TRAGIC TRENDS: SUICIDE PREVENTION AMONG VETERANS

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BEFORE THE

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CONTENTS

Monday, April 29, 2019

	Page
Tragic Trends: Suicide Prevention Among Veterans	1
OPENING STATEMENTS	
Honorable Mark Takano, Chairman	1
Prepared Statement	47
Honorable David P. Roe, Ranking Member	4
WITNESSES	
Dr. Shelli Avenevoli.Deputy Director, National Institutes of Mental Health, National Institutes of Health	5
Prepared Statement	49
Dr. Richard McKeon, Chief, Suicide Prevention Branch, Substance Abuse and Mental Health Services Administration	7
Prepared Statement	52
Dr. Richard Stone, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs	9
Prepared Statement	55
Accompanied by:	
Dr. Keita Franklin, National Director of Suicide Prevention, Department of Veterans Affairs	
STATEMENTS FOR THE RECORD	
American Veterans (AMVETS)	60
Disabled American Veterans (DAV)	67
Iraq and Afghanistan Veterans of America (IAVA)	71
The American Legion (TAL)	73
Vietnam Veterans of America (VVA)	77
Wounded Warrior Project (WWP)	78
Center for Disease Control (CDC)	86
Veterans of Foreign Wars (VWF)	88
The Independence Fund	91
QUESTIONS FOR THE RECORD	
Representative Lauren Underwood to National Institute of Mental Health (NIMH)	94
Representative Lauren Underwood to Dr. Richard Stone	95
Chairman Mark Takano to Veterans Affairs	97
Chairman Mark Takano Regarding the Public Health Model (Generally)	117
Representative Lauren Underwood to Veterans Affairs	122

TRAGIC TRENDS: SUICIDE PREVENTION AMONG VETERANS

Monday, April 29, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 7:15 p.m., in Room 1334, Longworth House Office Building, Hon. Mark Takano [Chairman of the Committee] presiding.

Present: Representatives Takano, Brownley, Rice, Lamb, Levin, Brindisi, Rose, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Sablan, Allred, Underwood, Roe, Bilirakis, Radewagen, Bost, Bergman, Banks, Barr, Meuser, Watkins, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good evening. I call this hearing to order.

First, I would like to welcome our witnesses this evening: Dr. Stone from the Veterans Health Administration, Dr. Avenevoli from the National Institutes of Health, Dr. McKeon from the Substance Abuse and Mental Health Services Administration.

Today's hearing will be the first of many this Committee will hold as it begins the critical work to address veteran suicide. I think we can all agree how important it is to take care of our veterans, which is why I have made ending veteran suicide my number one priority.

Sadly, America is facing a national public health crisis that demands urgency from Congress, the administration, medical and clinical professionals, veteran service organizations, and veterans themselves.

This morning we lost another veteran to suicide at a VA hospital. Two weeks ago, three veterans committed suicide on VA property in just 5 days. Seven veterans have ended their lives on VA campuses this year.

It is clear we are not doing enough to support veterans in crisis. While these incidents may be alarming, they do not tell the full story of veteran suicide in our country. It is harmful to veterans and overly simplistic solely to blame VA for these tragedies. We must come together as a Nation to address this crisis.

Too many Americans have been personally touched by this troubling trend. For me, it was my own uncle, a Vietnam veteran, who died by suicide. I still remember the day that I came home in September when I was 10 years old to find out that my Uncle Sabato (ph), a Vietnam war veteran, had taken his own life, and he lived

across the street from my own family. His suicide still haunts me from time to time to this day.

Each day, 20 veterans, servicemembers, reservists, and members of the National Guard die by suicide. One veteran lost to suicide is one too many, but 20 deaths a day, totaling more than 7,300 deaths per year, is unacceptable.

To put this in perspective, that is 1,800 more deaths per year than the 5,429 servicemembers who have been killed in action since 2001. Both numbers are surprising and further evidence of a frustrating and persistent problem that we fail to adequately address.

When you examine the statistics, barriers to access many veterans face become very clear. Only 6.1 of those deaths are veterans accessing services at VA, but 10.6 deaths a day are veterans not using the VA at all, and 3.8 current Active Duty or members of the National Guard are also committing suicide.

We all have a responsibility to act because there is no excuse for failing these veterans here at home. My Republican colleague, Ranking Member Roe, often says we haven't moved the needle far enough to reduce veteran suicide and he is right. That number has held steady at 20 deaths a day since 2014 for far too long. It is time for Congress to look at this crisis with fresh eyes.

In 2015, Congress passed the Clay Hunt Suicide Prevention for Americans Act, otherwise known as the SAV Act. But this well-intentioned effort hasn't done enough. Recently, I met with some members of Clay Hunt's unit who identified the specific challenges they faced as they transitioned out of the military.

We need to understand why this legislation hasn't done more to prevent suicides. We need to expand our understanding of mental health among veterans. We need to commit to providing the resources needed to implement a comprehensive plan.

Most importantly, Americans must hear from and listen to our veterans. We need to hear from veterans who have attempted suicide, understand their circumstances, and find out what they believe worked and what failed. These veterans have a story to share that can tell us something about our attempt to address suicide and how responsive government can be to their situation.

This Committee will not be indifferent to the problem's veterans face, nor will we turn a blind eye to the many causes that lead to veterans committing suicide, and I am glad that we could all come together today to begin to tackle this important issue. Ultimately, it is up to all of us to reduce and prevent veteran suicide because this is not a problem that VA can solve alone.

We know that dedicated doctors, nurses, and VA employees saved over 240 veterans from committing suicide on VA campuses in recent years. VA briefs me on each suicide at a VA facility, and there is still so much that we don't know.

We must involve partners at the Federal, State, and local levels and do a better job of supporting veterans in need regardless of whether that need is clinical or social.

By supporting clinically effective programs and increasing access to programs that mitigate the impact of concerns, be they financial, marital, substance abuse related, or physical health, veterans will feel the support they seek.

VA must also ensure that every interaction it has, not just in a clinical setting, makes veterans feel supported.

One example from VFW struck me when I was reading the statements for the record from the VSOs, and I quote:

The VFW is working with a veteran who was rushed to a VA hospital during a mental health crisis caused by untreated bipolar disorder and depression. The veteran was admitted to the medical center's inpatient medical health care clinic for 2 weeks, despite not being eligible for VA health care. The VA did save his life, but now he has a $20,000 bill. His mental health crisis was exacerbated by unemployment and his inability to provide for his family. With proper treatment, he has been able to return to work but still lacks the resources to pay the VA bill. The VFW is working on having his bill waived, but he will never return to VA if he has another mental health crisis," end quote.

Now, this is just one more testament to what we already know: When a veteran is faced with the sky-high cost of medical care, that can be a significant barrier to getting help, the help they need.

To really combat this crisis, we will have to change our mission. We must reexamine our approach to suicide prevention, exhaust our research possibilities, break the stigma faced by those seeking mental health services, and expand the health care and support we offer veterans.

Like all of those in this room, I believe Americans are ready to meet this challenge. Countering this crisis will require us to shine a national spotlight on veteran suicide, and there is still so much that we do not know. We need to better understand the root causes driving veteran suicide, hear from the families who have lost loved ones, and listen to the clinicians and social workers who are on the front lines battling to end veteran suicide.

As Americans, we are proud of the service and sacrifice that they have made for our country, but a "thank you for your service" isn't enough for our veterans in crisis. Instead, we must thank and honor our veterans with action, work together to deliver top quality health care, provide community support, and ensure we offer a stable transition out of military service and into quality, sustainable employment.

Truly, thanking veterans for their service means helping them when they need it most and to rise above political opportunism to support veterans in crisis. It is my hope that together we can curb this crisis.

Now, before I recognize Ranking Member Roe, I would like to point out that May is Mental Health Awareness Month, and we all have to do our part. I encourage every Member of this Committee to record a suicide prevention public service announcement to highlight VA's Be There campaign.

As the Wounded Warrior Project pointed out, quote, "If a treatment program does not offer a family or a caregiver component, and warriors go through clinical processes when they return home, it may leave the family or caregiver to feel left out, in the dark about what occurred," end quote.

We should all be doing all that we can to ensure family members and caregivers not only feel supported, but have access to much-needed resources as they help their loved ones recover.

In addition, I would encourage all of you to meet with both veterans who are suicide survivors and speak with families who have lost loved ones to suicide to better understand how we can work to end this crisis.

Now at this time I would like to recognize my friend and colleague, Dr. Roe, for 5 minutes for any opening remarks that he may have.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman, and thank you for holding this hearing tonight and also shining a light on veteran suicide.

Tonight's topic is the most important, most confounding, and the most heartbreaking one that we will discuss in this Committee.

While suicide is a tragedy no matter where it happens, it is particularly painful when it occurs on the grounds of a Department of Veterans Affairs medical facility with help mere feet away.

The last several weeks have seen four incidents of suicide on VA campuses, including one just today in Cleveland. My heart goes out to the surviving family members and friends of each of these veterans, and I want them to know that they are foremost on our minds here in this Congress. Their loved ones are a part of approximately 20 of our Nation's veterans, Active Duty servicemembers, and members of National Guard and Reserve who die by suicide each day.

That rate has remained largely the same since the 1990s despite two decades of sincere effort from administrations on both sides of the political spectrum and substantial increases in funding, staffing, programs, attention, and support for mental health care and suicide prevention inside and outside of the VA health care system.

Since 2005 alone, funding for VA mental health care has increased 258 percent to a high of $9.4 billion in the most recent request.

Unquestionably, too little progress has been made. Unquestionably, a business as usual approach to this crisis is not sufficient.

To be clear, the tragedy of suicide is a societal one that is in no way unique to VA or to veterans. Let me just give you an anecdotal description of why I know that is true.

In my State of Tennessee, when I graduated from medical school, we had Eastern State, Central State, and Western State mental hospitals. Those are all gone.

As I went across my district and held townhalls and roundtables this past 2 weeks, I met an EMT who told me that he worked in the ER on weekends. One weekend he had a man there who was in a room waiting for a bed in a mental hospital. He came back a week later, and the man was still in the emergency room.

For seniors, we have to transport people from Sullivan County, Tennessee—you don't know where that is—but to Memphis. And I can tell you, it is 500 miles away.

We do not have the mental health infrastructure not just for VA, but for our citizens in this country anymore, and it is something we are going to have to learn to deal with as a Nation. Of the 20 suicide deaths per day among our Nation's heroes, 14 have not received, as the Chairman said, VA health care in the 2 years pre-

ceding their deaths. This is a clear indication that VA alone cannot solve this crisis.

I commend President Trump for issuing two executive orders in the last 2 years to rally Federal, State, and local government agencies, as well as nongovernmental organizations, around this issue. I look forward to the hearing today about how those executive orders are working and how their impact will be measured moving forward.

I am also looking forward to delving into an important concept that Secretary Wilkie and his team, including Dr. Stone and Dr. Franklin who are both with us tonight, have been stressing recently, and that is that suicide is not exclusively a matter of mental health. It is quite a bit more complex than that, and solving it will require nothing less than harnessing the collective efforts of every community around in need long before the crisis point is reached.

Tonight's hearing would be incomplete if it didn't include a frank discussion about the role each one of us can play in our districts to stem the tragic tide of veteran suicide and about the deeper personal and societal issues, such as loss of purpose, belonging, and connection, that far too many Americans, not to mention veterans, are struggling with. Our goal should be more than just preventing suicide. It should be helping our veterans to live a life of meaning and joy.

I would like to also caution us all in having that discussion to resist narratives that paint veterans as victims, or a tragedy of suicide is insurmountable. We know from research and experience that treatment works and recovery is possible, and that is the principal message that I hope everyone takes home tonight with them.

I am grateful for all of our witnesses and audience members for being here this evening.

And I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Roe.

Again, appearing before us tonight is Dr. Shelli Avenevoli, and she is the Deputy Director of the National Institute of Mental Health; Dr. Richard McKeon, Chief, Suicide Prevention Branch of the Substance Abuse and Mental Health Services Administration; Dr. Richard Stone, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, and accompanied by Dr. Keita Franklin, National Director of Suicide Prevention, Department of Veterans Affairs.

And we will begin first with testimony from Dr. Avenevoli.

And, Dr. Avenevoli, you are recognized for 5 minutes to give your opening statement.

STATEMENT OF SHELLI AVENEVOLI

Ms. AVENEVOLI. Thank you. Good evening, Chairman Takano, Ranking Member Roe, and distinguished Members of the Committee. I am Dr. Shelli Avenevoli, the Deputy Director of the National Institute of Mental Health within the National Institutes of Health. It is an honor to appear before you today alongside my colleagues from SAMHSA and the VA.

Given the troubling rise in the national suicide rate in the past decades, suicide prevention research is an urgent priority for the

NIH. As the lead Federal agency for research on mental disorders, NIMH's portfolio includes projects aimed at identifying who is most at risk for suicide, understanding the causes of suicide risk, developing interventions, and testing the effectiveness of suicide prevention services in real world settings. In collaboration with our Federal and private partners, we work to translate these research findings into evidence-based practices.

Today I want to highlight research that has identified promising suicide prevention tools ripe for implementation within health care systems. When used effectively and in combination, these tools may increase the number of lives saved among veterans and among all Americans.

Healthcare settings are important for two reasons—access and opportunity. Nearly half of individuals who die by suicide had some type of medical visit in the 30 days prior to death, and around 80 percent did so in the year before death. In addition, about half of people who die by suicide had at least one emergency department visit in the year before death.

NIMH-funded research has identified a growing number of evidence-based suicide prevention tools that can be used right now in these health care settings. I would like to walk you through a scenario that showcases how the health care system, using some of these tools, can identify more people at risk for suicide, provide effective treatment, and ensure appropriate follow-up care.

So let's say you are depressed and feeling suicidal, but you haven't told anyone about these feelings. One day you have severe abdominal pain and you go to the emergency room. Your conversation with the doctor focuses on your physical pain, but because this emergency room screens all patients for suicide risk, the doctor asks you if you have had suicidal thoughts or attempted suicide.

Our funded research shows that screening all patients doubles the number of people we can identify who are in need of help for suicide risk.

So when you tell this doctor that you have been considering suicide, the doctor connects you with a social worker. The social worker asks questions to assess your level of risk, discusses treatment options with you, and works with you to develop a personalized safety plan. This safety plan describes approaches for reducing your access to lethal means, identifies specific coping strategies to decrease your risk, and lists people and resources that could help you in crisis.

Safety planning is an evidence-based intervention, and we are currently supporting research in the best ways to deliver this in various settings and populations.

As part of that safety plan, the social worker links you with a local crisis center that is part of the National Suicide Prevention Lifeline system. This crisis center works with your hospital to keep in contact with you by telephone over the next few months, a very high-risk time for suicide.

An NIMH-funded study has shown that this combination of screening, brief prevention, and follow-up contact reduced suicide attempts in the next year by about 30 percent.

A growing number of health care systems are implementing many of these evidence-based practices, but we know there is more

we can do. Through the National Action Alliance for Suicide Prevention, the NIMH, SAMHSA, CDC, VA, and other public and private partners are working towards a goal of zero suicide deaths in health care in which health systems implement these and other evidence-based practices. The zero-suicide framework includes comprehensive tracking of patient outcomes so we can monitor progress and identify additional ways to save lives.

Today I have highlighted just some of the suicide prevention tools our researchers have tested in the health care system. We are committed to working with our partners and stakeholders to ensure these evidence-based tools are implemented and accessible to all. Moving forward, we will continue to provide hope by supporting research to prevent suicide.

I want to thank the Committee again for bringing us together, and I am happy to address any questions you may have.

[THE PREPARED STATEMENT OF SHELLI AVENEVOLI APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Avenevoli.

Dr. McKeon, you are recognized for 5 minutes to give your opening statement.

STATEMENT OF RICHARD MCKEON

Mr. MCKEON. Thank you. Chairman Takano, Ranking Member Roe, Members of the Committee, thank you for inviting the Substance Abuse and Mental Health Services Administration to participate in this extremely important hearing on suicide prevention for America's veterans. I am Dr. Richard McKeon, Chief of the Suicide Prevention Branch at SAMHSA.

An American dies by suicide every 11.1 minutes. Suicide is the tenth-leading cause of death in the United States and the second-leading cause of death between ages 10 and 34. We lost over 47,000 Americans to suicide in 2017, almost the same number we lost to opioid overdoses. For each of these tragic deaths, there are grief-stricken families and friends, impacted workplaces and schools, and the diminishment of our communities.

SAMHSA's National Survey on Drug Use and Health has also shown that approximately 1.4 million American adults report attempting suicide each year, and over 10 million adults report seriously considering suicide.

As painful as these numbers are, our concern is intensified by the CDC's report that suicide has been increasing in 49 of the 50 States, with 25 of the States experiencing increases of more than 30 percent.

While Federal efforts to prevent suicide have been steadily increasing over time, thus far they have been insufficient to halt this tragic rise. We can only halt this rise nationally if we are also reducing suicide among the estimated 20 veterans a day who die by suicide, including those not in the care of the U.S. Department of Veterans Affairs.

All of us must be engaged in this effort, and for this reason, SAMHSA includes language in our suicide prevention funding opportunities prioritizing veterans and has worked actively with VA on suicide prevention since 2007.

While we have not as of yet been able to halt this tragic rise, we have seen that concerted, sustained, and coordinated efforts can save lives.

One area where such a concerted national effort has been made is youth suicide prevention. Cross-site evaluation of our Garrett Lee Smith Youth Suicide Prevention grants has shown that counties that were implementing grant-supported suicide prevention activities had fewer youth suicides and suicide attempts than matched counties that were not. However, this life-saving impacts fades 2 years after the activities have ended. This underscores the need to embed suicide prevention in the infrastructure of States and communities.

Congress has also provided SAMHSA $11 million to focus on adult suicide prevention, with $9 million appropriated to the Zero Suicide initiative.

This is an effort, as my colleague has expressed, to promote a systematic, evidence-based approach to suicide prevention and health care systems using the most recent findings from controlled scientific studies as part of a package of interventions that move suicide prevention from being a highly variable and inconsistently implemented individual clinical activity to a systemized and prioritized effort. It uses the most recent science on screening, risk assessment, safety planning, care protocols, and evidence-based treatment.

We have also been working through all of our suicide prevention grant programs to improve post-discharge follow-up since multiple studies have shown that rapid contact after discharge from EDs and in-patient units is a time of high risk.

The SAMHSA suicide prevention program that touches the greatest number of people is the National Suicide Prevention Lifeline, a network of 165 crisis centers across the country. The National Suicide Prevention Lifeline includes a special link to the Veterans Crisis Line, which is accessed by pressing 1. Last year, more than 2.2 million calls were answered through the lifeline, and that number has continued to grow at a rate of about 15 percent per year. However, the increasing call volume is also straining the lifeline system of community crisis centers which are responsible for responding to calls.

More recently, SAMHSA and VA have worked together to fund a series of mayor's challenges and governor's challenges to prevent suicide among all veterans, servicemembers, and their families. We have convened cities and States and policy academies and implementation academies to promote comprehensive suicide prevention for veterans. Multiple public and private partners are engaged in this effort.

As an example, in the Richmond Mayor's Challenge, the McGuire VA Medical Center and the Public Mental Health Center, Richmond Behavioral Health Authority, have developed a coordination and referral process to assure that veterans at risk don't fall through the cracks between VHA and community system. That work is now being implemented elsewhere in Virginia as part of the governor's challenge. We believe that this type of strong continuing interdepartmental effort that incorporates States and communities as partners is necessary to reduce veteran suicide.

In summary, SAMHSA is engaged in an unprecedented amount of suicide prevention activities, but we know we need to do more to play our role in halting the tragic rise in loss of life we are experiencing across the country.

In particular, we know we need to be engaged in a strong continuing collaborative effort with the Veterans Administration and others to reduce suicide among our Nation's veterans. We know we must be constantly looking to improve our efforts and to learn from both our successes and our failures.

We owe it to those who have served this Nation and to all those we have lost, as well as to those that love them, to continually strive to improve until suicide among veterans and among all Americans is dramatically reduced.

[THE PREPARED STATEMENT OF RICHARD MCKEON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. McKeon.

We will now hear from Dr. Stone, who will be recognized for 5 minutes to give his opening statement.

STATEMENT OF RICHARD STONE

Dr. STONE. Good evening, Chairman Takano, Ranking Member Roe, and Members of the Committee. I appreciate the opportunity to be here to discuss the critical work VA is undertaking to prevent suicide among our Nation's veterans. I am accompanied today by Dr. Keita Franklin, Executive Director of the VA Suicide Prevention Program.

Suicide is a serious public health tragedy that affects communities across this Nation, and recently this tragedy has occurred on the grounds of our VA health care facilities. In the last 6 weeks, six veterans have ended their lives on our health care facilities. Our facilities are designed to be places of safe haven for those who defended our Nation.

Although less than one half of 1 percent of suicides occur at both VA and civilian health care facilities, these events highlight the important discussion that we will have here tonight. All of us at VA feel these losses as we have dedicated our professional lives to provide health care and enhance the resilience of our Nation's veterans.

The 2018 National Strategy for Preventing Veteran Suicide is a multi-year strategy that provides a framework for identifying priorities, organizing efforts, and focusing community resources to prevent suicide among veterans. This approach has four key areas.

First, primary prevention that focuses on preventing suicidal behavior before it reaches the level of individual self-harm. Second, a whole-health approach that considers factors beyond just mental health. Third, application of data and research that emphasizes evidence-based interventions. And fourth, collaboration that educates and empowers communities to propagate suicide prevention efforts beyond the VA.

These efforts should move us from a crisis intervention focus to one that enhances the relational skills and resilience of our heroes.

We know that an average of 20 veterans die by suicide every day. This number has remained relatively stable over the last several

years. Of those 20, only 6 have used VA health care in the 2 years prior to their death while the majority, 14, have not.

In addition, we know from national data that more than half of Americans who died by suicide in 2016 had no mental health diagnosis at the time of their death. This is also true for our veterans.

