CENTERSTONE

May 9, 2016

The Honorable Jeff Miller
Chairman
House Committee on Veteran's Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Miller,

Centerstone Military Services (CMS) applauds the House Committee on Veterans Affairs for its efforts to support the United States Department of Veterans Affairs (VA) reduce suicide among our veterans. CMS is working zealously towards a future where all veterans will have convenient access to a wide range of high quality suicide prevention and treatment resources. CMS stands ready to offer clinical best practice methodologies, lessons from experience, and syntheses of research regarding suicide prevention and treatment models in the hopes of reducing our veteran suicide rates. Therefore, we welcome this invitation to address the Committee directly with our assessments of the most significant barriers to care and provide recommendations about how best to design a robust model of care for our at risk veterans. We are enthusiastic about Secretary Robert McDonald's leadership and hopeful that more progress can be made under his direction.

Undisputedly, the VA has long been aware of and concerned about veterans who die by suicide. To serve this population, the VA offers Veterans Crisis Line services, evaluations, assessments, appointments, and mobile phone resources. Additionally, the VA partners with community groups to provide care, and offers community providers an online toolkit with suicide prevention and treatment resources.[1] The VA also runs numerous specialized mental illness research, education and clinical centers (MIRECC), including the Center for Excellence for Suicide Prevention (VISN2), located in Canandaigua, N.Y.[2, 3] In the last ten years, Congress passed several key pieces of legislation to help increase the VA's access to mental health professionals, engage veterans, and create pathways like VA Choices for community providers to participate and meet demand. While the VA spearheaded efforts to bring clinical care to local communities, share knowledge with prestigious universities, lessen the stigma of mental illness, and understand the causation of suicide, numerous barriers still exist in getting excellent, prompt care to those at risk.

Tackling veteran suicide is one of the most complex challenges that the VA faces.[4] During 2012-2014, suicide was ranked the 10th leading cause of death in the nation, accounting for approximately 1.6% of deaths.[5, 6] Among active military service members and veterans, however, suicide is a much more common cause of death.[7] Military service can have momentous physical and psychological impacts, so

[1] http://www.mentalhealth.va.gov/communityproviders/partner_resources.asp
[2] http://www.mirecc.va.gov
[3] http://www.mirecc.va.gov/suicideprevention/
[4] Ramchand, Rajeev, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox and Christopher G. Pernin. The War Within: Preventing Suicide in the U.S. Military. Santa Monica, CA: RAND Corporation, 2011. http://www.rand.org/pubs/monographs/MG953.html. Also available in print form.
[5] Xu J, Murphy SL, Kochanek KD., & Bastian BA. (2016, Feb 16). Deaths: Final Data for 2013. *National Vital Statistics Reports.* 64(2) Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf
[6] Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2015). *U.S.A. suicide 2014: Official final data.* Washington, DC: American Association of Suicidology, dated December 22, 2015, downloaded from http://www.suicidology.org.
[7] https://www.afhsc.mil/documents/pubs/msmrs/2014/v21_n10.pdf#Page=14

even the healthiest recruits can become significantly more vulnerable to suicide compared to the general population.[8, 9] Tragically, even though suicide prevention efforts are now stronger than ever before, veteran suicide rates have recently increased.[10] Emerging research suggests that for every person who dies by suicide, as many as 115 individuals (e.g., family, friends, and community acquaintances) suffer the negative impacts.[11] Thus, more than one million individuals are directly or indirectly touched by suicide each year. Nevertheless, in the face of these daunting statistics, we believe effective suicide prevention for our veterans is possible.

