3) Assign an advocate at first contact, preferably a peer, to provide support to the veteran and help navigate the system while waiting for the first appointment.

(4) Decrease the amount of paperwork and "red tape" involved in getting veterans to their first mental health appointment.

(5) Create and implement a national public awareness campaign to support VA and Vet Center mental health staff recruitment focused on the rewards of working with veterans and issue a call to national service for mental health workers.

(6) Create and implement a national public awareness campaign that emphasizes the messages that veterans who are struggling can get help and that treatment can work. Suicide is not inevitable.

Thank you for the opportunity to submit this testimony on behalf of the Tragedy Assistance Program for Survivors (TAPS).

Curriculum Vitae – Kimberly Ruocco

Kim Ruocco has been a social worker for over twenty-five years providing mental health services in various settings both in the military and civilian communities.

Her husband, U.S. Marine Major John Ruocco, was a decorated Cobra gunship pilot and the father of their two sons. In 2005, Major Ruocco returned from a combat tour in Iraq and ten weeks later was preparing for a second tour of duty in Iraq when he lost his life to suicide.

Ms. Ruocco is currently the director for suicide postvention programs and survivor support at the Tragedy Assistance Program for Survivors (TAPS). In this capacity, with professional skill and personal dedication, Ms.Ruocco provides suicide prevention and postvention programs to military families and personnel throughout the country.

She has shared her story with the public, military audiences and veteran audiences, in order to inform prevention efforts, raise awareness about mental health, and help save lives. Ms. Ruocco shared her story with the congressionally-mandated Department of Defense Task Force on the Prevention of Suicide in the Armed Forces in 2009, and assisted a number of other families grieving deaths by suicide in stepping forward to share their stories to inform prevention efforts. The report issued by the task force in 2010 informs and underpins the Department of Defense's current suicide prevention program, and led to the creation of the Defense Suicide Prevention Office.

Ms. Ruocco has also worked collaboratively with the Department of Defense and the VA to improve mental health care access, educate others, and save lives. She has organized panels annually featuring suicide survivors sharing their stories to inform prevention efforts for the annual DoD/VA Joint Suicide Prevention Conference. She has spoken at dozens of military bases for audiences to encourage help-seeking and supporting mental health awareness. She has worked with the Marine Corps and the Army on development of prevention training videos using survivor stories.

Ms. Ruocco holds a master's degree in Clinical Social Work from Boston University and a bachelor's degree from the University of Massachusetts at Amherst.

Ms, Ruocco has completed the Psychological autopsy certificate training with the American Association of Suicidology (AAS). She will be working closely with AAS to provide psychological autopsies on U.S. Marines who die by suicide for the Department of Defense.

Ms. Ruocco and her two children are featured in the Sesame Street video "How Families Grieve" which is distributed throughout the United States and internationally to newly bereaved families.