We also know that a massive expansion of VA mental health providers and increased mental health access has done little to reduce the total number of suicides among America's veterans.

While there is still much to learn, there are some things that we know: Suicide is preventable, treatment actually works, and there is always hope.

Maintaining the integrity of VA's mental health care system is vitally important, but clearly, this is not enough. VA alone, without the help of all of you, cannot end veteran suicide.

The VA has expanded its suicide prevention efforts into a public health approach while maintaining and expanding our crisis intervention services. We ask all of you to help, and we appreciate the public service announcements many of you have already recorded.

VA is expanding our understanding of what defines health care by developing a whole-health approach that engages, empowers, and equips our veterans for lifelong health, improved resilience, and improved well-being. VA is uniquely positioned to make this a reality for our veterans and for our Nation. This effort is about enhancing individual resilience.

On March 5, 2019, the President signed Executive Order 13861, a national roadmap to empower veterans and end suicide, in order to improve the quality of life for our Nation's veterans and develop a national public health roadmap to lower the veteran suicide rate. This executive order will further VA's efforts to collaborate with partners and communities nationwide and to use the best available information to support all veterans.

We must partner with, empower, and energize all communities to engage veterans who do not use VA services. We are committed to advancing our outreach, prevention, empowerment, and treatment efforts, and we will continue to improve access to care. Our objective, however, is to give our Nation's veterans the top-quality care that they have earned, wherever and whenever they choose to receive it.

Mr. Chairman, this concludes my statement. My colleague and I are prepared to respond to your questions.

With your tolerance, sir, I would like to do something that I did before, and I would like everyone that has not done so already to take your phone out and to type in the Veteran Crisis Line, 1-800-273-8255. 1-800-273-8255. You will be prompted to press 1 if you are a veteran, and you will be connected to our professionals. You can also text 838255, 838255, to connect with a VA responder.

Mr. Chairman, thank you.

[THE PREPARED STATEMENT OF RICHARD STONE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Stone.

Let me say that Dr. Avenevoli, Dr. McKeon, and Dr. Stone's full written testimony will be included in the hearing record.

Let's move on to the questions. I will begin with myself. I recognize myself for 5 minutes. And my first question is for Dr. Stone.

Dr. Stone, VFW's statement provides an example where a veteran sought immediate treatment at a VA mental health clinic because, quote, she feared that she would take her own life, end quote.

The front desk clerk told her that she couldn't be seen immediately because she had completed a mental health appointment the previous day, and the next available appointment wasn't ready for a week.

Thankfully, this veteran survived despite failing to receive the appropriate care.

In contrast, at VA hospitals throughout the country employees have responded by saving 240 veterans' lives when they walked through the hospital doors needing help.

But let's put ourselves in the shoes of this woman for a moment. That interaction with the front desk clerk or a nurse or a police officer could have led to her life being saved or led to that veteran going to the parking lot and committing suicide. How should the front desk clerk have responded- And how is every VA employee trained to recognize the signs of a veteran in crisis?

Dr. STONE. Mr. Chairman, clearly this veteran should have been seen. I would be happy to review the events related to that if they can be provided to me by your staff.

Secondly, let me reference the bill that was created for the veteran that you referenced. Certainly I am very pleased that this veteran was admitted for a 2-week period of time, or at least that is my understanding.

I am deeply disappointed that the first I have heard about this bill is in this hearing. I think it would have been helpful when I had breakfast with that VSO 2 weeks ago and discussed suicide if we could have brought this to my attention. We could have alleviated 2 weeks of suffering for that veteran and his family. We will be happy to work with this.

I can only assume that the lack of eligibility for payment for those services through our normal budgeting reflects something in the veteran's background that made him or her ineligible.

But what should that front desk clerk have done- That front desk clerk has, in all likelihood, gone through SAV training, which is training that we give to our nonclinical personnel to recognize issues that veterans should have been seen and then evaluated by a medical professional.

It is notable that our police officers go through 30 hours of mental health training in order to recognize veterans in crisis. They also go through approximately 20 hours of actual scenario-based study in which they demonstrate their capability to diffuse and de-escalate situations. That has been recognized at our training academy, and a number of other Federal agencies and police agencies have sought that training from us.

I will defer to Dr. Franklin if she has additional comments.

Ms. FRANKLIN. The only other piece I would add is that I appreciate the context of the question with regard to the front desk, because everybody has a role when it comes to preventing suicide, and anybody in the hospital system can do the right thing, and we

are teaching them that through the training. We are teaching them to know the signs, know the symptoms, know what a risk is, and to take action at their level regardless of what level that is.

The CHAIRMAN. Dr. Franklin and Dr. Stone, if I were to ask any VA employee at a VA hospital how they should respond when a veteran in crisis walks through the door, what answer would I get?

Dr. STONE. The answer should be yes. The answer should always be yes and we welcome veterans to be seen. Every one of our sites, more than a thousand sites, have same day access for mental health services, regardless of veteran status.

The CHAIRMAN. Is every employee trained to recognize the signs of a veteran in crisis and to treat that veteran with compassion and respect?

Dr. STONE. Yes.

The CHAIRMAN. So Dr. Stone, I appreciate that you brought up earlier the issue with the $20,000 hospital bill. My question was, how does VA prevent veterans from relapsing into crisis upon discharge, including the way in which VA bills veterans for the care that they receive—My question would be, wouldn't sending a veteran a $20,000 hospital bill send the veteran into crisis and create another barrier for care?

Dr. STONE. We certainly know—and this is part of my opening testimony—we certainly know that many of the issues facing veterans that lead to suicide relate to relational problems, relationship problems, as well as financial problems, and it is deeply troubling that we would generate this bill if there wasn't a secondary insurance that should have been billed.

The CHAIRMAN. So it is very important that VA is able to exercise its role as a central coordinator of care in these cases.

Dr. STONE. Absolutely, sir.

The CHAIRMAN. My time is up, and I would now like to turn to Mrs. Radewagen for 5 minutes.

Mrs. RADEWAGEN. Thank you, Mr. Chairman, and thank you, Ranking Member Dr. Roe, for holding this very important hearing.

I also want to welcome the panel. Thank you for all you do.

My question is for Dr. Stone, and if anyone else has any comments, that would be appreciated.

There has been a tremendous amount of attention devoted to the three recent incidents of suicide on VA campuses. Do you see any connection among these incidents? And do you have any evidence that they are symptoms of an increase of suicide among veterans either in general or on VA property?

Dr. STONE. Each one of these incidences is a tragedy, and each one is an individual that we lost. What is difficult to understand is that a number of these incidences have occurred in individuals that we hadn't seen for a number of years, but yet they arrived on our campus and underwent an act of self-harm resulting in their death.

Clearly, as the Ranking Member pointed out in his comments, the fact that help was a few feet away is deeply troubling. But yet even if we fix that problem, 99.6 percent of veteran suicides are not occurring on our campuses.

Now, what do we know? We know that America has a problem on inpatient services, especially in psychiatric units, when there are not door alarms and weight alarms that can prevent suicides.

We learned that lesson tragically in West Palm Beach less than a month ago when a veteran actually timed our nurses walking through to check on them and then committed an act of self-harm resulting in his death immediately after the nurse walked through to check on him.

The lesson from that is that we are replacing every door across our system with weight sensors. Now, is it perfect? No. But it is the best that we have in order to correct this issue.

What else have we learned? We have learned that some of these veterans come to our campuses because—and we know this from the notes that they have left—that they know they will be taken care of, and they know their families will be taken care of.

There are those that would like to indict the VA in this process, and I would caution you that this is not as easy as me having just a few more policemen to go through the parking lots or the parking structures. But this is about a whole-of-society approach that reconnects veterans that are intensely lonely and with a feeling of hopelessness that results in these acts of self-harm.

Mrs. RADEWAGEN. Does anyone else have any comments? My time is running out.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Mrs. Radewagen.

I now would like to recognize Ms. Brownley, who chairs our veterans Health Subcommittee.

Ms. BROWNLEY. Thank you, Mr. Chairman, and I wanted to do a quick follow-up to your line of questioning.

Dr. Stone, you gave some very positive responses to the Chairman's questions in terms of what the VA does vis-a-vis responding to a veteran in crisis. My question is, how do you know that you are 100 percent correct?

Dr. STONE. We know because we tabulate on our training management system the amount of training that has been done.

Now, we certainly have new employees coming on board that need training, but you would think that with the large amount of redundancy in our system that there would be the possibility that each veteran would be able to be taken into our care effectively and without being turned away.

Ms. BROWNLEY. So training is enough in terms of ensuring that we have a 100 percent positive response to a veteran in crisis? I understand that people—there is turnover and that sort of thing, but it seems to me as though there needs to be more of that to know site by site that those things are actually being executed. That is my concern.

Dr. STONE. Congresswoman, thank you, and I appreciate it. It is my concern also. And I think that is why I mentioned amongst our police officers the ability to actually demonstrate empathy, to be able to demonstrate the ability to deescalate a crisis situation is absolutely essential.

Ms. BROWNLEY. Thank you.

Another question I had. The doctor from NIH laid out a program, an evidence-based safety program, I think that you called it. But

basically to quickly summarize, it is screening all patients, then a social worker drilling down a little bit more in terms of screening, and then obviously if that screening tells the professional that a veteran is in crisis, then linking she or he with a crisis center, perhaps within the VA, perhaps within the community. I think we all agree it is a community effort.

So evidence-based program, effective, good results, is this what we are doing in the VA every single day, screening every single patient, having a social worker do the screening, and then, if need be, linking that veteran to services?

Ms. FRANKLIN. Yes, Chairwoman, that is exactly what we are doing. We have received those results from NIMH, and we have implemented that enterprise-wide, exactly those three methodologies, not only screening in mental health but screening in every single clinic across the entire VA. If somebody gets seen in podiatry, they are getting a screen on suicide, make no mistake.

And the safety plans across the board, this past year we implemented a standardized safety plan protocol so that we could make sure that every safety plan that was done is done the same and is done with a high degree of rigor and evidence to the exact model that was briefed by my colleague and follow-up contact through caring outreach exactly following the research model. Yes, ma'am.

Ms. BROWNLEY. Thank you.

And the last question I had was on military sexual trauma. So it is my understanding, it has been a while since I read the report, but there was an OIG report, I think it was in 2018, that talked about MST claims. And the report, if I recall it correctly, said that 60 percent of the MST claims were incorrectly denied so that women and men, perhaps, were not receiving the benefits they needed. Obviously, MST is very much linked to the topic that we are talking about this evening.

If you could tell me, can you respond to that and let me know what the VA is doing about it?

Dr. STONE. Congresswoman, certainly. I represent VHA, not VVA, and I appreciate the question. And just to make sure that I have this right, we will check and get back to your staff to make sure that we answer this correctly. But my understanding is those denied claims are now all being reviewed to assure that they are accurate.

Ms. BROWNLEY. I would like a follow-up if you can provide it. I think it is of your interest. It is of our interest, obviously. I understand it is under VBA, but MST and the link here I think is very important, and I think we need to actually have very firm answers.

And my time is about to run out, but you mentioned in your testimony about a national network of women's health champions, which sounds to me like a new program. I don't have time to ask the question today. But I haven't heard about it and am very interested to understand what it is about.

I yield back.

The CHAIRMAN. Thank you, Ms. Brownley.

Now I will recognize Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I appreciate it. Thank you for holding this hearing. And I want to thank Dr. Roe as well.

Thank you for your testimony. I appreciate it so very much.

Dr. Franklin, quickly, what about screening more intensely for suicide awareness at DoD? Any comments on that?

Ms. FRANKLIN. Screening more intensely with DoD?

Mr. BILIRAKIS. DoD. Yeah. Yeah.

Ms. FRANKLIN. Yes. There was an executive order that was pushed out in this past year, not the one that Dr. Stone mentioned in his testimony but an earlier one, and this executive order calls for increased screening from DoD so that when troops are leaving the Active Duty side they have eyes on by a medical provider and those results are immediately pushed over to our mental health teams over on the VA side so that there is an accurate view on the servicemember's mental health status before they leave Active Duty.

Mr. BILIRAKIS. Okay. Very good.

Dr. STONE. Let me add just a little bit to that. I think this is absolutely correct. But in that first executive order, the ability for us to interact with a servicemember in the year before they leave Active Duty is absolutely essential. And the authorities you have granted us in allowing us to see servicemembers for that first year after they come off Active Duty is an absolute risk reduction.

I would ask the Committee to take a deep look at the work that has been done since the late 1990s in the Air Force that has actually integrated a resiliency, relationship-based training, and suicide awareness amongst all Active Duty and Reserve members of the Air Force. The Air Force has not seen the increase in the number of suicides that a number of the other uniformed services have. So this interaction and potentially modelling after the Air Force training is absolutely essential.

Mr. BILIRAKIS. Very good. Well, I would like to work with you, sir, on some legislation with regard to that because I think that would make a big difference. I really do.

Let me ask another question. I do have some prepared questions, too, but I don't know if we will have time. Can you tell me, and you may not have some statistics on this, but prior wars, prior eras, let's say the Vietnam era, even going back to World War II, give me some statistics with regard to suicide rates. How would we compare to what is going on today, the 20 a day, which is obviously much—one is much too high as far as I am concerned?

Can you give me any stats with regard to that, for instance the Vietnam era, as far as the suicide rate is concerned?

Ms. FRANKLIN. Yes. Absolutely, Chairman.

The data collection has gotten better over the years, so sometimes it is difficult to compare data across war efforts. We have only recently gotten a lot more savvy with our data and surveillance efforts.

But what I will tell you is that when we look at our current effort, we look, we see our highest rate of suicide right now amongst 18- to 34-year-olds when you look at the rate per 100,000, and we see our highest raw number amongst men over the age of 55, which we suspect comes from that other era, that other war effort. And so we also know that we have more veterans in that group or in that category.

And so that is what I offer. And I turn it back. Dr. Stone who may have more context.

Mr. BILIRAKIS. So with regard to how about percentages? You say you have more veterans in that category, but how about percentages? I mean, we are spending more money and we have more programs, but evidently it is not doing any good.

Dr. STONE. Twenty-one percent of the suicides that we experienced in 2016 were in veterans over 75 years old.

Mr. BILIRAKIS. All right.

Dr. STONE. When I add the 55 to 74 to that first group I mentioned, it adds up to over 60 percent of the suicides amongst veterans in this Nation.

Clearly, we need to recognize the fact that of the 20.4 million veterans in this Nation, 77 percent have experienced combat, and the long-term effect on these veterans cannot be underestimated.

Now, I grew up in a generational home. Multiple generations had been in that home. Everybody on that street were generational homes. I couldn't walk out the front door as a young child, but yet I had 20 moms that were up and down that street.

Just think about the neighborhoods that each of us live in today and recognize the isolation that many of us feel. I have lived in my current neighborhood for 4 years. I know the neighbors on either side. I have been in their homes. No one else.

Counter that to on-base housing that I experienced on Active Duty. When my family and I moved into a home, every single family in the neighborhood came to bring us food, to make sure we were all right, did we need anything. And every weekend after that for weeks we were welcomed into their homes until we became firm members of that community. This is a profound difference that we are seeing in all age groups of veterans.

Certainly, the 18 years of combat that we have experienced in the current environment has taken a tremendous toll on veterans under age 35, but make no mistake that the increased suicide rate amongst veterans affects all age groups.

The CHAIRMAN. Thank you, Dr. Stone. Thank you. Let's try to keep our comments within the 5. We have a lot of people to get through, but I allowed you to go on because it was so compelling, what you were saying.

Let us move on to Miss Rice for 5 minutes.

Miss RICE. Thank you, Mr. Chairman.

And thank you all for coming here to testify tonight.

Sir, I want to talk about an issue that—I don't think we can adequately address the issue of suicide amongst veterans without talking about guns, firearms. If you look at—there is no question that firearms are one of the most common means of completing suicide among the general population, and 69 percent of veterans have completed suicide via firearm.

Women veterans are also more likely to utilize firearms in the attempt and/or completion of suicide than their civilian counterparts.

It has been proven that restricting access to firearms may reduce suicide rates.

So this is for anyone on the panel. Has the VA studied gun violence in the veteran population? What research is currently available on gun violence in connection to suicide?

I am well aware that we as a body, Congress, has not been willing to fund a study to look at the overall reason for the epidemic of gun violence in this country, but since we are talking about the VA, I am specifically asking about the VA.

Is this an issue that warrants more research to shed light on why firearms are the most common means utilized? And what resources does VA offer to veterans that may choose to limit their access to firearms?

So anyone who wants to answer that.

Mr. MCKEON. Well, to put it in a national context, let me mention a couple of things.

So 51 percent of all suicides in America utilize a firearm. So it is clearly a very important issue. The collaborative safety plan that Dr. Avenevoli spoke to includes as part of that paying attention to access to lethal means when working with an individual who is suicidal. That frequently includes firearms. It can also include things like access to large amounts of pharmaceuticals or other dangerous substances.

SAMHSA, through our Suicide Prevention Resource Center, has an online course on counseling about access to lethal means. Again, this is within the context of someone who is suicidal and trying to reduce access to lethal means on a temporary basis.

And then finally I would mention that a number of our SAMHSA grantees are doing work with firearm-owning groups and things like what is called the Gun Shop Project, working with them and with other groups to try to have a collaborative effort to educate about suicide warning signs so that people know how to respond.

Ms. FRANKLIN. And the only other thing that I would add from the VA side, we are working hand in hand with SAMHSA on many of those initiatives that Dr. McKeon spoke about. We also train our mental health providers with a special training on access to lethal means and how to talk with veterans about this issue.

We do have a partnership with the National Shooting and Sports Foundation, and this is a partnership that helps us execute trainings in local communities with gun shop owners on signs and symptoms of suicide risk. And then we do work on this issue around putting time and space between the person at risk and any means that is lethal, and certainly firearms are the top means in our population as you note, but equally so, medication and a host of other issues around this topic.

Miss RICE. Dr. Stone, you mentioned before, you used the word "ineligibility." And to me, I just think it is the most insane policy that there is any man or woman who wore the uniform of this country and is—I don't care what they did—is ineligible for some kind of—for access to health care.

I wonder, Dr. Stone, if you can tell us what specific risks other than honorable discharges represent because of their limited access to VA mental health care services, specifically women veterans who are more likely to have experienced MST are also more likely to have received a bad paper discharge as retaliation for reporting MST before the 2-year mark when they would be eligible for VA

health care. So I think this is an issue that we need to talk about in terms of—I just don't think that there should be—that veteran and ineligibility should never go hand in hand.

Dr. STONE. I think, Congresswoman, you are exactly correct. And one of the big problems that we have, as the Chairman identified in his opening statement, is never-activated guardsmen and reservists. They have never been called to Federal service, so technically they are not a veteran, and I am not eligible to welcome them into the system.

Now, we have tried to overcome that by using our vet centers and combining, and we have worked very successfully with the Guard Bureau and the Army Reserve to try and move our vets center on a mobile basis into drill weekends.

But many of the suicides we are seeing in never-activated guardsmen and reservists are between age 35 and 54. So they are long since their service days. And how to reconnect with them or to give us the authority to engage them, it seems to me that if I can accept veterans with other than honorable paper, we ought to be able to accept the never-activated Guard and Reserve who account for about 2-1/2 to 3 of the daily suicides that we are seeing.

Miss RICE. Thank you, Dr. Stone. I think it is a conversation we should continue to have.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Miss Rice. Those are really great questions.

Mr. Bost, you are recognized for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman. And thank you for having the hearing tonight.

I just, just real quickly, there is something that I should bring up. You know, because it came up during the last questioning. You know, losing one veteran to suicide is tragic. And I know none of us take it lightly. That being said, the veteran's 2nd Amendment right and the ability to take that right away from them will not stop one of them from attempting suicide and, in fact, may discourage them from seeking help through the VA or through other means if they believe that they might lose that right. And I think that is a concern. And it depends on where you are at in the country. But I know where I come from and many of them have expressed that concern to me as well.

We are all committed to preventing suicide, and I am dedicated to ensuring that we are appropriately educating at-risk servicemembers and veterans and their families about firearm safety and providing them meaningful support to help them overcome the struggles that they face. But as I said, I do believe we want to be very, very careful when we go down that road.

But, Dr. Stone, you actually—I think you answered part of this, but I would really like to know, because you reference in your testimony the President's executive order from last year. And I wanted to thank him for signing that but ask you what, if any, outcomes and lessons have been learned from the EO since it was signed, especially when the veterans are being screened from benefits from the VA and going on through the TAP Program at DoD. What are we gleaning from that?

Dr. STONE. What we are learning, and I mentioned a bit about the Air Force experience that is incredibly intriguing. But what we also learned is that the more veterans and servicemembers learn about our services, the more they engage us. And it is the absolutely right thing to do for us to be engaged with them well before they get out of uniform.

Now, certainly, when you are sitting at the discharge station getting ready to get out, you don't want to hear very much. But in that 6 to 12 months before, it is time for us to engage. And the active services have all been very gracious in giving time for our staff to come in and talk about access as well as risk for that servicemember in the year after they leave service.

Now, I discussed earlier the difference in American society on the civilian side versus American society in uniform. These are dramatic changes for the servicemember who may have experienced 10, 15, or 20 years in uniform.

Mr. BOST. And believe me, I am not criticizing when I go down this next path. Okay? I am trying to figure it out as a Member of this Committee, and I am sure this whole Committee is asking this. You know, the VA is, but once again, back before us and telling us that combat veteran suicide is a top priority for the VA. But your budget continues to increase. Suicide prevention money, we are giving more money towards that.

But what actual results can be seen from a funding level that we are putting out there? We are not changing it. We are still at that 20 a day. We have got to come up with the ideas that truly change this. We have got to figure out that it that—if we are increasing money, we are not changing it, we are increasing programs, and we are not changing it, how do we become really effective and bring those numbers down?

Now, I know that you brought up the fact of the age. And the concern of the age too is—where are we at when they commit suicide? What other things might be going on in their life? Do we monitor that? Do we know those statistics? And how do we bring it down? Because every year we can come back and talk about it. But if we don't change the numbers, and we can raise the money every year, but if we don't change the numbers, we are not helping them.