To prevent a suicide, a comprehensive and systemic approach to treatment is needed. Without a systematic approach to mental health care, veterans are likely to fall through the cracks of the misfit puzzle pieces. Specifically, veterans need individualized treatment to reduce the impact of imminent risk factors for suicide (e.g., lack of belonging, perceived burdensomeness, symptoms of mental illness), and bolster the impact of protective factors (e.g., family, friends). In addition to quality content of treatment, timely access to treatment is associated with reduced suicide rates.[12] A powerful way to limit the effects of suicide risk factors is to ensure that veterans can access evidence-based treatments for (any of) their mental health disorder(s) (e.g., major depressive disorder, post-traumatic stress disorder) quickly. Of course, this is especially crucial when individuals are experiencing suicidal thoughts or preparatory behaviors. The demanding task we face, therefore, is to translate the newest research about effective suicide prevention and suicide treatment into clinical practice methods that can be implemented nationwide.

It has been possible for community mental health agencies, like Centerstone and Detroit's Henry Ford Hospital system, for example, to achieve a zero suicide rate for several consecutive months while serving tens of thousands of patients. Accordingly, we believe our country's VA hospitals can achieve the same. We recommend that the VA consider adopting a Zero Suicide Approach.[13] This approach has seven components:

1) Culture
2) Systematic Screenings
3) Timely suicide clinical pathway care
4) Trained workforce
5) Evidence based care
6) Continuing care
7) Data-driven quality improvement approach

1. Culture

As Peter Drucker said, "Culture eats strategy for lunch."[14] A healthcare provider can have a strategy to reduce veteran suicides, but that strategy will not be effective if the organization the veteran interfaces

[8] Kaplan, M. S., McFarland, B. H., & Huguet, N. (2009). Firearm suicide among veterans in the general population: findings from the national violent death reporting system. *Journal of Trauma and Acute Care Surgery*, *67*(3), 503-507.
[9] DoD Directive 6130.4, "Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces," April 2, 2004, retrieved from http://biotech.law.lsu.edu/blaw/dodd/corres/pdf/i61304_040204/i61304p.pdf
[10] Nock, M. K., Stein, M. B., Heeringa, S. G., Ursano, R. J., Colpe, L. J., Fullerton, C. S., ... & Zaslavsky, A. M. (2014). Prevalence and correlates of suicidal behavior among soldiers: results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA psychiatry*,*71*(5), 514-522.
[11] Cerel, J. (2015, April 18). *We are all connected in suicidology: The continuum of "survivorship."* Plenary presentation at the 48th annual conference of the American Association of Suicidology, Atlanta GA. [data from Cerel, Brown, Maple, Bush, van de Venne, Moore, & Flaherty, in progress]
[12] http://www.adaa.org/understanding-anxiety/suicide
[13] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC.
[14] Eaton, D. (2015). Making the shift: leading first with who we are, not what we do. *People+ Strategy*, *38*(3), 2-5.

with does not have a proactive, Zero Suicide culture. A Zero Suicide culture needs to be a "leadership-driven, safety-oriented culture that commits to dramatically reducing suicide among people under care and includes suicide attempt and loss survivors in leadership and planning roles."[15]

Gatekeepers and clinicians who believe that suicide is preventable are far more effective than those who have attitudes of suicide inevitability.[16] However, due to vicarious trauma, burnout, and compassion fatigue, well-meaning mental health staff can inadvertently support a culture of thinking suicide is inevitable. Hiring clinicians who believe suicide is preventable and have a high degree of activation is key. Additionally, a positive work environment that providers annual trainings to support clinicians in maintaining a Zero Suicide culture is important. If it is not already occurring, we suggest that the VA screen all mental health professionals for a zero suicide orientation before hire, screen regularly for compassion fatigue and vicarious trauma among their workforce, and train all of their staff on aspects of a Zero Suicide culture.

2. Systematic Screenings

The second step of the Zero suicide framework requires providers to be "systematically identifying and assessing suicide risk levels among people at risk."[17] In order to identify persons at risk of suicide, system-wide, systematic screenings are key. As the VA knows, veterans seeking treatment for psychological problems often turn to their primary care physician (PCP). This is similar to the non-veteran population where the PCP is a primary gatekeeper for suicide prevention. Ensuring that PCPs engage veterans in mental health screens that include a suicide risk assessment (e.g. the Columbia Suicide Severity Rating Scale) is a powerful step to ensure that all at-risk individuals are identified. For persons at higher risk of suicide due to a particular diagnosis like depression, we recommend using a treat to target tool like depression in every session. If depression levels increase, complimenting this tool with a more thorough suicide risk scale like the Columbia Suicide Severity Rating Scale is recommended.

