Special Operations Association of America

December 13, 2024

Statement for the Record
House Committee on Veterans Affairs
Subcommittee on Health

House Committee on Veterans Affairs
360 Cannon Office Building
Washington, D.C., 20515

The Special Operations Association of America (SOAA) is a 501c19 Veteran Service Organization (VSO) located in Washington, D.C. that advocates for Special Operations Forces (SOF) and their families; commissions research on issues that affect SOF members; and cultivates an engaged community of Active Duty and Veteran SOF and their families.

SOAA's mission is to provide sustained advocacy and research, education initiatives, and community building to ensure the success of the SOF community and their families.

Executive Director, David Cook

David Cook is the Executive Director of the Special Operations Association of America (SOAA). David spent a decade in the United States Army leading both conventional and special operations teams at home and abroad. In addition, David went to serve his country in a wholly different way, working for a Member of Congress focused on national security issues for more than a year. After leaving Congress, David developed strategy and policy for the Army Open-Source Intelligence Office and the Defense Intelligence Agency. David is now the Director of National Security for ShadowDragon, an ethical OSINT company.

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Dear Chairwoman Miller-Meeks and Ranking Member Brownley,

On behalf of our members of the Special Operations community and their families, we thank you for this opportunity to provide a statement for the record regarding MISSION Act access standards and the utilization of community care with respect to rehabilitative programs for the treatment of substance use disorders and mental health emergencies. These conditions are high-risk comorbidities to death by suicide and present with acute need for treatment, either through Department of Veterans Affairs programs or from trusted Community Care Network providers.

A recent study[1] commissioned by US Special Operations Command (USSOCOM), and conducted by the American Association of Suicidology, found that suicide rates among US Special Operations Forces are the highest in the military, being about 30% higher than conventional US forces. This study discussed the aggregate findings from 29 psychological autopsies of SOF members who died by suicide over a three-year period between 2012 to 2015, with the intent of improving our understanding of SOF deaths by suicide by researching risk factors and warning signs.

The study indicates traumatic brain injury (TBI), untreated emotional trauma, substance use disorders (SUD), and mental health disorders such as anxiety, depression, or Post-Traumatic Stress (PTS), as high-risk comorbidities to death by suicide among SOF members. Those autopsied masked these conditions, as many veterans do, due to stigma and that such conditions often required residential rehabilitative treatment programs (RRTP). Swift access to such programs, and de-stigmatization of such conditions, is imperative to saving the lives of SOF veterans at risk of death by suicide, and it is the duty of the Department of Veterans Affairs (VA) to provide these veterans timely treatment with their earned benefits.

Sadly, in many regions, the Department fails to provide life-saving RRTP to veterans due to internal policy demands and the lack of codified standards to enforce accountability to VA healthcare providers. Until October 2022, SOAA operated under the assumption that VA's mental health care in a residential/domiciliary setting - which includes SUD treatment - in what VA calls MH RRTP or the MH Residential Rehabilitation Treatment Program, was covered by the access standard authorities in the 2018 MISSION Act for travel distance and wait times. It was only through working with veterans in need of treatment that we discovered this law does not apply to MH RRTP access standards and practices, and that these programs were dictated by policy, VHA Directive #1162.

This VHA Directive #1162 requires that VA admit a Veteran seeking inpatient, residential care within 72 hours for priority patients and no more than 30 days after a VA assessment of any patient needing residential care. In practice, however, it is not unusual for veterans to wait beyond 72 hours or 30 days for care. In some cases, even after those limits are exceeded, a facility has exercised the latitude to continue to seek an available bed in another facility within the Veteran Integrated Service Network, sometimes a several states distance for the veteran, rather than approve a referral to a Community provider in the Community Care Network (CCN), which are often immediately available.

In some interactions with VA administrators at local facilities, our team has found that a veteran's VA primary care provider approved a referral to a CCN provider, but that the referral is overruled by administrative or senior clinical staff. There have also been some cases where veterans have been told by

[1]https://www.socom.mil/FOIA/Documents/Psychological%20Autopsy%20Study%20of%20Suicides%20among%20United%20States%20Special%20Operations%20Forces.pdf

an administrator that Community Care is not offered for residential treatment or where the VA administrative staff do not understand Community Care is a lawful option and are unfamiliar with how a referral is generated. In some cases, we have learned that VA staff did not discuss CCN care options with a veteran without prompting or until a caseworker inquires of a VA administrator or patient advocate.

HR 10267, "Complete the MISSION Act," would address these gaps in critical care for veterans and restore veterans' trust in the VA, that their earned benefits are in the hands of an institution with their best interest in mind. This legislation fulfills the spirit and intent of the MISSION Act while providing much needed codified standards for accessing care through the VA for veterans struggling with acute mental health or substance use conditions. VHA Direction #1162 has proven to be an insufficient guideline for or guardrail of VHA behavior, which has consistently demonstrated an aversion of CCN providers in favor of VA-only care, even at the cost of veteran lives.

The Special Operations Association of America is thankful for this opportunity to provide statements for the record regarding such a critical area of needed improvement in VHA policy. We welcome the opportunity to speak at greater length with your offices and staff, and look forward to supporting this critical legislation moving forward.

David Cook
Executive Director
Special Operations Association of America