Dr. STONE. Certainly, I can't disagree with your statement, Congressman. But I think the message here is that if this was 10 years ago, this would have been a $4 billion budget, and I would have half the number of mental health providers that I have today. We have same-day access to mental health services, but we haven't changed the numbers.

Now, there are those that would argue that maybe we have. Maybe this would be worse as a crisis if we didn't have 24,000 mental health professionals ready to see you today as a veteran.

If, in fact, this is not the answer, then we have some hard looks at each other and hard looks at ourselves in the mirrors about what society has become. And I mentioned that in the generational home that I mentioned earlier. These are very tough discussions to have. We do know that the incredibly high rates, the military sexual trauma, intimate partner violence, substance abuse, mental

health disorders lead to a dramatic escalation in female veterans as was mentioned by some of your colleagues earlier.

We know also, amongst all veterans, that it is—in the 2 weeks before becoming homeless, the rates of suicide go up dramatically. We also know that for veterans that are involved with the justice system, the month after they have been incarcerated—or after they get out from incarceration, dramatic levels of suicide. But this is true across all of American society. Frankly, that is a worldwide phenomenon.

Mr. BOST. Thank you.

The CHAIRMAN. Thank you, Mr. Bost.

I now recognize Mr. Lamb for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman.

Dr. Stone, I want to thank you for mentioning the whole health programs in your testimony and for being a supporter of those. I also have been struck by the potential in the VA's whole health program. And I got the chance to visit the program at the D.C. VA hospital, I believe it was last summer. And it was just—it is just a really promising area. And it is—I just commend the VA for pursuing it and being innovative and risk taking with that.

And what struck me about it was not just the value of the services themselves. The—it was—I think what we saw was acupuncture, meditation, yoga, and a couple other things. But you used the term empowering veterans. And what it really did was it gives veterans an active role in managing their own health care. It basically gives them a bunch of great nontraditional somewhat unusual options and says, Pick from these yourself. And whichever one you like, or you find valuable, keep coming back. And that was how they were running it.

And you could tell that from that a little community arose. And some of the same veterans would keep coming back to the same classes as they were able to. And they got to know each other and were looking out for each other and everything. And I think that—you know, when we were there, it was mostly older veterans. But I think there is a lot of potential to use a program like that to attract some of the younger veterans into the system, because military members on Active Duty now are being trained in some of the same stuff. DoD has been pretty good at getting some of these things out there. So I think people are more used to it.

So I have introduced legislation to try to expand the availability of whole health within the VA. And I would love to have your support on that. But I was just hoping that either you or Dr. Franklin could talk about any connection you believe exists between the availability of the whole health programs and your suicide prevention efforts, how those can go hand in hand.

Thank you.

Dr. STONE. As we modernize the VA, Congressman, one of the ten lanes of effort is to expand across the entire enterprise the whole health model. One of the things our colleagues have delivered in knowledge is an understanding of the role of physical exercise or the participation in team-based sports at any age has a dramatically preventative activity in reducing the suicide risk.

And I will defer to Dr. Franklin if she has other comments.

Ms. FRANKLIN. I appreciate your thoughts on the whole health care. And I am eager for us to execute it across the enterprise. It started with the 18 flagship entities, one of which you may have visited. And it is well under way for full execution across the enterprise. And this notion of focusing on the social determinants of health and thinking about veterans in the context of biological, sociological, psychological, and spiritual and allowing them to drive their care is the future of the organization, so I definitely appreciate it.

Mr. LAMB. Thank you both for your work on that.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Lamb.

Mr. Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. Thanks to everyone for being here. This is a subject that I know all of us take very seriously.

And I am not sure which one of you gave the following stats, so I apologize for that. The second leading cause of death in the age group 18 to 34.

What is number one, three, and four? Any ideas?

Mr. MCKEON. Well, in that age group, number one is accidents.

Mr. BERGMAN. Okay.

Mr. MCKEON. And three is—homicide is either third or fourth. But that, I don't remember exactly. We can certainly get that for you.

Mr. BERGMAN. Okay. Well—and also, in that—regardless of what is one, two, three, and four, is there, from a gross standpoint, big numbers, not finite data, is there any huge percentage difference? Now, accidents are accidents. But any significant percentage differences in, like, three and four? All of a sudden, just a drop off?

Mr. MCKEON. Well, I think that—one thing to remember, for example, is that while accidents may be at times very random, they are—

Mr. BERGMAN. I don't want to waste time on accidents, if that is okay. I just—we try—the bigger point here is a relative perspective of where it fits in causes of death as we talk to people and talk to other entities and figure out where to put, if you will, finite resources towards solving problems. An example, isolation we know causes potential suicidal ideations.

Back when some of us with gray hair entered the military, there were military barracks. You had the communal living where you had your bunk mate, you had that. Now we have private rooms, if you will, once you reach maybe E4 or E5. And that idea we are not able to have eyes on, on our fellow military members regardless.

So, you know, differences when it comes generationally to—when it talks about the community, the neighborhoods. You know your neighbors, or you don't know your neighbors. Well, you know, do you know your platoon mates? Do you know the people after you leave either the association? So I think there is differences societally here as we look at dealing with mental health.

State-sponsored programs. Do States have different programs that you can refer to as examples of how it is being done very well? Some States versus others. Not that we need to know, but are

there best practices being shared when it comes to—you know, the one-size-fits-all when it comes out of Washington, D.C., may not resonate in—you know, in northern Michigan or isolated areas or somewhere where—are more rural than urban. But are there any things you do to compare and contrast and take best practices?

Mr. MCKEON. I would mention a couple of things. Many States are making strong efforts for suicide prevention. An example of that is what is called the Colorado National Collaborative, which CDC has been very engaged in. The idea there is to try to promote suicide prevention in a comprehensive public health way and to bring it down to the local level. And, again, it is something that is being driven by those States and communities. There is Federal funding that is being utilized.

Mr. BERGMAN. I guess the question—because my time is running short, and I got a couple quick questions. But as long as we can see that best practices are being captured and then put out so that we gain from it, not just a one-size-fits-all perspective. And as far as a requirement for veterans to make contact within a year after leaving Active Duty, did I get that right? Okay. Any idea what percentage of those veterans are still in the individual ready reserve? Because that is—when you talk about that 18 to 34 group, a lot of those are still in that timeframe where they have a 4-year commitment. Who is doing that? How is that contact being made?

Dr. STONE. So we have talked to both the Army Guard and the Army Reserve who have the largest reserve—individual ready reserve.

Mr. BERGMAN. Yeah. But they are not in. When a young soldier, sailor, airman, marine who leaves Active Duty, they are under DoD, they are Title 10. But their responsibility is not Title 32.

So the point is who is taking care of those folks in the individual ready reserve?

Dr. STONE. That is very difficult to say.

Mr. BERGMAN. Okay. But you can take that for the record. And I would suggest, Mr. Chairman—I know my time is up—that would be an interesting—maybe for a round table for us to talk about that, because there is some significant differences there, especially given the age group that we are talking about here is the number two leading cause of death.

And I yield back.

The CHAIRMAN. The point is well taken, General Bergman. And it has been noted by my staff. And I take your suggestion.

Mr. Brindisi, you are recognized for 5 minutes.

Mr. BRINDISI. Thank you, Mr. Chair. Thank you, Dr. Stone, and to all our witnesses who are here today.

I just spent a couple weeks back in the district and had a chance to tour some of our VA clinics in anticipation of this hearing coming up. I had the opportunity to ask the professionals at our VAs what are some of the things that we can do collectively to try and reduce suicide? And one of the things that was mentioned to me on several occasions was focusing more on that transition period out of Department of Defense Active Duty life and into the VA. And how we can do a better job coordinating. And I know we touched upon this a little bit.

But are there ways—because my understanding—I am not a veteran, but as you are coming out of active military, there is a lot of information that is thrown at you. It is—one of the VA professionals actually likened it to a phrase I am pretty familiar with, drinking from a fire hose.

So what can we do—what kind of coordination efforts are taking place between the DoD and the VA? And is the DoD being cooperative in assisting the VA reach a veteran in that 6- to 12-month period prior to getting out of Active Duty?

Dr. STONE. So the answer is yes, DoD is being great partners in this process. We would always like to have more time to spend with the veteran, because the more time we spend with the veteran, the more likely they are to engage with us after they get out of service.

I think, secondly, are we effectively outreaching in that year after they get off of Active Duty? You have funded us very graciously, and we will spend about $200 million this year in outreach efforts of various types, everything from electronic billboards to Web sites in which we are reaching out, to even direct mailings. We mailed 500,000 letters to other than honorable in December of last year. And we are able to capture well over 1,000 veterans to come in and see us. But it all depends on the individual. And it all, most importantly, depends on when the individual is really open to hearing our message.

There is no doubt that we are the most integrated health care system when it comes to mental health. And the ability for us to interact with that veteran and provide integrated ongoing services is what is essential to their well-being in the future.

Mr. BRINDISI. Thank you for that.

And one of the interesting programs that I heard about from the VA region that I represent, I am not sure if you are familiar with something called Freeze the Keys? Have you heard of this before?

Dr. STONE. I have not, but Dr. Franklin may have.

Ms. FRANKLIN. No.

Mr. BRINDISI. Okay. So touching a little bit upon our conversation earlier about gun violence. So in the Syracuse VA region in upstate New York, they had told me about this program that they are implementing called Freeze the Keys where they will take the keys of a gun storage cabinet. The veteran may own a firearm they keep in a storage cabinet, and they keep that storage cabinet locked. And they will take the keys from the storage cabinet and put it into a cup and then put water in the cup, freeze the cup in a freezer. So when the veteran has the impulse that they may want to go get their firearm to commit suicide, they actually have to get the key out of that frozen cup which creates more time for them to think about the act that they may take.

And on this cup is a picture, perhaps, of a loved one, perhaps of a veteran's crisis suicide number. Just something that they are doing where they think it may give more time, because it is an impulse, it is a quick impulse when you want to take your life. This may give a little more time for them to think about it before they actually are able to get the key out of the ice and go to the storage cabinet, get the firearm, and commit suicide.

Sounds like a good practice.

Dr. STONE. One the most deeply troubling facts in survivors of suicide is that in about 25 percent, the distance between the decision to commit an act of self-harm to actually committing the act is 5 minutes. And in about half, it is less than 60 minutes. Anything that puts distance between that decision and attempts to deescalate the crisis has value, whether putting keys and freezing them in, putting a picture of a loved one, or simply the phone ringing of a loved one saying "I have been thinking about you" is a chance to deescalate.

Mr. BRINDISI. Thank you. I certainly encourage you, because it just seemed like a wonderful program that they are utilizing up in the area that I represent. Perhaps it is a practice that maybe we could use across the country to help give more time to make that decision.

The CHAIRMAN. Thank you, Mr. Brindisi.

Mr. Banks, you are recognized for 5 minutes.

Mr. BANKS. Thank you, Mr. Chairman.

Dr. Stone, I have a question for you at the outset. What are you and the Secretary doing to create a culture of urgency at the VA and the VHA to deal with veteran suicides?

Dr. STONE. Congressman, I think there is a culture of urgency. I think this is the Secretary's and my number one priority is to do everything we can to reduce or eliminate veteran suicide.

But as I said in my opening comments, we cannot do this alone. And we need the entirety of American society to dedicate themselves along with us and support us. It is, as I mentioned to your colleague, a telephone call to a veteran or somebody that you haven't seen, somebody from your faith group to pick up the phone.

One of the things we recognize in your State, your State has some of the lowest suicide rates in the Nation both among civilians and veterans. There is something unique that goes on in your State. It may be the small towns. It may be the faith-based communities. But there is something unique that the suicide rates in your State are dramatically lower than a lot of other areas.

The other thing we recognize is, in highly populous States like California and New York, there are reduced suicide rates over the more rural States. If I go to Montana or South Dakota, the rates are dramatically higher.

Is this about loneliness? Is this about isolation? Is this about being disconnected? The answers to all of those are yes.

Mr. BANKS. Can you point to for our benefit examples of ways within the bureaucratic organization that you are creating that sense of urgency better than before?

Dr. STONE. Yeah, I think so. And I am really proud of the 24,000 mental health providers and their staff. I think the way we show that is by absolute accessibility on a same-day basis. And even in places that are going to just open access to get veterans in. We will see almost 22 million ambulatory visits from mental health. And we are very proud of it. We are continuing to retain and attract behavioral health providers.

The increase in our telemedicine work where we will move from 13 percent of veterans this year to about 20 percent of veterans eligible—or able to participate in telemental health is extraordinary. I think all of this demonstrates our commitment.

But as I said earlier, simply hiring more mental health providers will make access better, but it won't fundamentally change the problems of homelessness or fundamentally change the problems of financial challenges or relationship changes.

You know, in the last 18 years, the Department of Defense has done wonderful work showing the problems with dwell time, that you can't go out for 15 months to combat, especially combat that is intense every single day. You know, you go back to the Vietnam era. One of your colleagues earlier asked. You go back to the Vietnam era. People went out for a week, and then they came back to the rear and they decompressed. These wars, you are in combat every single day.

In the time I spent in Afghanistan, the medical corps gets every bad thing that happens in war place. It was a flow of casualties every single day. You cannot underestimate the fact that the human mind and the human body must decompress from that. And when you go out for 15 months and come home for a year and then you go out again is an operational pace with an all-volunteer force that is unsustainable.

Mr. BANKS. Let me shift gears really quick.

Last September President Trump signed legislation I authored that would require the Secretary to conduct a study of 5 years of data analytics of the veteran crisis line.

Can you confirm that that process has begun or tell us about any progress of that today?

Dr. STONE. I can't, but Dr. Franklin may be able to.

Ms. FRANKLIN. Yes. Absolutely. There was a number of recommendations that came from that related to the veteran crisis line, and we have successfully closed out those recommendations.

Mr. BANKS. The recommendation—this was mandating a study of 5 years using data analytics to study the effectiveness of the veteran crisis line.

Ms. FRANKLIN. Okay. Forgive me. I may have crossed your question with IG recommendations.

But, absolutely, we can check on that and get an answer back to you for the record.

Mr. BANKS. Thank you.

My time has expired.

The CHAIRMAN. Thank you, Mr. Banks. I appreciated your questions.

And, Dr. Stone, I have asked my staff to take a look at this response that you gave on the nature of the deployments and how they differ today.

I will now recognize Mr. Pappas for 5 minutes.

Mr. PAPPAS. Thank you very much, Mr. Chair. And I appreciate the panel and your thoughts here today as we confront this critical issue for our Nation and for all our veterans and their family members.

I wanted to build off of one thing that Dr. Stone was discussing, and that was the VA police force. And you indicated a little bit of the training that goes in in terms of identifying the signs. And I think that is a really important discussion to have ensuring that they have that experience under their belt. We should be treating this as any other medical issue. So knowing the signs of mental ill-

ness should be just like knowing the signs for stroke or heart attack or anything else that someone might walk into a facility experiencing.

But I am wondering beyond that, as we look at the IG report around VA policing, if you have any further comments that you would like to offer in terms of implementation of the recommendations. There was concern around ensuring that police units were appropriately staffed at VA facilities around the country. And if you don't have anything further to add on that right now, certainly we can follow up and have a further discussion following this hearing.

Dr. STONE. I do. I think there is a number of things that are troubling in the way we structure police and police management. We are actually going through a process of restructuring regional management.

There is very little career mobility in the VA police force. It is pretty much run as a police force out of an individual health care facility. Because of that, it is hard for us to retain police officers. In addition, we have graded police officers at too low a pay scale, and our ability to retain very high-quality officers is really challenged. So there is a number of areas I would be happy to take offline with you that I think we could do a much better job of retaining these great officers that we have.

Mr. PAPPAS. Thank you. I appreciate that. We will certainly be following up.

As you know, on April 12, the administration's ban on transgender servicemembers went into effect. I have concern for that group. As you may know, transgender veterans are known to experience suicide at higher rates. And I am wondering what thoughts have been given to the handoff as these folks leave service in terms of making sure that they are getting the care that they need.

Dr. STONE. So there has been no change in the VA's posture. And that is that we continue to welcome all servicemembers to care. We provide all care regarding transgender work. The only thing we don't do is the surgery. But we welcome all transgender members, and we will continue to do so.

And—Dr. Franklin.

Ms. FRANKLIN. Sure. And I would just add that so much so with regard to Dr. Stone's comment, we recently developed a tool kit for all of our medical providers. And it is listed on our Web site. And it is a—we have disseminated across the entire enterprise. It really speaks to how to engage with this unique population. And exactly what you note, their increased risk for suicide particularly when you look at the nonveteran suicide data points to 12 to 19 percent increase risk with this population. And so we got out of that—in front of that as early as we could, developed the tool kit, and we are training our staff with a series of webinars on it as well.

Mr. PAPPAS. Thank you very much.

I am glad you handed out these cards and made sure that we all put the number in our phone, this has been an important resource to our district office as we get calls from vets in the State of New Hampshire. And I am hoping that you will continue to look for

ways to work elevate this resource as you implement the VA's national strategy for preventing veteran suicide.

As you explained, there are well-followed practices and procedures that are in place when a veteran calls who is in crisis, who is experiencing suicidal thoughts.

I wondered if you could comment on other situations that might come up on the line. Veterans who may be experiencing depression or mental illness and how those cases are handled. And I am wondering, I guess, what resources are available to clinicians on the crisis line, local suicide prevention coordinators to help facilitate services for these individuals. And I am thinking particularly around transportation.

Ms. FRANKLIN. Absolutely. It is such a good question, because not all the calls that come to the veteran crisis line are crisis related. But all the calls are important, and we tackle them in the same way. So we assess and triage and get folks into care depending on the level of care that they need and what they identify when they call the crisis line. In some cases, that care might be a warm handoff to a vet center. In some cases it might be a handoff into a community-based organization or one of our own medical centers in a non-crisis capacity.

When you are thinking about transportation, transportation can absolutely be a barrier to care. We have a number of entities where we are funding transportation capabilities. We are also partnering with a number of agencies. There is a good example happening in Massachusetts with Mass General where they are partnering with the local police force for off-duty police officers. And maybe you are familiar with it. Part of the home base capability that is connected to Mass General whereby retired police officers and off-duty police officers are helping to do that transportation piece of it making sure that that doesn't become a barrier for people getting into care when they need it most.

Mr. PAPPAS. Thank you very much.

I yield back.

The CHAIRMAN. Thank you, Mr. Pappas.

Now I recognize Mr. Meuser for 5 minutes.

Mr. MEUSER. Thank you, Mr. Chairman. And thank you, Dr. Roe. Thank you very much to our witnesses. I appreciate very much your service. Clearly, you are all very, very experienced and capable to be handling these important jobs, and I just really want to thank you for your service.

I do represent Pennsylvania's 9th congressional. We have over 50,000 veterans. We also maintain Fort Indiantown Gap Army training facility as well as the Lebanon VA. Seventy percent of the 20 suicide deaths per day among our veterans, which is absolutely heart wrenching, have not received VA health care, as we have been discussing, for the previous 2 years.

Conversations that I have with the Lebanon VA have made it clear that we need to work on meeting veterans where they are. And, for example, the Lebanon VA has partnered with local colleges, veteran-oriented campus groups. The VA provides instruction for college faculty to identify challenges and have VA staff contact points for veteran students, on a volunteer basis, who are willing to help.

So, Dr. Franklin, I will ask you, can you speak about the importance of community engagement, the need for such outreach? Is this something that is encouraged and is regularly practiced?

Ms. FRANKLIN. Yes. And I think it is something that has been practiced even more so in the last year and a half. This idea of partnering and outreach with community. And there is a number of different ways that we are doing it. On the one hand, at the national level, certainly putting the right MOAs and MOUs, memorandums of understanding and agreement into place and so that we solidify those relationships so that they stand the test of time.

And then also informal relationships. And I appreciate the fact that they are doing that right out in Pennsylvania, because we are teaching at the national level for them to do the same thing locally. And what we are doing is we are asking them to use their data and to use their data to define where to go for partnerships. And so when we look at the data and we see large numbers, our highest rate with 18- to 34-year-olds, we are asking them to work with veterans where they work, live, and thrive. And in some cases, you know, we believe they may be in university settings.

So the fact that you note that they are developing partnerships, trying to get after suicide outside the four walls of our VA system and that they are doing it with community partnerships like universities tells me that they are on track, and that is the future of the organization. We are really trying to push for broad partnerships in this focus on the fact, as the Chairman said, that we can't do it alone. And we need to increase our partnerships and community engagement.

Mr. MEUSER. Thank you.

The Lebanon VA also makes its grounds very inviting. It is lobby inviting. It creates social atmosphere for the veterans, and in many cases their families. They have a military museum within the facility.

Is this something that is encouraged in other VAs, Dr. Stone?

Dr. STONE. Yes, sir, it is. It is encouraged across the system. Many veterans find this a welcoming place and a place of social connection. And that is the big key to what we are discussing. It is why, for the veteran that wants it, we have chapels on our campuses. We have various veteran-related memorials. And these all seek to connect the veteran back to us and bring them into the system.

Mr. MEUSER. Yeah. That is very much in line with what you were referring to a couple of times today. So I am glad to hear that.

Do you consult with the DAV, the VFW, and the American Legion, many of the members are here today, I think, as well, on these issues? I mean, get their ideas on what they think should be done?

Dr. STONE. We do. In fact, I just finished a series of breakfast meetings with as many VSOs that would be willing to meet with us. And I think we met with 18 different organizations with—the specific question was how to solve this problem.

And it is my belief, as you figured out already from my earlier comments, that belonging, being part of something has huge value. Therefore, I believe that membership in the VSOs is protective. Now, we can't demonstrate that because nobody keeps numbers on

that, or very few of the VSOs do. But we believe it is protective and has huge value in connecting the veteran to the community.

Mr. MEUSER. Thank you.