While most people who kill themselves engage with a healthcare gatekeeper like a primary care physician (PCP) in the 3 months before their death, sadly, at least 66% of people who die by suicide never receive care for their suicidal symptoms.[18] As the VA looks at its screenings, we encourage them to evaluate their current system to ensure that their screenings address these three aspects of suicidality:[19]

1) **Signs of perceived burdensomeness**. Individuals with perceived burdensomeness believe that their death would be worth more than their life to the people in their lives. They are at a higher risk of suicide if a veteran believes that their death would provide relief to their spouse or children and that they are a burden to their loved ones.
2) **Thwarted belongingness**. Individuals with thwarted belongingness are isolated from social groups or have shrinking social networks. Veterans who had a strong sense of mission and

[15] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC
[16] Burnette C, Ramchand R, Ayer L. (2015). *Gatekeeper Training for Suicide Prevention: A Theoretical Model & Review of the Empirical Literature.* Santa Monica, CA: RAND Corporation. Retrieved on May 6, 2016 from http://www.rand.org/pubs/research_reports/RR1002.html.
[17] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC
[18] Covington, D., Hogan, M., Abreu, J., Berman, A., Breux, P., Coffey, E., ... & Dixon, H. (2011). Suicide care in systems framework. *National Action Alliance: Clinical Care & Intervention Task Force.[Retrieved January 9, 2013]*.
[19] Joiner, TE, Van Orden KA, Witte TK, Rudd DM. (2009). *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients.* Washington, DC: American Psychological Association.

belonging while in active duty often experience thwarted belongingness when they retire. Veterans that had to move repeatedly from base to base or have a history of multiple deployments often did not have the privilege of being able to set up resilient social groups and social networks outside of their military community.

3) **Acquired capability of suicide**.[20] Individuals with an acquired capability of suicide are typically those who practiced building up the courage to die, have a high pain threshold, are comfortable around violence, or are comfortable with death. Veterans have a high degree of courage, and they are more comfortable around violence and death than non-veterans.

As suggested by Dr. Thomas Joiner's Interpersonal Theory of Suicide,[21] veterans are a population that, if they have suicidal thoughts that develop into a true desire to die, may be more *able* to die than the general population. Thus, restriction to lethal means of suicide is an important aspect of suicide prevention among Veterans.

We also recommend that persons identified as suicidal have a conversation with their gatekeeper regarding firearms. A 2002 study of past suicides found that approximately 57%, and therefore a large majority of suicides, occurred by firearm.[22] Additionally, veterans are 1.3 to 1.6 times more likely to use firearms to kill themselves compared to the general population.[23]

3. Timely Suicide Clinical Pathway Care

The third step in the Zero Suicide protocol requires that providers work at "ensuring every person has a pathway to care that is both timely and adequate to meet their needs." [24] One of the things that Centerstone, as a direct provider of behavioral health services, finds helpful for our suicide prevention efforts is adopting a specialized Zero Suicide clinical pathway for suicide prevention. If the VA has not already implemented a system-wide Zero Suicide clinical pathway, we encourage them to do so.

Effective suicide prevention is a collaborative effort wherein a suicide prevention culture must be baked into the entire system, rather than being a disparate specialty.[25, 26, 27] While most organizations have protocols related to suicidality, research suggests that some of the current commonly used clinical care standards, such as hospitalization for suicidal ideation or preparatory behaviors, may exacerbate, rather than alleviate, the problem. In fact, the 24-hours after hospitalization for suicide risk is considered a critical period of risk.[28]

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[20] Anestis, M. D., & Joiner, T. E. (2011). Examining the role of emotion in suicidality: Negative urgency as an amplifier of the relationship between components of the interpersonal–psychological theory of suicidal behavior and lifetime number of suicide attempts. *Journal of affective disorders*, *129*(1), 261-269.