And you can clearly see by your words and intonations your dedication, all of you. So thank you on behalf of veterans, certainly in my district and everywhere, thank you.

Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Meuser.

Mrs. Luria, you are recognized for 5 minutes.

Mrs. LURIA. Thank you.

Dr. Stone, in the Department of Veterans Affairs fiscal year 2019 annual performance plan, strategic objective 2.2 states that the VA ensures at-risk and underserved veterans receive what they need to eliminate veteran suicide and includes three recommended interventions and follow-up care.

Are you familiar with this objective and do you know what the percentage metric was for satisfactory performance?

Dr. STONE. I am not, but Dr. Franklin may be.

Mrs. LURIA. Dr. Franklin, are you familiar with this?

Ms. FRANKLIN. I am not sure I am familiar with them exactly. I know that you might be talking about our REACH VA intervention.

Mrs. LURIA. Well, it was the only metric within the 2019 annual performance plan for the entire VA that I could find that related to suicide. And in this objective, it stated that you would have recommended interventions, three recommended interventions, and follow-up care.

And so in the performance plan, it said that you would seek to achieve this 65 percent of the time. Yet, Dr. Stone, earlier in your remarks, you said that this was your number one priority and that you were putting all efforts behind, you know, being 100 percent effective in this area. So seemingly, the 65 percent is a relatively low measure of effectiveness for your number one priority. Would you agree?

Dr. STONE. Congresswoman, I must admit to you, I am not familiar with this. And I would be more than happy to take a look at it and get back to your staff in the next 48 hours to talk about it.

Mrs. LURIA. I appreciate that. I would like to follow up about that particular metric, since, like I said, it was the only one in the plan that refers to suicide.

Dr. STONE. Because—if I might just go on for a minute. Many of these—so I came back to VA in July, and this may be a document that was created before I came back. But we will resolve this for the Committee. And I apologize to you for not being able to answer the question.

Mrs. LURIA. Understand. And I will look forward to the follow-up.

Dr. Franklin, last week I had the pleasure of meeting with a veteran's outreach program specialist and several counselors from one of our vet centers in the Hampton Roads area. And they were all incredibly dedicated to their mission and specifically focused on helping to end veteran suicide.

And the veterans outreach program specialist explained, you know, how he gets at this problem of reaching veterans in the com-

munity by going through barbershops, faith community, all types of different things where he reaches veterans in places where they are.

Do you find this particular role within that centers to be effective in helping reach those 14 out of 20 veterans that are not receiving care now?

Ms. FRANKLIN. Yes. Absolutely. This is a critical role. And I appreciate the fact That that you are mentioning barbershops, because we are pushing them towards what we call nontraditional partnerships. And certainly, our partnerships with VSOs, and we want them locally to reach out to people that connect that we have already mentioned on this panel today.

But one of the things I have really been pushing the workforce towards is to reach out to partners who are non-traditional and—

Mrs. LURIA. I understand. In the interest of time, I understand the effectiveness of that tactic. I am just wondering are we requesting enough funding, and do we have enough personnel in this role within the system to do this effectively across the country?

Dr. STONE. So we have 300 vet centers, including mobile vet centers. And I think we have enough personnel. But I spoke earlier today with the Chairman and discussed the fact that we must begin to move to much smaller engagement units. And I think the vet centers have been that model.

But please remember, it took the Vietnam veteran about 10 years to decide that they—they would come in for therapy. They didn't want to come in to our—

Mrs. LURIA. Okay. I would like to move on. I only have 1-minute left, and I wanted to touch on one thing, which was your outreach budget.

And looking at last year, only $1.5 million of the 6.2 million allocated for paid media, or slightly less than 25 percent, was spent towards that effort.

For fiscal year 2019, the budget is 47.5 million in suicide prevention. How much of that do you plan to use for paid media?

Dr. STONE. So if you break down the actual budget, one of the problems we had that you reference is that prior to 2019 budget, we lumped all of this together. And it was very hard to track. So when I arrived, we broke this out into six separate buckets so that we can track it. There is $206 million in those buckets. We expect to spend all of it.

Mrs. LURIA. So we are about halfway through the fiscal year. Would you anticipate that we are on track based off of the time remaining in the year to expend all of it effectively this year?

Dr. STONE. We are. We are—we expended, as of March 30, just under 50 percent. We have some additional obligations, especially in our centers of excellence and our demonstration projects. Although we have obligated the money, there was about $8 million that we pushed out to the field, those obligations haven't come back in. But we do expect to obligate all of that money.

Mrs. LURIA. Okay. And very quickly, what measures of effectiveness do you have for that spending? Are you tracking the number of engagements based off of the paid media that you are doing? And do you have any way to report back whether that spending is effective, and you are using it in the best methods?

Dr. STONE. We are. And, certainly, I am not in advertising or in in how they measure this. But as they—the measures that are beginning to come back indicate that they have been quite effective at recognition. The question is will they change behavior. And Dr. Franklin may have additional comments.

Mrs. LURIA. Okay. And specifically, like, can you tie that to increase calls to the crisis hotline or any other tangible metrics that you will be able to report and track over time and provide back to us based off of that spending?

Ms. FRANKLIN. Yes. Absolutely, we can. We are doing it through two primary metrics.

The CHAIRMAN. Dr. Franklin, I am going to have to ask you to get that back in writing, because we have got to move this along. It is a good question, but could you respond—

Ms. FRANKLIN. I can take it for the record and get back to her. Sure. Certainly. Yes, sir. Yes, sir. Yes, Chairman.

The CHAIRMAN. Thank you.

I would now like to recognize Mr. Barr for 5 minutes.

Mr. BARR. Thank you, Mr. Chairman. And thanks to Dr. Roe as well for holding this very important hearing. And thanks to our witnesses for your dedication and focus on this national crisis.

I did want to ask Dr. Stone about the topic that Mr. Bost was asking about in terms of the increase in overall commitment to the VA since 2005. Approximately a 258 percent increase in funding dedicated to VA mental health care, and yet we do continue to see, unfortunately, a rate of suicide at over 20 a day.

You mentioned a couple of things that I wanted to kind of explore and kind of unpack what is going on, why we haven't seen a decline in the total numbers. Is that—and you noted that there were a total number of deaths by suicide among middle aged and older adult veterans as the highest category. But we do also see, from your suicide data report, that the rates of suicide are highest among the youngest veterans.

So the rates are higher among the youngest veterans. And I did note, from the Iraq and Afghanistan Veterans of America testimony, that veterans aged 18 to 34, the post 9/11 generation, has the highest rate of suicide. Is that the explanation for why the numbers are still elevated even though we have made an additional financial commitment to addressing this national crisis? And if not, what is the cause of that.

Dr. STONE. Maybe some of my colleagues can, but I don't think I have a full answer to that question except I absolutely believe that not all of this is about mental health. I think significant amounts of this relate to personal, financial, and relationship-based problems and loneliness and isolation.

Secondly, you and I both know that the post 9/11 generation of veteran joined the military knowing they were going to combat. That is a unique individual in America that has not only joined but understands they were absolutely going to war. And the effect of that, I have already discussed. And the effect of recurrent deployments and what it does to ongoing relationships.

Mr. BARR. Thank you.

Recently my hometown of Lexington, Kentucky reached an important milestone in ending veteran homelessness. After a

multiyear collaborative effort, it was certified that no veteran was living outdoors or unsheltered, meaning that the VA certified an effective, quote, end to veteran homelessness in our community. This milestone is particularly important because, as many of us are aware, homeless veterans are at a significantly higher risk of suicide than non-homeless veterans.

Dr. Stone, Dr. Franklin, I notice that many suicide prevention resources that the VA provides are available only online or by phone, or information about mental health services are sent via mail.

Given the higher suicide homeless—the higher rate of suicide homeless veterans face, how is the VA reaching homeless veterans who obviously don't have access to those resources?

Ms. FRANKLIN. Yes. We have 444 suicide prevention coordinators with a surge underway to plus that up by another—a number of 246 more. And they actually do in-person outreach engagements where they are out in communities. We have a metric for them to do at least five face-to-face outward engagements to tap into people just like you mentioned. And many times, when I do my checks and I go out and do visits at the VA, they talk with me about these—that they do many more than five. Five is the requirement. But they are out. They are tapping into veterans where they are out in these communities. And they are familiar with shelters and local entities where the veterans are. And they are doing face-to-face outreach engagements.

Mr. BARR. Another quick question about the National Guard. Obviously, certain National Guard members who were never Federally activated are not eligible for VHA mental health services, yet they may go to the VA for help in a time of crisis. How does the VA handle these guard members who seek help?

Ms. FRANKLIN. We do not turn them away. We treat them. We bring them in into the fold. We give them care immediately, right away, barrier free, access free. Furthermore, Dr. Stone signed a MOA this year with the National Guard and the Reserve Leadership to have our mobile vet centers out at every drill weekend. And we did a one-for-one match with every drill weekend to assign it to a mobile vet center so that they are getting care early and consistently over time.

Mr. BARR. And in my remaining time, briefly, equine-assisted therapy, we see this in Central Kentucky, the horse capital of the world.

Dr. Franklin and SAMHSA, any of the witnesses here, what is the evidence in support of these adaptive sports therapies?

Ms. AVENEVOLI. So we have a whole center at the NIH that focuses on alternative therapies, or nonpharmacological therapies. What we find from most of this work is that they share components that are relevant to treating mental illness or suicide risk. I am not as familiar with equine-assisted therapy, but it does have key components of things like mindfulness and connection and attachment that are key components of a lot of our evidence-based therapies like cognitive behavioral therapy.

Mr. BARR. Thank you.

My time has expired.

The CHAIRMAN. Thank you. Mr. Barr.

I now recognize we can Mrs. Lee for 5 minutes.

Mrs. LEE. Thank you. And thank you all for being here and sticking through this.

First of all, I appreciate the approach, the whole health approach, that you are taking. And I wanted to address what you said, Mr. Stone, that it is not all about mental health. And in the CDC report that was included in our packet, it reported that more than half the people who died by suicide did not have a known mental health condition. It went on to say that many of these deaths were preceded by economic losses, physical health problems, and housing stress. And it further said that—it went on to identify seven strategies for helping deal with those individuals who are identified as high risk. The number one strategy was economic support.

Given that the highest—we are seeing the biggest increase in our younger veterans, and we are seeing a big increase in suicides across the country in young—our young members of our society, my question is, have you done any tracking on access to economic benefits to the veteran's benefits? You know, has there been any tracking in terms of risk in terms of who has committed these suicides? Have they had trouble accessing the VA benefits, et cetera?

Dr. STONE. So we do know anecdotally that there is financial problems related to a number of the recent on-campus suicides. But I cannot create a pattern for you that this relates to what I believe is anecdotal.

We do know, however, that at the point of impending homelessness, the incidence of suicide rate, which in veterans is just over 30 per 100,000, dramatically goes up to about 80 per 100,000 population.

So financial instability is an absolute risk factor.

Mrs. LEE. So I want to get into tracking and what you are doing also with respect to the Department of Defense and the executive order and the electronic health records, as the chair of the Subcommittee. I understand that you are collaborating on the screening tool for the new electronic health record system. What is the status of that collaboration?

Dr. STONE. It is an active collaboration at this time as we try to create a common platform that will allow not only access to data but common clinical pathways that allows us to capture information in the same way.

Mrs. LEE. Are there specific aspects of DoD policy and practice that you are incorporating, and vice versa?

Dr. STONE. Yes. Yes. There is active collaboration and the IPO that works with us to collaborate is actively engaged in this as are the work committees. We have 18 different committees that are working to collaborate.

Mrs. LEE. Well, seeing that the IPO is not fully formed, that is sort of a problem. And the fact that the—you know, the Department of Defense has not agreed to come to a round table that we had to discuss about this, I mean, we are not—I don't see evidence of the IPO.

Dr. STONE. So the IPO has been in existence for a fair length of time, and we have been working together for years as we have worked through this. Both secretaries committed to enhancing the IPO, and we are still working our way through those processes.

But as I stated earlier, I have found DoD a wonderful partner in this.

Mrs. LEE. So when the electronic health record goes live next spring, will suicide risk be a flag that is immediately available?

Dr. STONE. Yes.

Mrs. LEE. And are there any flags that will not be available by go live?

Dr. STONE. I would have to bring the work group leads that are actually working this. I will be attending in Kansas City next month, one of the work groups myself, to actually work through this process and observe it.

We have had four separate meetings that have brought clinicians and leaders together in order to make these decisions. The fifth will occur in the next couple of weeks, and then I will be out at work group six in order to work our way through this.

Mrs. LEE. Okay. Great.

One final question. What data will be collected from the health telenet platform? And how will it be used for further development of effective interventions?

Ms. FRANKLIN. We will have to take that for the record in terms of the specific data for telemental health—

Okay?

Mrs. LEE. All right. Thanks.

I yield.

The CHAIRMAN. Yeah. Thank you, Mrs. Lee.

Mr. Cunningham, you are recognized for 5 minutes.

Mr. CUNNINGHAM. Thank you, Mr. Chair. And thank you to every one of you for attending tonight.

Suicide prevention coordinators are critical to VA's efforts to prevent veteran suicides. I wanted to see if you all could speak to, in your opinion, as to what shortcomings the VA has with suicide prevention coordinators as far as mistakes they may make, or any issues or weaknesses found within that particular employment.

Ms. FRANKLIN. Sure. I can take that.

We have, I said earlier, 444 suicide prevention coordinators around the Nation. I would note that we are the only hospital system that has employed full-time suicide prevention coordinators to get after this issue. We are in the process of hiring up another 246. This is based on an analysis that was done over the past year that recognized the fact that we plussed up our veteran crisis centers. As you well know, this has been briefed to this Committee.

And then we also created a new capability called REACH VET, which is a predictive algorithm that produces a red flag and looks at a number of variables and provides a force function for our SPCs and others inside the hospital system to do caring outreach to veterans that present with high risk. And so that has created an additional workload and burden on this capability that was stood up over 11 years ago. And as well it is a time to just continue to reset and refresh the community. We offer a training for them every other year in collaboration with DoD called a DoD VA suicide prevention conference where we do an ongoing assessment of their needs, and we make sure that we are training them with the latest evidence-based practices and that we are supporting them. They are taking care of our Nation's veterans who are at most high risk,

and we care for them as well. And we want to make sure that we are providing them the best care possible.

We recently also conducted an analysis to further advance public health entities other than just suicide prevention coordinators that are doing straight clinical work. We want to make sure we are doing additional work outside the community with outreach so that it is a holistic approach.

Mr. CUNNINGHAM. Right.

And of those 246 additional hires, how many vacancies waiting to be filled, if any?

Ms. FRANKLIN. So those are not vacancies. Those are additional plus ups above and beyond.

Mr. CUNNINGHAM. Are there any current vacancies waiting to be filled?

Ms. FRANKLIN. We don't have the vacancy rate with just SPCs, but we have it with our mental health writ large which includes all of our social workers and psychologists and others. And the vacancy rate hovers around 10 percent. I know Dr. Stone might want to add to that.

Dr. STONE. Yeah, I do. Because we are working with a segment of health care delivery that no one else has ever done before, we are still figuring this one out. And when I say that, the average of suicide prevention coordinator will have a cohort of about 90 patients. But yet, not all of them are they contacting every day. In some instances, especially in those people coming out of our emergency rooms that are at risk, they are being contacted by the nurses or, actually, even the provider.

We implemented, as was mentioned by my colleagues, a post-suicide attempt suicide prevention contract that I have spoken about previously, not here today but in previous testimony, that has been pretty dramatic at reducing future suicide rates. But the individuals that are actually interacting with that at-risk veteran are either the nurses or the actual provider that cared for them in the emergency room.

So adding the additional personnel is a recognition that we continue to grow in our engagements, in our veteran crisis line, as well as identifying at-risk veterans by going through what we call our REACH VET Program. We have now identified over 30,000 veterans that we considerate at substantial risk of future suicide, and making positive contact with them is essential.

Mr. CUNNINGHAM. I appreciate that, Dr. Stone.

And one final question for you, as I am trying to, you know, understand what you testified to here today.

Let's say you are king for the day. And for every extra dollar of funding that you received, how much of that would you put into addressing mental health within the VA hospital and, you know, suicide prevention coordinators addressing the issue head on. And then what percentage of that dollar would you allocate towards the issues you previously identify, whether it be homelessness or economic, basically those underlying factors.

Dr. STONE. I think having sat through the last couple hours here with me, you understand—well understand very well my answer. This is not a financial problem. This is a problem of the society

that we live in. And this is about the interpersonal connections that we each have to each other as a society.

I can hire another 20,000 mental health providers. And what I can say to you is that people in crisis will get great care. And they will come in or be seen in the same day as they are today. I can hire additional people for at-risk.

But this is about moving to the left. Moving towards the fact that we need to reduce risk. And it goes back to your colleague's comments earlier about whole health and identifying what connects us as humans to other humans and finding stabilization as a society that is much different than it was for those veterans that came home 30, 40, and 50 years ago.

Mr. CUNNINGHAM. I appreciate your time. And I appreciate the service each of you all provide.

I yield back.

The CHAIRMAN. Thank you, Mr. Cunningham.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman, and I just want to thank all the witnesses for being here this evening.

Dr. Stone and Dr. Franklin, I sat down and had a conversation with the director of the VA Long Beach Medical Center, and he mentioned a pilot program that they are running called the Veterans Medical Evaluation Team or VMET. Have you heard of it? Yeah.

So for those of you who don't know, this program is a partnership between the Department of Veterans Affairs in Long Beach and also law enforcement, local law enforcement to actively reach military veterans in trouble even if they are not connected with the VA system. They train local police officers. Even a VA clinical technician will even often go with the law enforcement officer on calls when it is regarding a veteran. He touted this as a very successful pilot program that they are running, and we heard about several other examples of successful pilot programs that local VA hospitals are running as well just here this evening.

How is the VA kind of collecting this data from these? I mean, obviously you are encouraging local VA hospitals to go out and to run community programs, but how is the VA overall collecting this data and then deciding if these pilot programs are successful and then trying to implement them out on a larger scale?

Ms. FRANKLIN. It is a very good question, and I appreciate this example that is happening in your area because we have 24 cities that are working with us and 7 States. We call them mayors and governors challenge, and they are implementing, just as you described, creative evidence-based approaches that involve training community members and accessing care and reaching veterans where they work, live, and thrive.

We bring them in in collaboration with our colleagues here from SAMSA to train them on these approaches so that they can execute these, and we monitor them over time through a technical assistance arm that is offered through my colleague, Richard McKeon, who is here today. And we do it together. We host a series of monthly calls with local mayors and governors, county teams to learn the best practices.

And we have created an online IT platform where we call it a community of practice where they can also input their best practices and the data into this platform where anybody across the VA can go in, look, share, and learn. And so that is a little bit of how we are doing it. I want to have Dr. McKeon also share because he is helping us on this effort.

Mr. MCKEON. Yes. I think it is a very important initiative because it is really trying to promote comprehensive approaches to suicide prevention at the local level which is what we think is really needed. And so we look forward to our continued partnership with the Veterans Administration around this work both in the cities and the rural areas and among States.

Mr. CISNEROS. So we are sharing best practices which is great, but has there been any example of a program where you have taken a program and said okay, we need to implement this nationwide because it is working?

Ms. FRANKLIN. Yes. I will give you one example that was actually done under the leadership of Dr. Stone, and that involves our ER work. So there was an initial early study that spoke to the importance of aftercare when people leave our ERs where they are getting a simple intervention, also mentioned by my NIMH colleague, around caring outreach with a phone call to veterans when they leave the emergency room. And it pointed towards significant reductions in suicide when they have this caring outreach, and we had done it in a pocket, I believe it was seven of our facilities, and we had tracked the data over time in a small pilot.

And when Dr. Stone got in the seat of the executive director, we had a series of meetings that put it on a fast track for full implementation across the entire VA system, every ER. I don't know if that sounds like—

Dr. STONE. And this is specifically directed at survivors of a suicide attempt. And as was mentioned earlier by our colleagues, they had seen a 30 percent reduction. We are actually seeing a 50 percent reduction in future suicide attempts.

Mr. CISNEROS. You know, we have heard numerous times today this is basically going to take a village. The VA can't do it by itself. Everybody is going to need to get involved working with local law enforcement and local officials as well to make this all happen.

The last thing I have, you had mentioned the program that you have been working with, with the Air Force, and you have been able to work with the Air Force to kind of help minimize the numbers. That is the first I heard of this program. I would love to see more information about that, and I would really—if it is being so successful with the Air Force, why haven't we been able to implement it with the other services?

Dr. STONE. I would not speculate, sir, on what the other services have done or not done. I have been out of uniform since 2014. I can tell you that we in VA are incredibly intrigued with the fact that the Air Force has taken as far back as 1996 the integration of suicide prevention strategies and integrated them into virtually every level of officer and enlisted training.

And in response to 18 years of warfare, they have seen almost no increase in Air Force veterans or Air Force active servicemembers of suicide rates.

Mr. CISNEROS. Well, my time has expired, but if you can make that program, the information about it available to us, I would appreciate that. Thank you.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Mr. Cisneros.

Ms. Underwood, you are recognized for 5 minutes.

Ms. UNDERWOOD. Thank you, Mr. Chairman.

Dr. Franklin, annual reviews of VA's suicide prevention and mental health services have found that most veterans receive good mental health care from the VA. Despite that, though, the suicide rates for veterans in my home State of Illinois is almost double the rate of the general population. I am a public health nurse. I prepared for this hearing tonight by reviewing the medical research on the subject, and I would like to walk through some of that research briefly with you today.

Suicide attempts for servicemembers are more likely to result in death than they are for civilians. Is that correct?

Ms. FRANKLIN. Yes, ma'am, it is.

Ms. UNDERWOOD. So let's talk about what the research says might contribute to that so we can make sure implementing evidence-based policies to prevent it. You are aware that both men and women veterans have much higher rates of firearm ownership and easier access to firearms than the general population. Is that correct?

Ms. FRANKLIN. Yes. Yes Chairwoman.

Ms. UNDERWOOD. Okay and so veterans, of course, already are familiar and comfortable with firearms than the general population. Is that correct?

Ms. FRANKLIN. Yes.

Ms. UNDERWOOD. Okay. So we know that both men and women veterans are more likely than civilians to use firearms for suicide. Is that correct?

Ms. FRANKLIN. Seventy percent more, yes.

Ms. UNDERWOOD. Okay. And so this is especially more dangerous because attempting suicide with a firearm is more deadly than with any other method?

Ms. FRANKLIN. Absolutely.

Ms. UNDERWOOD. Okay. So I really do commend the VA for calling attention to firearm suicide among veterans, and currently the VA's national suicide data report found that intervention focused on preventing self-harm by firearm are integral to preventing veteran suicide. Since 2008, the VA has offered free gun locks to veterans in an effort to reduce suicide. Is that correct?

Ms. FRANKLIN. Yes, we have.

Ms. UNDERWOOD. Okay. And so the VA has an educational campaign as well. I saw fliers myself during my visit to the Level Healthcare Center back home last week, but obviously veteran suicide remains at a critical level. VA health professionals receive training on providing lethal means counseling to veterans. Is that correct?

Ms. FRANKLIN. Yes, we do.

Ms. UNDERWOOD. Okay. Can you tell us what that training looks like?

Ms. FRANKLIN. The training is focused on how to talk with veterans in a firearm friendly way that is culturally relevant. We don't want our clinicians to lose veterans or to turn them off by using the wrong term or to have them begin to talk about this issue in a way that brings it into the public square and is a potential political issue.

We teach our clinicians that it is about safety, and the training is focused on protecting the environment as is the last question in the safety plan that both of my colleagues here from SAMSA and NIMH mentioned. It is about assessing the environment for all causes and manner of safety issues, and we focus the training on putting time and space between the person at risk and the identified means with many of the things that were talked about at this hearing this evening like whether it is the freeze method or storage of firearms or even having a peer involved and having a peer hold a weapon while—a firearm while a veteran is at imminent risk.

Ms. UNDERWOOD. And so who receives the training? So, you know, you mentioned that the professionals do get it, but which categories of professionals?

Ms. FRANKLIN. Mental health professionals.

Ms. UNDERWOOD. Okay. In the written testimony, it talked a lot about how many veterans received primary care, and most or many of these screenings are done by the primary care providers. Do you see any utility in training your VA primary care providers in these methods?

Ms. FRANKLIN. Yes. If it were up to me, we would train the entire VA on how to talk about lethal means. It is a short training. It is available online. It is easy to take, and we would monitor and assess it over time and continue to make it better, absolutely yes, ma'am.

Ms. UNDERWOOD. Is that a resource constraint that prevents the primary care providers and others being mandated or required to undergo this training?

Ms. FRANKLIN. Quite honestly, I don't think it is about resources. I think it is about getting their commitment and getting them on board to do it. We certainly have work to do in this space to make sure the primary care docs prioritize that in their training rotation and platform, if you will.

Ms. UNDERWOOD. Okay. Well, I think that this Committee would certainly support elevating that among the priority measures for the primary care providers. And if there is anything that we can do to accelerate that, I think it would be useful. We want to make sure that all health care professionals are armed with the resources that they need in order to properly service our veterans.

Has the VA engaged at all with firearm dealers and ownership groups to find ways to increase their involvement with veteran suicide prevention?

Ms. FRANKLIN. Yes, absolutely. That is why we have a participate with the National Shooting and Sports Rifle Foundation which I mentioned earlier. It is an MOA, so it is an official partnership. It involves the whole leadership chain. It is not just with my single program. It is between the whole VA and the whole National Shooting and Sports Foundation.

And it also involves the American Foundation for Suicide Prevention which is another non-profit that is heavily engaged in the research in this space. And it calls for the three agencies to work together to bring firearms owners, dealers, and even trade organizations to the table and teach them about signs and symptoms of risk.

Actually, the State of New Hampshire has had quite a bit of success in this as has the State of Colorado, and so we are doing quite a bit of work in this space.

Ms. UNDERWOOD. And when you say bring together, are you actually hosting these meetings?

Ms. FRANKLIN. We are not hosting them at the national level, but they sure are hosting them locally, and they are even going door to door to firearm dealers and people that sell, and they are talking with them about suicide risk. Richard McKeon may have some additional information.

Mr. MCKEON. So in numerous States, this kind of work is going on with SAMSA funding, so SAMSA is not convening those meetings directly, but our funding that goes to States has been used in a number of different States to fund this kind of activity.

Ms. UNDERWOOD. Well, thank you so much for sharing this information. I do think that there might be some utility as we explore evaluating these types of partnerships and seeing if there is more of a direct role that these agencies can play. And certainly if our Committee can be helpful in accelerating that, we stand by to do so. Thank you.

Ms. FRANKLIN. Thank you, Chairwoman.

The CHAIRMAN. Mr. Rose, you are recognized for 5 minutes.

Mr. ROSE. Thank you, Mr. Chairman. To the witnesses, thank you so much for being here today. Dr. Stone, Dr. Franklin, I can see that you are deeply committed to this issue. My fear is that there are some things, as you mentioned, that are out of our control. And I am saying this as someone that was an infantry platoon leader in Afghanistan 6 years ago, and one thing is our operational tempo and the intensity of our deployments. So my questions today center around the effects of these issues on suicides. I am going to read off a few statistics to you, and then I have a few questions.

In a report published in 2018 by the Uniformed Services University, it shows that those who served 12 or fewer months before their first deployment were approximately twice as likely to attempt suicide during or after their second deployment. Also, in additional studies, those redeployed within 6 months or less were 60 percent more likely to attempt suicide. Were you aware of these statistics?

Dr. STONE. I am.

Mr. ROSE. Have you seen any further causal relationship between the number of deployments and the intensity of deployments as it relates to suicide between the 18 to 34 demographic, particularly the post 9/11 combat veterans?

Dr. STONE. Certainly there are some deeply troubling issues regarding operational pace that you bring up and I referenced earlier in testimony. And that is not only the intensity of ongoing combat in a 12- to 15-month deployment as well as the dwell time when we bring servicemembers back. That was extensively studied in the

Army STARS Program. It was also a point of interest for General Chiarelli as the Vice Chief of Staff of the Army who spearheaded a number of studies on dwell time and relationship-based effects related to the amount of suicides in ground troops in both the Army and the Marine Corps, and all of that work was done in cooperation with the Marine Corps.

Mr. ROSE. So my question, though, is as you see further evidence relating deployments and op tempo to suicides, amongst young men and women, do you think it is within your purview to make recommendations to the Active Duty Army as to what they should change, and note that if they do not change those things, they are creating an avoidable, and what I would argue, incredibly wrong risk of suicide amongst our veteran populations. Do you think that is within your purview to make those recommendations to the Active Duty Army?

Dr. STONE. I think that identifying data and sharing that data with our uniformed colleagues is entirely appropriate. I am not the decisionmaker.

Mr. ROSE. And so—no, of course not. But I am talking about recommendations. And so would you recommend to the Active Duty Army, would you say that it is responsible to redeploy soldiers with less than 6 months of dwell?

Dr. STONE. Those are decisions that the active component must make.

Mr. ROSE. I am asking as a health care professional if you would say it is responsible.

Dr. STONE. And I am saying to you, Congressman, that those are decisions that the active component must make. We can provide data. We can share that data. We have a cooperative environment in which we as health care professionals are discussing this, but you can go back through the 20 years of this war and really look at the push and pull between the size of the ground force and the relationship between the medical professionals that were advising senior leaders and decide for yourself how that has been handled.

I was in uniform for 23 years. I served on the Army staff. I had my chance to say what I needed to say and was welcomed by senior leaders and was proud to work alongside the ground combat forces. That said, my job at this point is to take care of 20 million veterans that want to see us and to take care of their problems. The decisions on dwell time, combat time are certainly in a discussion between you and those active leaders.

Mr. ROSE. Okay. I understand.

Now, moving on to National Guard soldiers presently serving in the National Guard, how do you explain, what is your understanding of this crisis with suicides amongst National Guard soldiers who have not deployed, and do you think that the training op tempo has any connection to this and the fact that it has increased dramatically in the last 20 years?

Dr. STONE. I think there is some deeply troubling parts of the National Guard, and I referenced this earlier in testimony when I said that every one of these servicemembers joined knowing that they were probably going to combat. This is a different National Guard than simply a guard that takes care of the national or the State-related problems of floods, hurricanes, and tornadoes.

This combat force is an area of debate that has been highlighted recently in a book called Signature Wounds. Is the pace too much for the ground combat forces of the guard? These are individuals that have served tremendously well in combat, but the force—the stress on that force is significant and one that I think we all need to consider.

Mr. ROSE. Do you think it is within your purview to make recommendations to the National Guard?

Dr. STONE. And we have entered into an MOU with the National Guard, and the National Guard has been a wonderful partner. General Catavee has been great in our meetings about discussing and trying to do everything he possibly can to reconnect.

One of the things that we see is that there is a lower rate of suicide in guard members than there is in reserve members in spite of the fact that the guard is much larger. There is something protective about the connection within States.

Remember that the Army Reserve is a force that you might travel 400, 500, or 600 miles in order to do your reserve service. The guard has something protective about it that we need to study more, and I can tell you that the leadership of the guard and the Army Reserve has been great about entering in these conversations openly and with a sense of self examination.

Mr. ROSE. Thank you very much again for your time and for your service.

The CHAIRMAN. Thank you, Mr. Rose, for your questions.

Mr. LEVIN. Oh. Actually, not Mr. Levin. I am sorry Mr. Levin. Mr. Watkins, you are recognized for 5 minutes.

Mr. WATKINS. Thank you, Mr. Chairman. Thank you to the panel for being here. These questions will go to anybody who would like to answer.

So having served or lived and worked both in service and as a paramilitary contractor for 8 years in Iraq and Afghanistan, I know firsthand some of the challenges servicemembers face when they come back home, and my question is how do you—the metric of 22 suicides a day. I want to take a closer look at that for a deeper understanding.

That metric kind of hints and suggests this narrative that it is Gulf War veterans, but am I learning right that it is—a lot of those suicides are Vietnam era veterans?

Dr. STONE. 21 percent of the national veteran suicide number is over age 75, percent is between age 55 and 74, 27 percent is between age 35 and 54. And 15 percent is 18 to 34.

Mr. WATKINS. All right. Thanks. Is the VA open to—alternative is a very loaded phrase, but other means of therapy aside from psychotherapy, for example, transcendental meditation?

Ms. FRANKLIN. I think you might be talking about complementary care, and absolutely. It is part of our whole health model, and there are a number of treatments. I don't know that the ones that you specifically mentioned are on that list. I can get back to you on that, but we are open to any and all forms of complementary or adjunct care to treatment plans, yes.

Mr. WATKINS. And do you have data that could measure the efficacy of those as compared to the more traditional psychotherapy?

Ms. FRANKLIN. We don't have data specifically when those are implemented alone. What happens is they are traditionally implemented as part of a broader care system. So for example, a client might get cognitive behavioral therapy with additional complementary care and thus and such, and it is typically evaluated as part of the full system of care, a full treatment plan, if you will, for a veteran.

Mr. WATKINS. Are the veterans open to those approaches?

Ms. FRANKLIN. It appears as though they are. I have read quite a bit in the literature about them being open to things like yoga and other forms of that type of therapy.

Mr. WATKINS. Are Active Guard and Reserve commanders open to those approaches as well? I know it is tough for you to say.

Dr. STONE. I think there has been tremendous progress in the openness of active leaders to these because it can keep soldiers in the fight, and soldiers do very well with these types of training.

I think the early intervention and the embedding of both behavioral health providers with the active component formations has shown tremendous value in both special operations as well as traditional ground forces.

Mr. WATKINS. Should those take a bigger role in soldiers' basic trainings?

Dr. STONE. I think that making servicemembers aware of the role of complementary medicine is tremendously valuable. Probably the hardest data we have really relates to organized sports activities and the protective effect of organized sports activities. And the fact that I think in our latest—the last year's report, it identified that about 150 minutes of organized exercise had really demonstrable protective effect in veterans.

Mr. WATKINS. Great. Thank you so much. I have no doubt there would be many more suicides if it weren't for your efforts, so thank you for your service.

I yield my time.

The CHAIRMAN. Thank you, Mr. Watkins.

And now, Mr. Levin, you are recognized for 5 minutes.

Mr. LEVIN. Well, thank you, Mr. Chairman, for holding this hearing on what is a critically important issue to all of us around the country. Particularly in my district in San Diego and Orange County, there is a very large veteran population, home to Marine Corps Base Camp Pendleton. I had an opportunity during the district work period to visit with the leader of the San Diego VA as well as have several meetings with many of the veteran service organizations and other non-profits that are leading in this and related issues.

I wanted to ask another question about the intersection of guns and suicide as it pertains to veterans. In its national suicide data report, the Department of Veterans Affairs calls for, and I quote, "a continued focus on innovative crisis intervention services."

One crisis intervention tool that 15 states have now adopted and that is shown to reduce suicides is called an extreme risk law. When someone is showing warning signs of being in crisis and a risk to themselves or others, these laws allow their family members or law enforcement to ask a judge to temporarily restrict their access to firearms.

When Connecticut stepped up enforcement of its extreme risk law, it saw a 14 percent reduction in the State's firearm suicide rate, and in the 10 years after its extreme risk law went into effect, Indiana saw a 7.5 percent reduction in its firearm suicide rate. The impact of an intervention tool like this could be magnified for the veteran population because not only do veterans have a higher rate of suicide than the general public, but they are more likely to use a firearm compared to both the general public and to any other method.

To each of our panelists, do you think Congress passing extreme risk legislation is one thing we could do right now to help address the veterans suicide crisis?

Mr. MCKEON. Well, Congressman, I think that we are very aware of the extreme risk protective orders, and the data from places like Connecticut and Indiana are very encouraging. I was at a presentation just last week around this very issue in States that have passed this. I think we want to work closely to make sure that family members and others are aware of the availability of this. I am not really able to take a stance on whether national legislation, but I think that in those States that have taken this, we want to make sure that those who surround veterans and others who are at risk for suicide are aware of it as a potential.

Mr. LEVIN. Thank you, Doctor. Anyone else care to comment?

Well, another area that I wanted to address is collaboration between the Department of Defense and the Veterans Affairs Administration. For me, and for those that I have spoken with, it appears to be a critical aspect for an effective veterans' suicide prevention relationship between private and defense and the VA. And this means ensuring a warm handoff as servicemembers leave the military but also sharing relevant information that can inform VA's intervention strategies.

Now, I understand that the military keeps track of which servicemembers are at higher risk for suicide. Dr. Stone, my question for you is does the DoD share this information with the VA, and if not, have you requested, or will you request they do so?

Dr. STONE. I think sharing of the medical records is a lot different than a commander calling another commander when you move a servicemember or PCS a servicemember. One of the things we implemented when I was still in uniform was warm handoffs between line commanders, not just the mental health professionals. I think we have had an excellent discussion and earlier we discussed about our combined use of clinical practice guidelines of how we do transitions and handoffs.

I think you have identified an area that we could do better, but I will tell you there is good discussion going on, and I am absolutely optimistic that as we implement the electronic medical record on a common platform, the ability to instantly see what is going on from the time the servicemember joined the military will go a long way from the longitudinal viewer that we have today where we have to toggle in and out of our current Vista system to an electronic record viewer from DoD. So a common platform is essential.

Mr. LEVIN. Thank you. I really appreciate all of your work on behalf of veterans, and thank you for taking the time with us tonight.

And I yield back the balance of my time.

The CHAIRMAN. Thank you, Mr. Levin.

I want to thank all of the witnesses for appearing before this Committee today. It certainly has been a long and strenuous evening, and I appreciate your willingness to work with this Committee in combating this tragic crisis.

This is a first of, I think, many hearings that we will be conducting as well as round tables on this topic of veteran suicide, and we will, as I said in my opening remarks, continue to hear from all the stakeholders including the families of those veterans that have committed suicide, those veterans that have survived suicide, and the many other professionals and stakeholders and VSOs that have insights to help this Committee take action and to really make a difference in reversing this trend that we see in veteran suicide.

I understand that the minority does not wish to make a closing statement. I will conclude with these words. To the veterans who are watching this hearing and to those struggling with the thoughts of suicide, a grateful Nation cares for you. Both your service and life are valued, and your continued existence is necessary to advancing the causes for which you so selflessly served. You sacrificed everything to preserve our freedoms. We, as a Nation, are committed to preserving your life.

If you or someone you know is contemplating suicide or in need of additional assistance, please call the suicide prevention lifeline at 1-800-273-8255. That number again is 1-800-273-8255. And when you call that number, press 1 to get in touch with a professional that is waiting to assist you.

All Members will have five legislative days to revise and extend their remarks and include extraneous material.

Again, thanks for all of the witnesses for appearing today before this Committee, and this hearing is now adjourned.

[Whereupon, at 9:48 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Chairman Mark Takano

Good evening. I call this hearing to order.

First I would like to welcome our witnesses this evening: Dr. Stone, from the Veterans Health Administration, Dr. Avenevoli from the National Institutes of Health, and Dr. McKeon from the Substance Abuse and Mental Health Services Administration.

Today's hearing will be the first of many this Committee will hold as it begins the critical work to address veteran suicide. I think we can all agree how important it is to take care of our veterans which is why I have made ending veteran suicide my number one priority.

Sadly, America is facing a national public health crisis that demands urgency from Congress, the administration, medical and clinical professionals, veteran service organizations and veterans themselves.

This morning, we lost another veteran to suicide at a VA hospital. Two weeks ago, three veterans committed suicide on VA property in just five days. Seven veterans have ended their lives on VA campuses this year.

It's clear we are not doing enough to support veterans in crisis. While these incidents may be alarming, they do not tell the full story of veteran suicide in our country. It is harmful to veterans and overly simplistic to solely blame VA for these tragedies. We must come together as a nation to address this crisis.

Too many Americans have been personally touched by this troubling trend-for me, it was my own uncle, a Vietnam veteran, who died by suicide. EXPOUND ON STORY.

Each day 20 veterans, servicemembers, reservists, and members of the National Guard die by suicide.

One veteran lost to suicide is one too many. But 20 deaths a day -- totaling more than 7,300 deaths per year is unacceptable. That's 1,800 more deaths per year than the 5,429 servicemembers who have been killed in action since 2001.

Both numbers are surprising and further evidence of a frustrating and persistent problem that we've failed to adequately address.

When you examine the statistics, the barriers to access many veterans face become very clear. Only 6.1 of those deaths are veterans accessing services at VA. 10.6 deaths a day are veterans not using VA at all, and 3.8 current active duty or members of the National Guard.

We all have a responsibility to act because there's no excuse for failing these veterans here at home.

My Republican colleague, Ranking Member Roe, often says we haven't ″moved the needle″ far enough to reduce veteran suicide. He's right. That number has held steady at 20 deaths a day since 2014-- far too long. It's time for Congress to look at this crisis with fresh eyes.

In 2015, Congress passed the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, but this well intentioned effort hasn't done enough. Recently, I met with several members of Clay Hunt's unit, who identified the specific challenges they faced as they transitioned out of the military.

We need to understand why this legislation hasn't done more to prevent suicides. We need to expand our understanding of mental health among veterans. We need to commit to providing the resources needed to implement a comprehensive plan.

Most importantly, Americans must hear from and listen to our veterans. We need to hear from veterans who have attempted suicide, understand their circumstances, and find out what they believe worked and what failed.

These veterans have a story to share that can tell us something about our attempt to address suicide and how responsive government can be to their situation.

This committee will not be indifferent to the problems veterans face nor will we turn a blind eye to the many causes that lead to veterans committing suicide. And I'm glad we could all come together today to begin to tackle this important issue.

Ultimately, it's up to all of us to reduce and prevent veteran suicide because this is not a problem VA can solve alone. We know that dedicated doctors, nurses, and VA employees have saved over 240 veterans from committing suicide on VA campuses in recent years. VA briefs me on each suicide at a VA facility, and there's still so much we don't know. We must involve partners at the federal, state, and local levels and do a better job of supporting veterans in need regardless of whether that need is clinical or social.

By supporting clinically effective programs and increasing access to programs that mitigate the impact of concerns -- be they financial, marital, substance abuse related, or physical health -- veterans will feel the support they seek.

VA must also ensure every interaction it has, not just in a clinical setting, makes veterans feel supported. One example from VFW struck me when I was reading the statements for the record from the VSOs:

And I quote: ″The VFW is working with a veteran who was rushed to a VA hospital during a mental health crisis caused by untreated bipolar disorder and depression. The veteran was admitted to the medical center's inpatient mental health care clinic for two weeks, despite not being eligible for VA health care. VA saved his life, but now he has a $20,000 bill.

His mental health crisis was exacerbated by unemployment and his inability to provide for his family.

With proper treatment he has been able to return to work, but still lacks the resources to pay the VA bill. The VFW is working on having his bill waived, but he will never return to VA if he has another mental health crisis.″

This is just one more testament to what we already know-when a veteran is faced with the sky-high cost of medical care, it can be a significant barrier to getting the help they need.

To really combat this crisis we will have to change our mission. We must reexamine our approach to suicide prevention, exhaust our research possibilities, break the stigma faced by those seeking mental health services, and expand the healthcare and support we offer veterans. Like all of those in this room, I believe Americans are ready to meet this challenge.

Countering this crisis will require us to shine a national spotlight on veteran suicide. There is still so much we do not know. We need to better understand the root causes driving veteran suicide, hear from the families who have lost loved ones, and listen to the clinicians and social workers who are on the front lines battling to end veteran suicide.

As Americans, we are proud of the service and sacrifice veterans have made for our country, but a polite ″Thank You for Your Service″ isn't enough for our veterans in crisis. Instead, we must thank and honor our veterans with action, work together to deliver top quality healthcare, provide community support, and ensure we offer a stable transition out of military service and into quality, sustainable employment.