[21] Joiner, T. E. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.

[22] Romero, M. P., & Wintemute, G. J. (2002). The epidemiology of firearm suicide in the United States. *Journal of Urban Health*, *79*(1), 39-48.

[23] Kaplan, M. S., McFarland, B. H., & Huguet, N. (2009). Firearm suicide among veterans in the general population: findings from the national violent death reporting system. *Journal of Trauma and Acute Care Surgery*, *67*(3), 503-507.

[24] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC

[25] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.* Washington, DC: HHS, September 2012. Retrieved from: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf

[26] http://www.sprc.org/sites/sprc.org/files/library/phasp.pdf

[27] http://www.sprc.org/basics/about-suicide-prevention/comprehensive

[28] See: Geddes & Juszczak, 1995; Geddes, Juszczak, O'Brien & Kendrick, 1997; Goldacre, Seagrott, & Hawton, 1993; Ho, 2003; Lawrence et al., 2001; Troister et al., 2008; Yim et al., 2004.

Ideally, an organization's Zero Suicide clinical pathway includes collaboration with other providers (i.e. law enforcement, other health care providers). To make sure this collaboration runs smoothly, a consistent zero suicide clinical pathway designed with clear protocols, standards, and communication avenues needs dissemination.[29]

The Zero Suicide clinical pathway is the model Centerstone has adopted. We and other providers find it very effective in treating suicidal patients. As the CEO of Cedars Sinai Medical Center explains, "When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent, may not materialize. It's about purposefully aiming for a higher level of performance."[30] Therefore, we believe it is important for the VA to embrace the aspirational goal of zero suicides. The Zero Suicide clinical pathway requires organizational change and commitment to the following:

1) Leadership and staff need to believe that suicide is preventable so that they act in ways that reflect this belief.
2) Veterans in crisis need timely access to services – often same day service.
3) Clinicians need to be trained in best practice therapies.
4) Physical and behavioral health care providers need to communicate openly and work cooperatively in order to refer patients from one clinician to another without allowing patients to go without care during their treatment journey.[31]
5) There needs to be continuous transparent collection and communication of data and outcomes in order to assess the effectiveness of therapies and, moreover, improve therapies going forward.

The Zero Suicide clinical pathway is helpful to Centerstone in furthering our efforts to prevent suicides. We provided consultation to other organizations seeking to implement this model, including the U.S. Air Force and Kaiser Permanente. However, we are aware there might be an even more effective way to reduce suicides. We believe the VA is in a good position to incentivize interested and knowledgeable groups to draft even more detailed suicide prevention assessment and treatment protocols.

4. Trained Workforce

The fourth step in adopting a Zero Suicide clinical care model is "developing a competent, confident, and caring workforce." [32] There are two factors that are currently huge barriers in organization's achieving this workforce:

1) The mental health professional shortage; and
2) Insufficient behavioral health professional training

Mental Health Professional Shortage

As we all know, the current network of VA providers cannot meet the high demand. This has led to many VA's limiting the number of mental health services they provide veterans, and some, like the VA in Clarksville, TN, to no longer accept new patients.[33] The VA is well aware of the supply and demand disparity, and has taken steps to expand their network. The Veterans Choice Program (VCP), for

[29] Ibid.
[30] http://www.jointcommission.org/assets/1/18/ma13_feature1_reprint.pdf
[31] Covington, D., Hogan, M., Abreu, J., Berman, A., Breux, P., Coffey, E., ... & Dixon, H. (2011). Suicide care in systems framework. *National Action Alliance: Clinical Care & Intervention Task Force.[Retrieved January 9, 2013]*.
[32] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC
[33] http://www.npr.org/2016/04/22/474388101/overcrowding-forces-tennessee-va-clinic-to-stop-accepting-new-patients

instance, gives veterans on the waitlist for more than 30 days, the opportunity to seek services with outside VA providers.[34]

We encourage the VA to continue this trend and increase the number of viable external mental health providers it partners with in order to bring faster, good quality, and diversified care to veteran populations the VA is unable to treat. To identify such organizations or non-profits, we recommend that the VA evaluate 1) the organization's suicide prevention clinical pathway, and 2) the organization's ability to provide personalized care for the veteran.