Truly thanking veterans for their service means helping them when they need it most and rise above political opportunism to support veterans in crisis. It is my hope that together, we can curb this crisis.

Before I recognize Ranking Member Roe I'd like to point out that May is Mental Health Awareness Month and we all have to do our part. I encourage every member of this Committee to record a suicide prevention PSA to highlight VA's Be There campaign.

As Wounded Warrior Project pointed out, ″. if a treatment program does not offer a family or caregiver component, and warriors go through clinical processes then return home, it may leave the family or caregiver to feel left in the dark about what occurred.″

We should be doing all we can to ensure family members and caregivers not only feel supported but have access to much needed resources as they help their loved one recover.

In addition, I would encourage all of you to meet with both veterans who are suicide survivors and speak with families who have lost loved ones to suicide to better understand how we can work to end this crisis.

To the veterans watching this hearing, and to those struggling with thoughts of suicide: A grateful nation cares for you. Both your service and life are valued, and your continued existence is necessary to advancing the causes for which you so selfless served - You sacrificed everything to preserve our freedoms. We, as a nation, are committed to preserving your life.

If you, or someone you know, is contemplating suicide or in need of additional assistance please call the suicide prevention lifeline at 1-800-273-8255 and press 1 to get in touch with a professional that is waiting to assist you.partnerships, build new ones, and improve suicide prevention strategies through scientific research.

Prepared Statement of Shelli Avenevoli, Ph.D.

Good evening, Chairman Takano, Ranking Member Roe, and distinguished Members of the Committee. I am Shelli Avenevoli, Ph.D., Deputy Director of the National Institute of Mental Health (NIMH) within the National Institutes of Health (NIH). It is an honor to appear before you today alongside my colleagues, Richard A. Stone, M.D., Executive in Charge, Veterans Health Administration (VHA); Keita Franklin, LCSW, Ph.D., Executive Director, Suicide Prevention, U.S. Department of Veterans Affairs (VA), Office of Mental Health and Suicide Prevention; and Richard T. McKeon, Ph.D., M.P.H, Chief, Suicide Prevention Branch, Center for Mental Health, Substance Abuse and Mental Health Services Administration (SAMHSA).

I want to thank this Committee for your sustained interest in the NIH, where we work to ensure that our nation remains the global leader in biomedical research and advances in human health. I also want to thank the Committee for bringing us together to address the challenges of suicide prevention in this country, for veterans and all Americans.

The Centers for Disease Control and Prevention (CDC) reported that 47,173 Americans took their own lives in 2017.[1] This is a part of a two-decade trend that has resulted in a 33 percent rise in the national suicide rate.[2] As the national lead for research on suicide risk and prevention, and as part of the National Action Alliance for Suicide Prevention, NIMH works with the CDC, SAMHSA, VA, and other federal agencies and private partners to better understand - and help reduce - suicide risk.[3]

Suicide prevention research is a top priority for NIH.[4] Over the past five years, NIH has steadily increased its support for suicide research across the spectrum, from basic to applied research. NIH spent approximately $52 million on suicide research in fiscal year (FY) 2016, $68 million in FY 2017, and $96 million in FY 2018. NIMH continues to support research aimed at understanding the complex mechanisms underlying suicide risk to inform the development of transformative prevention and treatment interventions of tomorrow. We also support research to test the effectiveness of treatments, as well as identify promising new clinical interventions to prevent suicide and treat suicide risk. Together with our federal and private partners, we work to translate research findings into practice by facilitating wider use of evidence-based prevention and treatment interventions.

Comprehensive suicide prevention efforts require multiple approaches, within and beyond the healthcare system. I want to begin by focusing on opportunities within the healthcare system related to access and clinical innovations. It is estimated that nearly half of individuals who die by suicide see a healthcare practitioner in the 30 days prior to death, and around 80 percent do so in the year before [5]death[6]. In addition, estimates indicate that approximately half of suicide decedents have at least one emergency department (ED) visit in the year before death. Recent research has identified several specific interventions that healthcare systems can implement to identify individuals with suicide risk more quickly, and help treat and reduce suicide risk to save lives.

A key step to helping someone with elevated suicide risk is timely identification. One way to do this is to ask people directly about suicide risk, especially in healthcare settings. The NIMH-funded Emergency Department Safety Assessment and Follow-up Evaluation study (ED–SAFE) demonstrated that a 3-item screening tool improved providers' ability to identify individuals at risk for suicide. This study showed that when screening was conducted on all patients - regardless of the reason for their ED visit - the number of patients identified as being at risk for suicide was double the number identified under usual care.[7] If used universally, the ED–SAFE researchers estimated that suicide risk screening tools could identify more than three million additional adults at risk for suicide each year. Use of enhanced suicide risk screening is expanding - including in the VA, which began a new screening initiative in 2018.[8]

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[1] https://webappa.cdc.gov/sasweb/ncipc/mortrate.html
[2] https://www.cdc.gov/nchs/products/databriefs/db330.htm
[3] https://theactionalliance.org/
[4] https://www.nimh.nih.gov/about/director/messages/suicide-prevention.shtml
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026491/
[6] https://www.ncbi.nlm.nih.gov/pubmed/12042175
[7] https://www.ncbi.nlm.nih.gov/pubmed/26654691
[8] https://www.blogs.va.gov/VAntage/55281/va-sets-standards-in-suicide-risk-assessment-offers-support-to-community-providers/

In addition to screening people for suicide risk during healthcare visits, we now know that it is possible for healthcare systems to use data from electronic health records in novel ways to help identify people with suicide risk. The first application of these methods to identify suicide risk occurred as part of NIMH's partnership with the Department of the Army in conducting the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS; the largest U.S. study of mental health risk and resilience ever conducted among military personnel).[9] Researchers from NIMH and Army STARRS then partnered with the VA to develop predictive models of suicide risk among veterans receiving VA health care. This research demonstrated the feasibility of developing algorithms to identify patients within the VA system whose predicted suicide risk was 20–30 times higher than average. While these patients with very high predicted risk were already receiving a lot of health care, most of them had not been flagged as having elevated suicide risk using existing identification methods.[10]

Using analyses of VA electronic health records, the research led directly to the VA's Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment (REACH–VET) program, which currently applies an algorithm each month to the VA patient care population to identify a small fraction (0.1 percent) of patients with the highest predicted suicide risk. Suicide prevention coordinators at each VA facility work with these patients and their clinicians on suicide-focused clinical assessment and ways to enhance treatment. The VA was the first healthcare system in the United States to utilize these methods in their suicide prevention programs. Other systems are beginning to follow the VA, including some of the 13 healthcare systems across the United States that are part of NIMH's Mental Health Research Network.[11]

Identifying people who need help is a key first step, but screening alone is not sufficient. Improving patient outcomes requires that effective interventions be initiated during the health care encounter when someone is identified with suicide risk. Moreover, to enhance continuity of care, follow-up with the patient should be made when the patient is discharged back into the community. During the initial encounter, one promising approach is the Safety Planning Intervention adapted by the VA,[12] in which a clinician collaborates with the patient to identify specific strategies to decrease the risk of suicidal behavior, such as ways to reduce the patients' access to lethal means during a time of crisis, and to identify personalized coping strategies.[13] Safety planning can be combined with proactive follow-up with the patient, by telephone and/or in writing, to provide psychosocial support and encourage engagement in follow-up care. NIMH's ED–SAFE study, which focused on ED patients at risk for suicide, found that brief interventions in the ED, plus up to seven follow-up phone calls to the patient by a clinician, reduced suicide attempts by about 30 percent during a 12-month period.[14] Consistent with this finding, a recent study conducted in VA EDs found that a Safety Planning Intervention with follow-up phone calls reduced suicidal behavior by nearly 50 percent over 6 months, and doubled the likelihood of individuals receiving follow-up mental health treatment.[15]

Multiple agencies, including NIMH and VA, are supporting several research studies that have uncovered benefits from an intervention called "caring communications," in which patients are sent follow-up written communication - by postcard or letter, or now also by text message - in the weeks and months after they are identified with suicide risk. Such communications, which convey general support to the patient, have been found to reduce suicidal behaviors up to a half in the subsequent year.[16] While we do not yet know the exact "how and why" these follow-up interventions work, the common element is regular and supportive contact with the patient during a critical period when they transition between structured healthcare settings and the community. Research shows that caring communications is a very high-value intervention; that is, it is a relatively low-cost intervention compared to its benefits.[17] Telephone or written follow-up communications can be provided by the hospital where the patient was identified, from a centralized facility coordinated by the health system, or by staff from Crisis Line programs such as the National Sui-

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4286426/
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539821/
[11] https://www.ncbi.nlm.nih.gov/pubmed/29792051
[12] https://amhcajournal.org/doi/abs/10.17744/mehc.34.2.a77036631424nmq7
[13] https://www.mentalhealth.va.gov/docs/VA—SafetyPlan—quickguide.pdf
[14] https://www.ncbi.nlm.nih.gov/pubmed/28456130
[15] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2687370
[16] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2723658
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750130/

cide Prevention Lifeline or the Veterans Crisis Line. This type of proactive follow-up is, unfortunately, not yet part of standard practice.

For individuals who cannot be safely discharged to outpatient care because of severe suicide risk, there is an urgent need for fast-acting interventions. These individuals could receive rapid acting treatment in EDs and inpatient psychiatric units. Several potential fast acting medications have received recent Food and Drug Administration (FDA) approval: brexanolone infusion for severe postpartum depression, and esketamine nasal spray for rapid resolution of treatment resistant depression. Both of these medications must be delivered under an FDA approved Risk Evaluation and Mitigation Strategy. Other promising rapid acting interventions have been available for some time but have not been tested as a first-line intervention for acute suicide risk. We need studies that can determine safety, dosing, duration and combinations of treatments,[18] so that we avoid risk of addiction for some of these treatments (e.g., ketamine and/or related compounds), and find combinations of treatment that result in longer recovery periods. The VA has had National Protocol Guidance on Ketamine Infusion for Treatment Resistant Depression and Severe Suicidal Ideation since 2017, and there are VA studies, for example, testing ketamine for PTSD and treatment-resistant depression, and esketamine for suicide [19]risk [20].

Earlier I mentioned that comprehensive suicide prevention efforts require multiple approaches, within and beyond the healthcare system. The National Action Alliance for Suicide Prevention identified a range of best healthcare practices, collectively called Zero Suicide,[21] for improving outcomes among individuals at risk for suicide, and NIMH is investing in research to evaluate the real-world experiences of health systems that implement Zero Suicide programs. Zero Suicide practices include suicide risk screening, safety planning, treatments that target suicide risk (e.g. cognitive behavior therapy; dialectical behavior therapy), follow-up phone calls, and caring communication interventions I just described. To estimate the effects of such practices on suicide attempts and deaths, and to inform ongoing quality improvement, it is necessary to monitor the outcomes of patients who are identified as being at risk and treated. The 21st Century Cures Act (Pub. L. 114–255) called for the development of the federal Interdepartmental Serious Mental Illness Coordinating Committee,[22] which has specifically recommended that health systems track patient survival after events like an ED visit during which suicide risk is identified. The VA already tracks the mortality of all veterans, and links mortality data to healthcare data for veterans receiving VHA care. Some other U.S. health systems do so as well, including Medicare, Medicaid, and many of the systems that are part of the NIMH Mental Health Research Network. But most U.S. healthcare systems and health insurers currently do not link their populations to information on mortality, which has significantly limited the ability to both study and improve healthcare practices that could prevent suicide.

For many people, suicide risk is associated with comorbid mental illness. Early identification and effective treatment of such illnesses is important for many reasons, including the potential to prevent people from becoming suicidal in the first place. There are too few mental health service providers in the United States, and individuals who go on to die by suicide are most commonly seen by a primary care provider. Therefore, I want to highlight an evidence-based approach for treating mental illnesses in primary care settings called the Collaborative Care model. Collaborative Care is a specific approach that enhances "usual" primary care by adding two key services: care management support for patients receiving mental health treatment; and regular consultation between a mental health service provider and the primary care team, particularly for patients who are not improving. Numerous studies - including some conducted in the VA - have shown that Collaborative Care improves the quality of care and patients' satisfaction of their care, mental and physical health outcomes including faster recovery, and improved functioning in people with common mental illnesses.[23] Importantly, several studies have also found that Collaborative Care reduces suicidal [24]ideation.[25] Medicare added pay-

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[18] https://www.ncbi.nlm.nih.gov/pubmed/28249076
[19] https://www.ncbi.nlm.nih.gov/pubmed/29727073
[20] https://clinicaltrials.gov/ct2/show/NCT03788694-term=Marianne+Goodman&rank=2
[21] https://theactionalliance.org/healthcare/zero-suicide
[22] https://www.samhsa.gov/ismicc
[23] https://www.ncbi.nlm.nih.gov/pubmed/22516495
[24] https://www.ncbi.nlm.nih.gov/pubmed/14996777
[25] https://www.ncbi.nlm.nih.gov/pubmed/17038073

ment for Collaborative Care in 2017, and some other healthcare systems and insurers are now also doing [26] so [27].

In addition, I would like to highlight two other areas of research relevant to this hearing. First, access to 24/7 suicide crisis support anywhere in the United States is available through the toll-free National Suicide Prevention Lifeline. [28] The Lifeline is a critical component to U.S. suicide prevention, and offers access to the Veteran's Crisis Line. [29] NIMH includes the Lifeline as a crisis resource in all suicide prevention materials; media recommendations [30] for safe messaging on suicide state that providing ways to access crisis support is key. In addition, many NIMH suicide prevention research protocols use the Lifeline as part of their safety assurance. NIMH research has shown that it is worth investing in quality improvements in telephone crisis services because these services can decrease distress and suicidal behavior, and improve linkage to care. [31] Utilization of these services is increasing, in general and especially after media coverage of the suicide deaths of celebrities. It is critical that we find ways to support increased capacity for national crisis lines during surges in call volumes after such widely-reported events. Second, researchers estimate that approximately 1,800 additional suicide deaths occurred after extensive media coverage of actor and comedian Robin Williams' death. [32] This points to the opportunity for public and private partners to work with the media to implement safer reporting and messaging about suicide, including information on how to get help. We can, and should, work together with the media to minimize "contagion" or "imitation" of suicides, including veteran suicides on VHA campuses.

In sum, there exist evidence-based approaches to reducing suicide risk. However, translating research into real world settings requires strong collaborations in order to facilitate and expand the use of effective suicide prevention practices to all communities, to change the "tragic trend." Our partnerships with the Army, VA, CDC, SAMHSA, and other agencies have led to important findings on suicide risk identification, interventions, follow-up care, and overall healthcare system improvements. As partnered Agencies, we are beginning to see how a growing number of healthcare systems - VA and elsewhere - are implementing evidence-based suicide prevention practices. Through the National Action Alliance for Suicide Prevention, federal and private healthcare partners are sharing information about lessons learned as they work to include suicide prevention efforts as a standard practice. To increase our potential to save lives, we must continue to leverage existing partnerships, build new ones, and improve suicide prevention strategies through scientific research.

Prepared Statement of Richard T. McKeon, Ph.D., M.P.H.

Chairman Takano, Ranking Member Roe, Members of the Committee - thank you for inviting the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in this extremely important hearing on suicide prevention for America's veterans. I am Richard McKeon, Chief of the Suicide Prevention Branch in the Center for Mental Health Services, SAMHSA.

An American dies by suicide every 11.1 minutes, and as the recent Centers for Disease Control and Prevention (CDC) Vital Signs analysis shows, this tragic toll has been increasing all across the country. Suicide is the 10th leading cause of death in the United States, the second leading cause of death between ages 10 and 34. We lost over 47,000 Americans to suicide in 2017, almost the same number we lost to opioid overdoses. For each of these tragic deaths, there are grief stricken families and friends, impacted workplaces and schools, and a diminishment of our communities. When one of these deaths involves an American who has served his country in the military, as happens on average 20 times each day, we as a nation suffer additionally. SAMHSA's National Survey on Drug Use and Health has also shown that approximately 1.4 million American adults report attempting suicide each year, and over 10 million adults report seriously considering suicide. This leads to huge direct medical costs, and more importantly, tremendous human misery.

As painful as these numbers are, our concern is intensified by the CDC's report that suicide has been increasing in 49 of the 50 states, with 25 of the states experi-

[26] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
[27] https://www.ncbi.nlm.nih.gov/pubmed/27973984
[28] https://suicidepreventionlifeline.org/
[29] https://www.veteranscrisisline.net/
[30] http://reportingonsuicide.org/
[31] https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12339
[32] https://www.ncbi.nlm.nih.gov/pubmed/29415016

encing increases of more than 30 percent. These increases have been taking place among both men and women, and across the lifespan. While Federal efforts to prevent suicide have been steadily increasing over time, thus far, they have been insufficient to halt this tragic rise. We can only halt this rise nationally if we are also reducing suicide among the estimated 20 veterans a day who die by suicide including those not in the care of the U.S. Department of Veterans Affairs (VA). All of us must be engaged in this effort, and for this reason SAMHSA includes language in all our suicide prevention funding opportunities prioritizing veterans and has worked actively with VA on suicide prevention since 2007. While we have not as of yet been able to halt this tragic rise, we have seen that concerted, sustained, and coordinated efforts can save lives.

One area where we have made a concerted national effort, namely youth suicide prevention, has produced evidence that lives have been saved. Cross-site evaluation of our Garrett Lee Smith State/tribal youth suicide prevention grants has shown that counties that were implementing grant-supported suicide prevention activities had fewer youth suicides and suicide attempts than matched counties that were not. However, this life-saving impact fades two years after the activities have ended when there is no longer a difference in suicide rates between counties who implemented youth suicide activities and counties that did not.. withThe greatest impact was seen in counties that have had the longest period of sustained funding for their efforts. This underscores the need to embed suicide prevention in the infrastructure of states, local, and tribal and communities. While all 50 states have received a Garrett Lee Smith (GLS) state grant, sometimes the suicide prevention activities end when the grant ends. An example of the successful implementation of a GLS grant is the White Mountain Apache tribe in Arizona, which received three consecutive GLS grants and has shown a reduction of almost 40 percent in youth suicides. In that community, a suicidal youth, wherever they may be on the reservation, will be seen by a trained Apache community worker rapidly after their suicide risk has been identified and the individual will be linked to needed treatment and supports. This example demonstrates the value of the GLS grants at the county level and also the value of timely access to effective suicide prevention and intervention services. In addition to decreasing suicide rates, an economic evaluation of the GLS program estimated $4.50 in cost savings per dollar invested in the GLS program [1].

In Fiscal Years (FY) 2017 and 2018, Congress provided SAMHSA, for the first time, $11 million dollars to focus on adult suicide prevention, with $9 million appropriated to the Zero Suicide initiative. Zero Suicide is an effort to promote a systematic evidence-based approach to suicide prevention in healthcare systems using the most recent findings from controlled scientific studies as part of a package of interventions that moves suicide prevention from being a highly variable and inconsistently implemented individual clinical activity to a systematized and prioritized effort. The Zero Suicide initiative uses the most recent science on screening, risk assessment, collaborative safety planning, care protocols, evidence-based treatments and care transitions (providing rapid follow up after discharge from inpatients units and Emergency rooms), as well as ongoing continuous quality improvement. The Zero Suicide initiative was inspired by the success of the Henry Ford Healthcare system in reducing suicide by more than 60 percent among those receiving care, and other early adopters such as Centerstone in Tennessee, one of the Nation's largest community mental health systems, have shown similar results. More recently the state of Missouri has shown that it is possible to reduce suicide among those receiving care in the state's community mental health system. As an example of this approach, Centerstone's protocol for treating those identified at high risk requires that an outreach phone call be made promptly if the person at risk misses a scheduled appointment. In one instance, a person on the Centerstone high risk protocol missed his appointment and when the follow up phone call was made the person was on a bridge about to jump. Instead, he came to Centerstone and agreed to be hospitalized. SAMHSA has funded 19 states, tribes and health care systems to incorporate Zero Suicide and technical assistance in implementing this approach, and this has been provided to many more through the Suicide Prevention Resource Center. SAMHSA has also been working through all of its suicide prevention grant programs to improve post discharge follow up since multiple studies have shown that rapid contact after discharge and prompt link to outpatient services can prevent suicide attempts. SAMSHA's efforts can and do make a difference in communities.

The SAMHSA suicide prevention program that touches the greatest number of suicidal people is the National Suicide Prevention Lifeline (the Lifeline). The Lifeline is a network of 165 crisis centers across the country that answer calls to the toll-

[1] Garraza et al An Economic Evaluation of the Garrett Lee Smith Memorial Suicide Prevention Program" Suicide and Life Threatening Behavior , December 2016

free number 800–273–TALK (8255). The National Suicide Prevention Lifeline includes a special link to the Veterans Crisis Line, which is accessed by pressing "one". The Lifeline is available 24 hours a day, 7 days a week, and in many communities in America it is the only feasible option for a suicidal person to reach out for help. The Lifeline is available late at night or on a Sunday afternoon and for some can be more helpful than a costly visit to an Emergency Department. Last year, more than 2.2 million calls were answered through the Lifeline, and that number has continued to grow at a rate of about 15 percent per year. About 25 percent of Lifeline callers are actively suicidal at the time of the call and some of them need emergency rescue services. The Lifeline also provides a chat service through the website, and the percentage of those using the crisis chat service who are actively suicidal is even higher. We believe this is reflective of the rising rates of suicide in youth, who may be more likely to use a chat service. Evaluation studies have shown that callers to the Lifeline experience decreased suicidal thoughts and hopelessness by the end of the call. Follow-up calls from Lifeline centers are frequently experienced as lifesaving. However, the increasing call volume is also straining the Lifeline system of community crisis centers which are responsible for responding to calls and chats. These crisis centers are not directly operated or funded by SAMHSA. The Veterans Crisis Line and their three centers are directly operated by VA, and other Lifeline community crisis centers depend on local or state funding. When local crisis centers are unable to answer Lifeline calls, the calls must be answered by designated regional back up centers. When calls go to regional back up centers, the amount of time it may take to answer the call can increase. SAMHSA has summarized these issues in its report to the Federal Communications Commission (FCC) as required under the National Suicide Hotline Improvement Act. SAMHSA's report calls attention to the fact that if the FCC and Congress were to designate a 3 digit N11 number for suicide prevention this would likely lead to a substantial increase in Lifeline calls. While such an increase in Lifeline calls and in seeking help is vitally important, it depends on the availability of centers to promptly answer the calls to be lifesaving.

SAMHSA and the VA have been working together to prevent suicide since 2007, when the Veterans Crisis Line was first established and the "press one option" was introduced into the National Suicide Prevention lifeline message. More recently, SAMHSA and VA have worked together to fund a series of Mayor's Challenges and Governor's Challenges to prevent suicide among all veterans, service members, and their families, regardless of whether they are receiving care though VA. Supported through an Interagency Agreement with VA, SAMHSA's Service Members, Veterans and their Families Technical Assistance Center, has convened cities and states in what are called policy academies and implementation academies to promote comprehensive suicide prevention for veterans. Multiple public and private partners are engaged in this coordinated effort for which onsite technical assistance is also provided. As an example, in the Richmond Mayor's Challenge, the McGuire VA Medical Center and the public mental health center, Richmond Behavioral Health Authority, have developed a coordination and referral process to assure that veterans at risk don't fall through the cracks between VHA and community systems. A caring contact letter from the McGuire VA Medical Center is to be included in the discharge packet for veterans leaving community hospitals. The work in Richmond is now being implemented elsewhere in Virginia as part of the Governor's Challenge. We believe that this type of strong, continuing, interdepartmental effort that incorporates states and communities as partners is necessary to reduce veteran suicide. SAMHSA and VA also work together through the Federal Working Group on Suicide Prevention, which includes VA, Department of Defense, Department of Justice, Department of Homeland Security, CDC, National Institute of Mental Health, Indian Health Service, Administration for Community Living, and the Health Resources and Services Administration. SAMHSA and VA also work with other public and private organizations through the Nation Action Alliance for Suicide Prevention, which was stood up with SAMHSA funding in 2010 and has engaged over 250 organizations since its inception. The Action Alliance worked with the Office of the Surgeon General, SAMHSA, and others to revise the National Strategy for Suicide Prevention and continues to engage partners from multiple sectors to promote comprehensive suicide prevention efforts.

SAMHSA also worked with the National Academy of Sciences on a workshop on suicide and serious mental illness and serious emotional disturbance to improve prevention and intervention strategies. This workshop included a focus on veterans. SAMHSA is also developing a toolkit to assist families when a loved one is suicidal.

In summary, SAMHSA is engaged in an unprecedented amount of suicide prevention activities, but we know we need to do more to play our role in halting the tragic rise in loss of life we are experiencing across the country. In particular, we know

we need to be engaged in a strong continuing, collaborative effort with VA to reduce suicide among veterans. We know we must constantly be looking to improve our efforts and to learn from both our successes and our failures. We owe it to those who have served this Nation and to all those we have lost, as well as to those that loved them, to continually strive to improve until suicide among veterans, and among all Americans is dramatically reduced.

Prepared Statement of Richard A. Stone, M.D.

Good evening, Chairman Takano, Ranking Member Roe, and Members of the Committee. I appreciate the opportunity to discuss the critical work VA is undertaking to prevent suicide among our Nation's Veterans. I am accompanied today by Dr. Keita Franklin, Executive Director, Suicide Prevention Program.

Introduction

Suicide is a serious public health crisis that affects communities across the country, and recently, this terrible tragedy occurred on the grounds of our VA health care facilities when three Veterans ended their lives in a single week. VA health care facilities are designed to be safe havens for the women and men who defended our Nation, and a suicide among fellow Veterans and those who have given their lives to care for them is heartbreaking. We are deeply saddened by this loss.

Our promise to Veterans remains the same: to promote, preserve, and restore Veterans' health and well-being; to empower and equip them to achieve their life goals; and to provide state-of-the-art treatments. Veterans possess unique characteristics and experiences related to their military service that may increase their risk of suicide. They also tend to possess skills and protective factors, such as resilience or a strong sense of belonging to a group. Our Nation's Veterans are strong, capable, valuable members of society, and it is imperative that we connect with them early as they transition into civilian life, facilitate that transition, and support them over their lifetime.

The health and well-being of the Nation's men and women who have served in uniform is the highest priority for VA. VA is committed to providing timely access to high-quality, recovery-oriented, evidence-based health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers wherever they live, work, and thrive.

These efforts are guided by the National Strategy for Preventing Veteran Suicide. Published in June 2018, this 10-year strategy provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans through a broad public health approach with an emphasis on comprehensive, community-based engagement. This approach is grounded in four key focus areas as follows:

- Primary prevention that focuses on preventing suicidal behavior before it occurs;
- Whole Health that considers factors beyond mental health, such as physical health, social connectedness, and life events;
- Application of data and research that emphasizes evidence-based approaches that can be tailored to fit the needs of Veterans in local communities; and
- Collaboration that educates and empowers diverse communities to participate in suicide prevention efforts through coordination.

Mental Health and Suicide Prevention

We know that an average of approximately 20 Veterans die by suicide each day; this number has remained relatively stable over the last several years. Of those 20, only 6 have used VA health care in the 2 years prior to their deaths, while the majority - 14 - have not. In addition, we know from national data that more than half of Americans who died by suicide in 2016 had no mental health diagnosis at the time of their deaths.

Through the National Strategy, we are implementing broad, community-based prevention initiatives, driven by data, to connect Veterans outside our system with care and support on national and local facility levels targeted to the 14 Veterans outside VA care.

When we look at our data from the years 2015 to 2016, we see a small decrease in the number of suicides; there were 365 fewer deaths by suicide in 2016 compared to 2015. This means we are moving in the right direction, but if there is still one suicide, we know there is significantly more work to be done. We are also concerned about the fact that we are seeing a rise in the rates of Veteran suicides among those

aged 18 - 34 in the past 2 years. Efforts are already underway to better understand this population and other groups that are at elevated risk, such as women Veterans, never Federally-activated Guardsmen and Reservists, recently separated Veterans, and former Servicemembers with Other Than Honorable (OTH) discharges.

We have seen a notable increase in women Veterans coming to us for care. Women are the fastest-growing Veteran group, comprising about 9 percent of the U.S. Veteran population, and that number is expected to rise to 15 percent by 2035.

Although women Veteran suicide counts and rates decreased from 2015 to 2016, women Veterans are still more likely to die by suicide than non-Veteran women. In 2016, the suicide rate of women Veterans, with 257 women Veterans dying by suicide, was nearly twice the suicide rate of non-Veteran women after accounting for age differences.

These data underscore the importance of our programs for this population. VA is working to tailor services to meet their unique needs and have put a national network of Women's Mental Health Champions in place to disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care.

For all groups experiencing a higher risk of suicide, including women, VA also offers a variety of mental health programs such as outpatient services, residential treatment programs, inpatient mental health care, telemental health, and specialty mental health services that include evidence-based therapies for conditions such as posttraumatic stress disorder (PTSD), depression, and substance use disorders.

While there is still much to learn, there are some things that we know for sure. Suicide is preventable, treatment works, and there is hope.

Established in 2007, the Veterans Crisis Line provides confidential support to Veterans in crisis. Veterans, as well as their family and friends, can call, text, or chat online with a caring, qualified responder, regardless of eligibility or enrollment for VA. VA is dedicated to providing free and confidential crisis support to Veterans 24 hours a day, 7 days a week, 365 days a year. However, we must do more to support Veterans before they reach a crisis point, which is why we are working with internal partners like VA's Homeless Program Office and Office of Patient Centered Care and Cultural Transformation in their deployment of Whole Health and with multiple external partners and organizations. In an effort to increase resiliency, VA must empower and equip Veterans, through internal partners like these, to take charge of their health and well-being and to live their life to the fullest.

VA's premier and award-winning digital mental health literacy and anti-stigma resource, Make the Connection (at www.MakeTheConnection.net), highlights Veterans' true and inspiring stories of mental health recovery and connects Veterans and their family members with local VA and community mental health resources. Over 600 videos from Veterans of all eras, genders, and backgrounds are at the heart of the Make the Connection resource. The resource was founded to encourage Veterans and their families to seek mental health services (if necessary), educate Veterans and their families about the signs and symptoms of mental health issues, and promote help-seeking behavior in Veterans and the general public.

With more than 593,000 visits to more than 180,000 Veterans in Fiscal Year (FY) 2018, VA is a national leader in providing telemental health services -defined as the use of video teleconferencing or telecommunications technology to provide mental health services. This is a critical strategy to ensure all Veterans, especially rural Veterans, can access mental health care when and where they need it. VA offers evidence-based telemental health care to rural and underserved areas via 11 regional hubs, expert consultation for patients via the National Telemental Health Center, and telemental health services between any U.S. location - into clinics, homes, mobile devices, and non-VA sites via VA Video Connect, an application (app) that promotes 'Anywhere to Anywhere' care. VA also offers tablets for Veterans without the necessary technology to promote engagement in care. VA's goal is that all VA outpatient mental health providers will be capable of delivering telemental health care to Veterans in their homes or other preferred non-VA locations by the end of FY 2020.

VA has deployed a suite of 16 award-winning mobile apps supporting Veterans and their families by providing tools to help them manage emotional and behavioral concerns. These apps are divided into two primary categories - those for use by Veterans to support personal work on issues such as coping with PTSD symptoms or smoking cessation and those used with a mental health provider to support Veterans' use of skills learned in psychotherapy. Enabling Veterans to engage in on-demand, self help before their problems reach a level of needing professional assistance can be empowering to Veterans and their families. It also supports VA's commitment to be there whenever Veterans need us. In FY 2018, VA's apps were downloaded 700,000 times.

A Public Health Approach to Suicide Prevention

Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. VA alone cannot end Veteran suicide. We know that some Veterans may not receive any or all of their health care services from VA, for various reasons, and we want to be respectful and cognizant of those choices.

As VA expands its suicide prevention efforts into a public health approach while maintaining its crisis intervention services, it is important that VA revisit its own infrastructure and adapt to ensure it can lead and support this effort. VA has examined every aspect of the problem, looking at it through the lens of each subgroup, level, and model, and VA is putting changes into place that leverage thoughtful investments of new practices, approaches, and additional staffing models. It is only through this multi-pronged strategy that VA can lead the Nation in truly deploying a well-rounded, public health approach to preventing suicide among Veterans. Preventing suicide among all of the Nation's 20 million Veterans cannot be the sole responsibility of VA; it requires a nationwide effort. Just as there is no single cause of suicide, no single organization can tackle suicide prevention alone. VA developed the National Strategy with the intention of it becoming a document that could guide the entire Nation. It is a plan for how EVERYONE can work together to prevent Veteran suicide.

Suicide prevention requires a combination of programming that hits many levels, including universal, selective, and indicated strategies. This "All-Some-Few" strategic framework allows VA to design effective programs and interventions appropriate for each group's level of risk. Not all Veterans at risk for suicide will present with a mental health diagnosis, and the strategies below employ a variety of tactics to reach all Veterans.

- Universal strategies aim to reach all Veterans in the U.S. These include public awareness and education campaigns about the availability of mental health and suicide prevention resources for Veterans, promoting responsible coverage of suicide by the news media, and creating barriers or limiting access to hotspots for suicide, such as bridges and train tracks.
- Selective strategies are intended for some Veterans who fall into subgroups that may be at increased risk for suicidal behaviors. These include outreach targeted to women Veterans or Veterans with substance use challenges, gatekeeper training for intermediaries who may be able to identify Veterans at high-risk, and programs for Veterans who have recently transitioned from military service.
- Indicated strategies are designed for the relatively few individual Veterans identified as having a high risk for suicidal behaviors, including some who have made a suicide attempt.

Current VA efforts regarding lethal means safety highlight this model. From education on making the environment safer for all present, to training on how to increase effective messaging around firearms in rural communities, to creation of thoughtful interventions around lethal means safety by clinicians when someone is in crisis, the "All-Some-Few" framework permeates the work we do.

Guided by this framework and the National Strategy, VA is creating and executing a targeted communications strategy to reach a wide variety of internal and external audiences. Our goals include the following:

- Implementing research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes, and behaviors;
- Increasing awareness about the suicide prevention resources available to Veterans facing mental health challenges, as well as their families, friends, community partners, and clinicians;
- Educating partners, the community, and other key stakeholders (e.g., media and entertainment industries, other Government organizations) about the issue of Veteran suicide and the simple acts we can all take to prevent it;
- Promoting responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to Veteran suicide;
- Explaining VA's public health approach to suicide prevention and how to implement it at both the national and local level;
- Increasing the timeliness and usefulness of data relevant to preventing Veteran suicide and getting it into the hands of intermediaries who can save Veterans' lives.

Promoting VA Suicide Prevention, Whole Health, and Mental Health Services

Suicide prevention requires a holistic view - not just at the systems level but at the personal care level as well. VA is expanding our understanding of what defines health care, developing a Whole Health approach that engages, empowers, and equips Veterans for life-long health and well-being. VA is uniquely positioned to make this a reality for our Veterans and for our Nation. The Whole Health delivery system includes the following three components: empowering Veterans through a partnership with peers to explore their mission, aspiration, and purpose and begin their overarching personal health plan; equipping Veterans with proactive, complementary, and integrative health approaches (e.g., stress reduction, yoga, nutrition, acupuncture, and health coaching); and aligning the Veteran's clinical care with their mission and personal health plan.

By focusing on approaches that serve the Veteran as a whole person, Whole Health allows Veterans to connect to different types of care, new tools, and teams of professionals who can help Veterans better self-manage chronic issues such as PTSD, pain, and depression.

VA is dedicated to designing environments and resources that work for Veterans so that people find the right care at the right time before they reach a point of crisis. However, Veterans must also know how and where they can reach out and feel comfortable asking for help.

VA relies on proven tactics to achieve broad exposure and outreach while also connecting with hard-to-reach targeted populations. Our target audiences include, but are not limited to women Veterans; male Veterans age 18–34; former Servicemembers; men age 55 and older; Veterans' loved ones, friends, and family; organizations that regularly interact with Veterans where they live and thrive; and the media and entertainment industry, who have the ability to shape the public's understanding of suicide, promote help-seeking behaviors, and reduce the risk of copycat suicides among vulnerable individuals.

VA uses an integrated mix of outreach and communications strategies to reach audiences. We proactively engage partners to help share our messages and content, including Public Service Announcements (PSA) and educational videos and also use paid media and advertising to increase our reach.

Outreach efforts included the Mayor's Challenge program, care enhancements for at-risk Veterans, the #BeThere campaign, and development of the National Strategy for Preventing Veteran Suicide. This also included, in partnership with Johnson & Johnson, releasing a PSA titled "No Veteran Left Behind," featuring Tom Hanks via social media. VA continues to use the #BeThere Campaign to raise awareness about mental health and suicide prevention and educate Veterans, their families, and communities about the suicide prevention resources available to them. During Suicide Prevention Month (September), the suicide prevention program implemented a dedicated outreach effort for the #BeThere Campaign, including several Facebook Live events that reached more than 160,000 people, a satellite media tour promoting the campaign that reached more than 8.9 million on television and 33.9 million on radio, partner outreach, and more. Through this outreach, we generated more than 347,000 visits to the Veterans Crisis Line Web site during Suicide Prevention Month.

Data is also an integral piece of our outreach approach, driving how we define the problem, target our programs, and deliver and implement interventions. Each element of our strategy is designed to drive action; these elements are intended to be collectively and wherever possible, individually measurable so that VA can continually assess results and modify approaches for optimum effect.

All these efforts are with the intent to serve Veterans at risk of suicide whether or not they receive services at VA. We continue to work to better understand and target prevention efforts towards the 14 Veterans who die by suicide every day who were not recent users of VA health services. These groups comprise many of our target audiences. For example, in 18–34 year-olds, suicide rates among this age group are increasing, and we are focusing on channels and strategies to get in front of this audience.

We are leveraging new technologies and working with partners on live social media events and continuing our digital outreach through online advertising. However, VA also continues to rely on our traditional partners like Veterans Service Organizations (VSO), non-profits organizations, and private companies to help us with their person-to-person networks and to help spread the word.

VA is also working with Federal partners, as well as state and local governments, to implement the National Strategy. In March 2018, VA, in collaboration with the Department of Health and Human Services, introduced the Mayor's Challenge with a community-level focus, and just last month, debuted the Governor's Challenge to take those efforts to the state level. The Mayor's and Governor's Challenges allow VA to work with 7 governors (from Arizona, Colorado, Kansas, Montana, New

Hampshire, Texas, and Virginia) and 24 local governments, chosen based on Veteran population data, suicide prevalence rates and capacity of the city or state, to develop plans to prevent Veteran suicide, again with a focus on all Veterans at risk of suicide, not just those who engage with VA.

Our partnership with the Department of Defense (DoD) and Department of Homeland Security (DHS) is exemplified by the successful implementation of Executive Order (EO) 13822, Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life. EO 13822 was signed by President Trump on January 9, 2018. The EO focused on transitioning Servicemembers (TSM) and Veterans in the first 12 months after separation from service, a critical period marked by a high risk for suicide.

The EO mandated the creation of a Joint Action Plan by DoD, DHS, and VA for providing TSMs and Veterans with seamless access to mental health treatment and suicide prevention resources in the year following discharge, separation, or retirement. The Joint Action Plan was accepted by the White House and published in May 2018 and has been under implementation since that time. All 16 tasks outlined in the Joint Action Plan are on target for full implementation by their projected completion dates, and 7 out of the 16 items are completed and in data collection mode. Some of our early data collection efforts point towards an increase in TSM and Veteran awareness and knowledge about mental health resources, increased facilitated health care registration, and increased engagement with peers and community resources through the Transition Assistance Program (TAP) and Whole Health offerings.

TAP curriculum additions and facilitated registration have shown that in the first quarter of FY 2019, 81 percent of 7,562 TSM respondents on the TAP exit survey reported being informed about mental health services. In addition, data from the previous quarter demonstrated that 35.6 percent of the 36,801 TSMs listed in the TAP Data Retrieval Web Service registered/enrolled in VA health care before, during, or within 60 days of their VA TAP Course. Whole Health data is demonstrating that between March and December 2018, 96 percent of VA medical centers (VAMC) reported offering Introduction to Whole Health. Introduction to Whole Health is open to all Veterans and employees. Nationally, the total number of reported participants in Introduction to Whole Health is over 10,000 since March 2018. Of these, over 990 TSMs have attended Introduction to Whole Health. In the first quarter of FY 2019, over 425 TSMs attended Introduction to Whole Health in the first quarter of FY 2019, with 6 percent of these referred to mental health services.

Through the coordinated efforts of VA, DoD, and DHS, the following actions took place:

- Any newly-transitioned Veteran who is eligible can go to a VAMC, Vet Center, or community provider, and VA will connect them with mental health care if they need it.
- In December 2018, VA mailed approximately 400,000 outreach letters to former Servicemembers with OTH discharges to inform them that they may receive emergent mental health care from VA, and certain former Servicemembers with OTH discharges are eligible for mental health care for conditions incurred or aggravated during active duty service.
- Some DoD resources available to Servicemembers, such as Military OneSource, will now be available to Veterans for 1 year following separation.
- After the first year, eligible Veterans may still receive mental health care support through VA, Vet Centers, the Veterans Crisis Line, or from a referred community resource.
- Veterans will also be able to receive support through VA partners and community resources outside of VA, like VSOs.

EO 13822 was established to assist in preventing suicide in the first year post transition from service; however, the completed and ongoing work of the EO will likely impact suicide prevention efforts far beyond the first year through increasing coordinated outreach, improving monitoring, increasing access, and focusing beyond just the first year post transition and into the years following transition. VA is working diligently to promote wellness, increase protection, reduce mental health risks, and promote effective treatment and recovery as part of a holistic approach to suicide prevention.

On March 5, 2019, EO 13861, National Roadmap to Empower Veterans and End Suicide, was signed to improve the quality of life of our Nation's Veterans and develop a national public health roadmap to lower the Veteran suicide rate. EO 13861 mandated the establishment of the Veterans Wellness, Empowerment, and Suicide Prevention Task Force to develop the President's Roadmap to Empower Veterans

and End a National Tragedy of Suicide (PREVENTS) and the development of a legislative proposal to establish a program for making grants to local communities to enable them to increase their capacity to collaborate with each other to integrate service delivery to Veterans and to coordinate resources for Veterans. The focus of these efforts is to provide Veterans at risk of suicide support services, such as employment, health, housing, education, social connection, and to develop a national research strategy for the prevention of Veteran suicide.

This EO implementation will further VA's efforts to collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they are engaging with VA. This EO, in addition to VA's National Strategy, further advances the public health approach to suicide prevention by leveraging synergies and clearly identifying best practices across the Federal Government that can be used to save Veterans' lives.

The National Strategy is a call to action to every community, organization, and system interested in preventing Veteran suicide to help do this work where we cannot. For this reason, VA is leveraging a network of more than 60 partners in the public, private, and non-profit sectors to help us reach Veterans where they live, work, and thrive, and our network is growing weekly. For example, VA and PsychArmor Institute have a non-monetary partnership focused on creating online educational content that advances health initiatives to better serve Veterans. Our partnership with PsychArmor Institute resulted in the development of the free, online S.A.V.E. (Signs, Ask, Validate, and Encourage and Expedite) training course that enables those who interact with Veterans to identify signs that might indicate a Veteran is in crisis and how to safely respond to and support a Veteran to facilitate care and intervention. Since its launch in May 2018, the S.A.V.E. training has been viewed more than 18,000 times through PsychArmor's internal and social media system and 385 times on PsychArmor's YouTube channel. S.A.V.E. training is also mandatory for VA clinical and non-clinical employees. Ninety-three percent of VA staff are compliant with their assigned S.A.V.E. or refresher S.A.V.E. trainings since December 2018. This training continues to be used by VA's Suicide Prevention Coordinators (SPC) at VA facilities nationwide, as well as by many of our VSOs.