We also encourage the VA to look at funding services provided by other professionals in the mental health workforce who are not therapists. We believe life skills and recovery coaching services are a wonderful adjunct to therapy for persons at risk of suicide. Increasing connectedness, belongingness, and reducing the sense that you are a burden can sometimes happen more quickly by knocking on the veteran's door to check in, helping the veteran receive a service animal, teaching the veteran how to reach out via social media to his old unit, or providing behavioral activation support for the veteran to start being physically active again. While Medicaid funds mental health case managers, recovery coaches and peer specialists to provide these life skills and rehabilitation services in some states, we are not aware of it currently being funded by the VA Choices program. Peer support specialists, bachelors level case managers, and other members of the mental health workforce can help fill gaps in the safety net for veterans at risk.

Insufficient Mental Health Professional Training

We believe the VA has a platform that can be effective for the promotion of evidence-based suicide prevention training and evidence-based therapies addressing suicidality as core competencies for mental health professional graduate training programs. We find many clinicians coming to Centerstone without these trainings. We have to supplement their training in order to ensure these clinicians have adequate suicide prevention skills. Currently, only a fraction of licensed clinicians feel professional training programs adequately prepared them to recognize and treat clients at risk for suicide.[35] Those who are interested in gaining suicide prevention skills now independently pursue accreditation (the American Association of Suicidology provides links to courses on their website).[36] Unfortunately, this reality suggests even those who are seeking treatment and presenting with symptoms of suicidal ideation are not enthusiastically embraced by the system and, as a result, are not receiving the critical services they need. If our aim is excellent care and not simply adequate care, then practitioner training is a key area of concern.

However, this void also presents the opportunity for significant progress. As briefly mentioned above, the VA now leads multiple specialized mental health centers for excellence, including one specifically devoted to suicide prevention. The VA could lead programs to disseminate their knowledge by hosting professional panels to speak to large interested audiences about current research, offering robust internship programs to those in school, or being creative about spreading their knowledge. Any steps to transform suicide prevention from a narrow specialty to a routine practice may benefit the care provided.

[34] http://hospitals.unm.edu/vapc3/choice.shtml
[35] http://www.suicidology.org/training-accreditation/rrsr
[36] http://www.suicidology.org/training-accreditation/school-suicide-prevention-accreditation

5. Evidence-Based Care

The fifth component of the Zero Suicide clinical model requires the organization to use "effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality." [37] It is important veterans identified as at risk for suicide receive efficacious care. Some therapies show positive results for suicidal patients, but many lack evidence of their usefulness for preventing suicidality. The following are several modern evidence-based practices that effectively lowered suicide rates. All of these therapies are researched at a dosage (at least once weekly) that is powerful enough to be impactful. There is no research we are aware of showing effective suicide prevention occurring only through once-a-month therapy visits. That is, contact in care should be weekly at a minimum.

Cognitive Behavioral Therapy (CBT) is a broad category of face-to-face therapy. CBT has six outlined objectives and employs a 3-phase model to help bring patients out of suicide mode. The objectives of CBT are to provide psychoeducation, reduce suicide risk factors, enhance effective coping, minimize social isolation, increase medical adherence, and plan for safety.[38] In Phase I, the patient tells the story of his/her most recent suicide episode; in Phase II, the clinician helps the patient build skills to manage risky thoughts and emotions; in Phase III, the clinician guides the patient through a relapse prevention exercise.[39] CBT methods have reportedly reduced the likelihood of repeated suicide attempts in approximately 50% of patients after only an average of 9 hours of therapy.[40]

Dialectical Behavioral Therapy (DBT) is a specific form of CBT developed in the 1980s. Similarly to CBT, the focus of DBT is to help individuals build and practice skills that will help them identify thoughts and belief systems that make their life harder. DBT teaches patients to manage their emotional trauma rather than simply taking them out of crisis mode, and employs both weekly individual therapy sessions and longer group therapy sessions.[41]

The **Collaborative Assessment and Management of Suicidality (CAMS)** model is an intensive outpatient care system relying on an interactive approach to suicide risk assessment enabling the patient to identify the triggers to their suicidal state.[42] A 2005 study comparing a small number of CAMS patients to generally-treated suicidal patients revealed that CAMS patients reached complete resolution of suicidality 4-6 weeks earlier than under usual care.[43]

The **Attempted Suicide Short Intervention Program (ASSIP)** model is a newer evidence based treatment. There was excellent research published this year supporting this short-term intervention for persons who have attempted suicide.[44, 45]

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[37] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC
[38] Ghahramanlou-Holloway, M., Neely, L. L., & Tucker, J. (2014). A cognitive behavioral strategy for preventing suicide. *Curr Psychiatr*, *13*(8), 18-28.
[39] Ibid.
[40] Ibid.
[41] http://psychcentral.com/lib/an-overview-of-dialectical-behavior-therapy/
[42] Jobes, D. A., Wong, S. A., Conrad, A. K., Drozd, J. F., & Neal-Walden, T. (2005). The collaborative assessment and management of suicidality versus treatment as usual: A retrospective study with suicidal outpatients. *Suicide and Life-Threatening Behavior*, *35*(5), 483-497.
[43] Ibid.
[44] Heisel MJ, Duberstein PR, Talbot NL, King DA, & Tu XM. (2010). Adapting Interpersonal Psychotherapy for Older Adults at Risk for Suicide: Preliminary Findings. Prof Psychol Res Pr. 40(2): 156-164. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2889497/
[45] ASSIP, Attempted Suicide Short Intervention Program. https://clinicaltrials.gov/ct2/show/NCT02505373

We recommend that the VA use these clinician-endorsed and evidence-based models. Additional research is needed to develop and adapt therapeutic approaches that directly target suicidal thoughts. Many evidence-based approaches could be modified to more specifically target suicidal thoughts and behaviors.

6. Continuing Care

The 6th standard for the Zero Suicide Clinical Model has organizations provide "continuing contact and support, especially after acute care." [46] We strongly agree prompt access to comprehensive, local personalized care is essential to helping persons with mental illness and suicidality thrive. As a national provider of suicide prevention services (NFL Lifeline & National Suicide Prevention Lifeline) and, moreover, as a provider of behavioral health care to approximately 150,000 people with serious mental illness, we find we need to be available 24/7/365.

Many of the veterans we see are fortunate because they have a caregiver. Most are spouses, and some are parents who have dedicated themselves to the care and welfare of their veteran. These caregivers enable these veterans to have a home, to have their medications regulated and act as the first line of defense in the battle against suicide. Their mental health and wellbeing, as well as their knowledge of their veteran must be taken into consideration. Centerstone Military Services, through their online support services offered under Courage Beyond provide a place for the caregiver to access support and often leads to the veteran accepting the counseling help they need. Without care from the caregivers, veterans' homes would not be the safe spaces they need.

In designing our Centerstone suicide prevention model, we asked our clients at risk of suicide and their loved ones for input. They were very clear about what they did not want. For example, when seeking treatment for suicidal thoughts and behaviors they did not want to be put on hold. They did not want to wait seven days for an appointment when in crisis. They did not want or could not drive an hour to see someone. They did not want to be funneled into a "one size-fits-all" door for care. If they missed an appointment because they were too depressed to leave the house, they wanted a caring check-in from a human being at the other end – not an impersonal letter with a scolding.

Knowing these wants helped us design a system aspiring to address these issues. We provide multiple doors for persons to access care – from our Courage Beyond Facebook groups to traditional individual psychotherapy care provided by the Centerstone Military Services national provider network. Centerstone provides crisis texting lines, crisis phone lines, secure online chat rooms, and, where funded, crisis walk-in clinics and mobile crisis staff that can meet clients wherever they are – on a bridge, at work, in a police station, or at home. For our Centerstone Military Services crisis counseling services, we have a commitment to not make a veteran in crisis drive more than 30 minutes to a therapy appointment. This means, in some states like Montana, our clinicians sometimes need to reach out to the client. This has been truly transformative, and our prompt, timely services to both the veteran and their loved ones were credited by the Tennessee National Guard in 2014 for helping them achieve a year of zero suicides after one of their worst years of suicides ever.

[46] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC

7. Data-Driven Quality Improvement Approach

The seventh and last Zero Suicide clinical model standard requires organizations to be "applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk." [47]

We know that the VA captured a huge amount of data related to mental health screenings and suicide prevention. We encourage the VA to transparently track data related to suicide prevention and to make public on the VA Compare website key performance indicators related to its hospital's efforts to prevent suicide. From our perspective, several outcomes we find to be important to make transparent are:

- The percentage of people screened for suicide. The federal standard is annually, but we advocate for more frequent screenings (i.e. monthly or every session) for persons at risk.
- The percentage of people who the screen identified as suicidal who received the suicide prevention pathway protocol.
- The percentage of people at risk for suicide who are seen at least weekly by a therapist.

We also strongly encourage the VA to consider implementing a standardized patient program to evaluate its suicide prevention system that uses veterans, peers, or third party external "secret shopper" auditors to ensure that:

- Screenings occur with the client present;
- The mental health provider gives the screenings conveying a sense of warmth, safety, and trust; and
- The therapy interventions being given are the actual evidence based treatments.

We also want to note that the VA is collecting extensive and meaningful data. This informations is a key component to building focused treatments for potentially suicidal populations because it can complement our understanding of suicidal populations and provide criterion to either keep or discard discrete treatment methods. According to the 2012 Suicide Data Report, "information gathered through NDI, state mortality records, Suicide Behavior Reports, Veterans Crisis Line, and the VA's universal electronic medical records have contributed to an increased understanding of suicide and risk management by identifying gaps in existing knowledge, opportunities for intervention and the impact of VA-sponsored suicide prevention programs."[48]

Also, since 9/11, many organizations make it their mission to offer care to active military service members, to veterans, and their families. Many of these organizations, like the Tragedy Assistance Program for Survivors (TAPS) and the Iraq & Afghanistan Veterans Association (IAVA), for instance, have gathered immense amounts of metrics the VA could utilize identifying interventions that would impact hard-to-reach veterans at risk of suicide that it is currently not actively engaging.

As a senior military officer having commanded soldiers at the brigade level and below, I believe this cooperative effort from the government, private and public sectors is essential to reaching a Zero Suicide goal. During my most recent command, I lost two soldiers to suicide resulting from PTSD. Like the refrain from many family member who lost service member loved ones to suicide, "if I knew then what I

[47] Grumet, JG. (ND) *What is Zero Suicide?* Suicide Prevention Resource Center: Washington, DC
[48] Kemp, J., & Bossarte, R. (2013). *Suicide data report: 2012*. Washington, DC: Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program.

know now about military related suicide," these service members would still be alive. This crusade should continue until all service members are truly home.

Thank you so very much for considering these suggestions. We very much appreciate your leadership in this matter, and we hope that it will lead to substantive improvements in the care for the thousands of Veterans in our great country at risk for suicide.

Sincerely,

Colonel Kent Crossley
Executive Director
Centerstone Military Services