Our partnership with Caring Bridge, a global, non-profit social media network that allows people with health issues to stay connected to their families and loved ones during a health journey, has resulted in Caring Bridge's launch of a military-specific forum. The forum focuses directly on the needs of Servicemembers, Veterans, and their families. This interactive site is also helping us reach those Veterans who are not currently in VA's health care system.

Conclusion

VA's goal is to meet Veterans where they live, work, and thrive and walk with them to ensure they can achieve their goals, teaching them skills, connecting them to resources, and providing the care needed along the way. Through open access scheduling, community-based and mobile Vet Centers, app-based care, telemental health, more than 400 SPCs, and more, VA is providing care to Veterans when and how they need it. We want to empower and energize communities to do the same for Veterans who do not use VA services. We are committed to advancing our outreach, prevention, empowerment, and treatment efforts, to further restore the trust of our Veterans every day and continue to improve access to care. Our objective is to give our Nation's Veterans the top-quality experience and care they have earned and deserve. We appreciate this Committee's continued support and encouragement as we identify challenges and find new ways to care for Veterans.

This concludes my testimony. My colleague and I are prepared to respond to any questions you may have.

Statements For The Record

American Veterans (AMVETS)

Joseph Chenelly
Executive Director
AMVETS

Chairman Takano, Ranking Member Roe, and honorable members of the House Committee on Veterans' Affairs, I appreciate the opportunity to present you with

our views on the mental health and suicide epidemic plaguing our Nation's veterans' community.

As the largest veteran nonprofit to represent all of our Nation's veterans, we are dedicated to pursuing those issues that are most negatively affecting our veterans or that stand to provide the greatest positive benefit to them. As such, the three most pressing issues AMVETS is working to address this Congress are: addressing our mental healthcare crisis and suicide epidemic, addressing the critical needs of women veterans, and providing timely access to high-quality healthcare.

In the past year, AMVETS has made significant investments to perform a second to none advocacy role for our Nation's veterans. We have assembled a world-class team of veterans' advocates with significant Capitol Hill experience. We have asked that team to prioritize the mental health and suicide epidemic. In our opinion, there is clearly no bigger issue affecting our Nation's veterans and Servicemembers than the more than 6,000 veterans and Servicemembers taking their lives each year. For far too long this issue has been quietly placed on the backburner.

As we stated in our joint testimony before the House and Senate committees on veterans' affairs on March 7, our Nation's veterans could not be sending a clearer message that VA mental healthcare is not working than by killing themselves in VA parking lots. According to the Washington Post, from October 2017 through November 2018, 19 veterans have died by suicide on VA campuses. Marine Col. Jim Turner killed himself in the Bay Pines VA Medical Center parking lot weeks before Christmas. Dressed in his dress blues uniform, bearing his medals, he left us with this message: "I bet if you look at the 22 suicides a day you will see VA screwed up in 90%."

Our National Commander provided emotional oral testimony as he recalled the story of an AMVETS Post Commander who took his life in the parking lot of his post. The issue is raw and real for our AMVETS family.

From October 2017 through November 2018, more than 6,000 veterans died as a result of suicide. In that same time period, the Senate held one hearing on veterans' mental health, the House held two, and more than $8 billion was spent in an effort to address the issue. Despite veterans killing themselves on VA campuses, and record expenditures by VA to address mental health, VA continues to insinuate that veterans killing themselves have not participated in VA care (recently).

The narrative on Capitol Hill has been relatively mundane with lawmakers highlighting the disturbing number of deaths, suggesting more needs to be done, providing increases to the mental healthcare budget, and then moving along to other priorities. VA highlights a need for additional funding to pay for more practitioners and clinical space, while providing scant information on the effectiveness of its programs. The majority of VSO's, including AMVETS, have supported these efforts hoping that more clinicians, more space, and pay raises for mental health practitioners would lead to better outcomes: none of this has substantively moved the needle.

In short, we must confront an uncomfortable and deeply troubling truth: VA's current efforts and approaches to suicide prevention and mental health are not working.

How do we know this- In the simplest of terms, the suicide numbers aren't decreasing. After a statistical correction led to the drop from 22 to 20 suicide per day, the numbers of veteran suicides per day has barely budged. This is in spite of billions of dollars, new legislation, and a considerable amount of activity in the form of speeches, executive orders, and other initiatives.

The VA's efforts related to mental health simply are not working. The independent evaluation that was completed as part of The Clay Hunt SAV Act found scarce evidence of improvements to veterans lives despite tens of billions of dollars being spent over the past decade, and a generally unaffected rate of suicide. This evaluation explored VA effectiveness across the broad spectrum of mental health programming, and perhaps more damning than what the data show is what they don't - most of what the VA is doing relative to mental health is not being tracked.

"new innovative and engaging approaches for the treatment of PTSD are needed." The Journal of American Medical Association (JAMA) 2015

The failures detailed in the Clay Hunt report validates what is clear across PTSD treatments more generally - they are not working. Half of those who might benefit from mental health treatment will not seek it due to access challenges and stigma; of those who do, we see dropout rates ranging from 40–90 percent; and of those who complete treatment, up to two-thirds of successfully treated individuals retain the PTSD diagnosis (Schnurr, 2007; Steenkamp 2015).

Figure 1: Veteran Suicides, 2005–2016

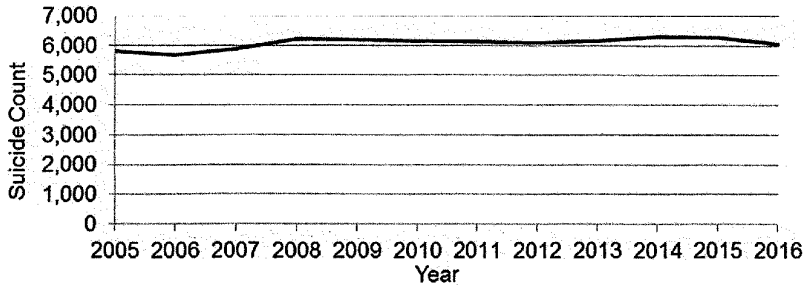
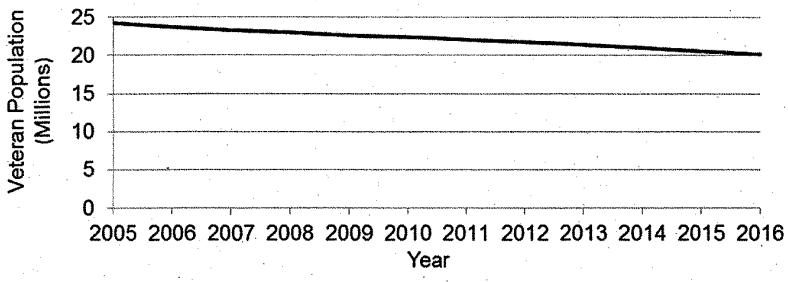


Figure 2: Veteran Population, 2005–2016



**Source: VA National Suicide Data Report (September 2018)*

"These findings point to the ongoing crisis in PTSD care for service members and veterans. Despite the large increase in availability of evidence-based treatments, considerable room exists for improvement in treatment efficacy, and satisfaction appears bleak based on low treatment retention.we have probably come as far as we can with current dominant clinical approaches." The Journal of American Medical Association (JAMA) 2017

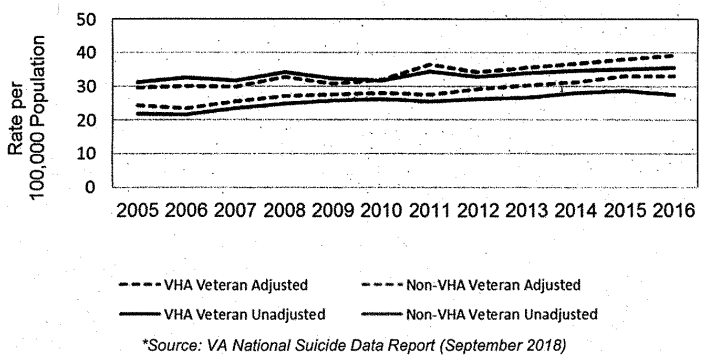
Trauma-focused therapies appear to be only marginally more effective than non-trauma-focused psychotherapies (e.g. interpersonal psychotherapy, acceptance and commitment therapy), questioning the use of these interventions as "first-line" treatments considering their high dropout rates (via Tedeschi and Moore 2018).

"If a veteran is not interested in a trauma-focused psychotherapy, or if the therapy is not available, the VA/DoD guidelines (2017) recommend the use of four specific medications to include three selective serotonin reuptake inhibitors (paroxetine [Paxil], sertraline [Zoloft], fluoxetine [Prozac], and one serotonin norepinephrine reuptake inhibitor (venlafaxine [Effexor]). Even though many more medications are used with veterans battling PTSD and related disorders, the guidelines do not support their use due to a lack of research supporting their efficacy or because the risks of these medications outweigh the benefits." (Tedeschi and Moore, 2018)

As we have already highlighted, we are concerned by the limited research available to show these pharmacological approaches are having significant positive outcomes for veterans over a significant period of time. Additionally, extended use of these psychotropics has been linked to suicide and depression, the exact outcome VA is working to combat.

"Are we somehow causing increased morbidity and mortality with our interventions?" Dr. Thomas Insel, former Director, of the National Institute of Mental Health

Figure 7: Suicide Rates Among Veterans Who Did and Did Not Use VHA, 2005–2016



*Source: VA National Suicide Data Report (September 2018)

Explanations or Excuses-

When the VA is queried about the efficacy - or lack thereof - of current approaches, they resort to a couple of fallbacks. One is to point to their use of evidence-based treatments, which passes the buck back to the mental health authorities and associations. A second, and far more troubling, is their effort to consistently "blame the patient."

The VA consistently references the fact that out of the 20 suicides that occur each day amongst veterans, 14 have had little to no access to the system over the prior two years. The implication - notwithstanding the fact that six veterans in active treatment also took their lives - is that if had they been engaged in VA care, they might have had a different fate. The fundamental question that the 14 of 20 statistic raises is what we know about the veterans who have fallen through the cracks. Are they receiving VA benefits- What happened that led them to not access VA care- Has the VA called or communicated with them in the past two years- Had they ever received mental health treatment from VA- In a world where dropout rates are extravagant, it would be reasonable to posit that at least some of these men and women might have sought help and found it lacking. These are just some of the questions that this soundbite raises - and yet, we have no answers. Answers that would allow us to attack this issue effectively, and would be far more consistent with the public health approach that VA has supported with respect to suicide.

A Vicious Loop

We have yet to see anything that VA or civilian authorities are doing that would inspire confidence that they have a clue about what to do to address the suicide epidemic. With treatments adopted from the civilian world - which is experiencing a horrific suicide crisis of its own - the question is this: on what basis can VA tell us that more resources, more providers, and more treatments is the answer- If we do the same thing over and over again and still expect a different result, that is the definition of insanity.

While the VA claims to hold suicide prevention as its top priority, in truth, VA's top priority is self-preservation. They will blame veterans, Congress, VSOs - anything but accept accountability for their failures. The truth is that VA does not know what works for suicide prevention nor what effective mental health approaches might look like. The one thing that veterans need and deserve from VA is what one would expect from a great military leader - humility. The humility to acknowledge that the current approach isn't working, that we must be open to new and innovative approaches, and that veterans deserve better. Humility to acknowledge that the VA system - from bad service to long wait times - might in fact prevent those who would have benefited from seeking help. Humility to recognize that most veterans don't want to talk to someone they don't know about things they can't understand; they certainly don't want a fistful of pills that numb and offer a plethora of terrible side effects.

Humility - the recognition that we don't have all the answers but we damn sure better start looking in new places - is what AMVETS is asking for. We don't expect VA to solve the problem on their own. And at the same time, we know that you can't start solving a problem until you recognize you have one. And VA - let us state

unequivocally since you won't - we have a suicide problem and we don't have the answers of what to do about it yet.

Recommendations

If our words come across as harsh or intense, they are. They come from a place of pain, loss, anger, frustration, disappointment, and devastation. Our members have all directly experienced the cost of the suicide epidemic in the losses of our brothers and sisters, friends and mentors, guides and teachers.

So what needs to happen next- Beyond the recognition that we must stop pretending that more resources and more treatments will do trick, we believe we need to take action in the following areas:

Follow The Data

We need to dive deeply into the 14 out of 20 suicides per day and understand VA touchpoints, VBA benefits being received, prior VHA engagements, and so forth.

While the VA sought to sugar coat the report required by the Clay Hunt SAV Act, the independent evaluation discussed earlier is damning. It indicates that the average veteran did not experience any clinically significant change in their symptoms - whether they were in outpatient care or residential treatment. The report also revealed that the VA is not collecting basic metrics for mental health in the large majority of instances.

This report truly is a "smoking gun" for it reveals that for all the billions spent, we have seen little to no progress.

The vast majority of veterans with mental health struggles will either never seek care or dropout before completion. Exploring options that address these two challenges - by expanding the mental health continuum beyond just clinical options and leveraging the role of peers - must be high on the to-do list.

Fix Transition

Considerable efforts have been undertaken to revise the transition process so it accommodates a longer timeframe and is more supportive of transitioning service members. However, we know that many veterans struggle with the loss of identity, purpose, and connection upon departing the military - a theme best captured in Sebastian Junger's book Tribe. These challenges extend far beyond employment and the mind, into subjects of the heart and soul. It is essential to extend transition beyond its current myopic focus on employment, to account for the loss of all that is great and good about military service. This loss contributes to considerable challenges and was the subject of an outstanding piece on transition stress by Dr. George Bonanno and Meaghan Mobbs in the Clinical Psychology Review. The psycho-social aspects of the transition - much ignored by the current process - were also the subject of a remarkable paper from the VA Center of Innovation. When we disregard these challenges as part of the transition process, we set veterans up for failure and lead them to conflate struggle in post-military life with PTSD from deployments.

Get Left of Boom

The phrase "left of boom" is a military idiom that refers to the U.S. military's effort to disrupt insurgent cells before they can build and plant bombs. We believe a lot can be learned from the military's efforts to thwart IED attacks as we look to tackle veteran and servicemember suicide and look toward building solutions moving forward. A critical component of this prevention-focused approach calls for far greater alignment and collaboration between DoD and VA - and the recognition by DoD that they bear great responsibility for the plight of so many veterans who struggle in post-military life. With the suicide crisis now affecting active duty service members at numbers not seen in at least a decade, there is great reason to believe that changes within DoD would effect not only veterans but help to address the current mental health epidemic across the active duty force. To this end, we believe that exploring the Leadership Continuum within all services is critical. While there are myriad definitions of leadership, we subscribe to the view that leadership requires three critical components - as noted by the Harvard Business Review - intelligence (IQ), technical expertise, and emotional intelligence (EQ). It is in the latter area that service members and veterans - and large swaths of the general public - struggle. We believe that integrating notions around EQ into the Leadership Continuum could meaningfully address mental health challenges within the active duty force and, more importantly, as it relates to the current subject, set up veterans for success in post-military life.

As stated above, we believe that a large component of the suicide epidemic ties back to leadership. Well led units suffer from far lower rates of PTSD and suicide

than poorly led ones. To that end, we believe that the pathologization of struggle - and the resulting medical approach that is applied - is a large part of the challenge. If you cannot define a problem accurately, you certainly aren't capable of solving it. To that end, recognizing that much of the veterans' suicide epidemic ties back to active duty and transition leadership - and a lack of effective training - helps to recontextualize how we will solve this problem meaningfully and sustainably.

As a result of this lack of training and leadership, most veterans approach the VA, if they ever do, following transitions from the military that have gone poorly for a latitude of reasons. This may be in the form of financial challenges, substance abuse, marital problems, a lack of social support, nutrition and physical activity, employment, and a host of other issues.

The crux of the point here is, we need to find ways to train our service members and veterans as left of boom as possible. By working with them as early as possible, and building the capacity to struggle on the front end, we can ensure that veterans can navigate the ups and downs that are part of life - and certainly post-military life - in a constructive manner.

A Proposed Roadmap Forward

AMVETS is asking Congress to work with us to end the status quo. We are asking for Congress and VA to take accountability, measure outcomes and results, and invest in helping veterans become their best selves. Let's help them become our Nation's best citizens.

As such, AMVETS would greatly appreciate Congress's consideration to create a bicameral taskforce that combined would hold an event at least once every month. Specifically, we are hopeful that Congress will closely evaluate the programs and methods currently funded at VA, their long-term effects and outcomes in helping veterans live high quality lives, while also considering any alternative approaches that are leading to positive outcomes by mitigating negative symptoms, creating notable improvements in quality of life and, ultimately, stemming the suicide epidemic.

Additionally, we propose a quarterly hearing to attack our veterans' mental health epidemic, and by extension, possibly, our Nation's mental health problems. The Veterans Affairs and Armed Services committees have a real opportunity to change our Nation for the better. There is nothing inherent about veterans and mental health.

Mental healthcare challenges are human issues and are not specific to veterans or service members.

We appreciate Chairman Takano and Ranking Member Roe's leadership in hosting this first hearing to address this issue. We would greatly appreciate your consideration to hold another no later than July of this year. We recommend that the topic of the hearing focuses on the findings of the report required by the Clay Hunt SAV Act: the 2018 Annual Report: VA Mental Health Program and Suicide Prevention Services Independent Evaluation. If we don't better understand the outcomes of the crux of our existing supported programs, then we cannot reasonably start to chart a more effective path forward. Such a hearing should consist of individuals who have significant research backgrounds in this field who can provide their own independent assessment of the data that was provided to VA.

We also would encourage the committee to assign senior staff, and/or additional staff, to this issue. Our experience has largely been with junior staff, with few senior staff seeming actively engaged on the issue, likely as a result of the committee's prioritization of Choice/Mission, versus this epidemic. We would also encourage the Committee to provide these staff with a significant oversight budget. We are aware of few trips made by the committee staff or personal staff of HVAC Members to various nonprofits, VA mental health facilities, and other non-VA facilities working to tackle suicide and mental health. The bottom line is if this issue is going to be a priority, then Members of Congress, senior staff, and personal office Veteran Legislative Assistants, should be present at key events regarding suicide and mental health, while also conducting significant oversight off of Capitol Hill, and should be supported and funded to do so.

As we have mentioned, DoD also owns this epidemic. For many of our veterans, their downward spiral starts at their transition from the military. That moment when they leave behind their band of brothers, lose their mission and purpose, and often find themselves isolated. This is a critical final touch point, one in which crucial training can be provided prior to their geographic dispersion. Finding meaningful ways to engage the House Armed Services Subcommittee on Personnel is critical if we are going to truly move this issue Left of Boom. Doing so will save money on expensive ineffective treatments down the road, and more important, it will save lives.

Conclusion

Chairman Takano, Ranking Member Roe, and members of the committees, I would like to thank you once again for the opportunity to present the issues that impact AMVETS' membership, active duty service members, as well as all American veterans. As the VA continues to evolve in a manner that can improve access to benefits and healthcare, it will be imperative to remember the impact that any changes to those systems have on millions of individuals who defended our country. We cannot stress enough the need to preserve and strengthen the VA as a whole, across all administrations, in order to ensure the agency can deliver on President Lincoln's sacred promise now and in the future. Working to fix our broken mental healthcare system is part of that commitment.

Executive Director Joseph Chenelly

Joseph R. Chenelly was appointed national executive director of the nation's fourth largest veterans service organization in May 2016. In this capacity, he administers the policies of AMVETS, supervises its national headquarters operations and provides direction, as needed, to state and local components. Joe previously served as AMVETS' national communications director.

Joe Chenelly is the first veteran of combat operations in Afghanistan and Iraq to lead one of the nation's four largest veterans service organizations' staffs.

A native of Rochester, N.Y., Joe enlisted in the U.S. Marine Corps in 1998, serving with the 1st Marine Division, and was honorably discharged as a Staff Sergeant in April 2006. He is a combat veteran of Operation Enduring Freedom and Operation Iraqi Freedom, having served in Afghanistan, Pakistan, Iraq, Kuwait, East Timor and the Horn of Africa.

Joe became a veterans' advocate, a journalist, and a political adviser after his time in uniform. He covered military and veterans matters on staff with Leatherneck magazine, the Military Times newspapers, USA TODAY and Gannet News, reporting on operations in the Middle East, Southwest Asia, Africa, as well as disaster relief in the United States.

Joe was named one of the 100 "most influential journalists covering armed violence" by Action on Armed Violence in 2013. He was the first U.S. Marine combat correspondent to step into enemy territory after September 11, 2001, as a military reporter in Pakistan and Afghanistan. He also reported from the front-lines with American and allied forces in Kuwait and Iraq as that war began. He was on the ground for the start of both Operation Enduring Freedom and Operation Iraqi Freedom.

Joe served as AMVETS' national communications director in 2005, and for the past eight years as assistant national director for communications for the Disabled American Veterans (DAV) in Washington, D.C. leading grassroots efforts through social networking and new media.

He has also served as president of Social Communications, LLC, and as a public affairs officer director for the Department of Navy. Joe is an alumni of Syracuse University and Central Texas College. He resides in Fairport, N.Y., with his wife Dawn, a service- connected disabled Air Force veteran, and their five children.

ABOUT AMVETS

Today, AMVETS is America's most inclusive congressionally-chartered veterans service organization. Our membership is open to both active-duty, reservists, guardsmen and honorably discharged veterans. Accordingly, the men and women of AMVETS have contributed to the defense our nation in every conflict since World War II.

Our commitment to these men and women can also be traced to the aftermath of the last World War, when waves of former service members began returning stateside in search of the health, education and employment benefits they earned. Because obtaining these benefits proved difficult for many, veterans savvy at navigating the government bureaucracy began forming local groups to help their peers. As the ranks of our nation's veterans swelled into the millions, it became clear a national organization would be needed. Groups established to serve the veterans of previous wars wouldn't do either; the leaders of this new generation wanted an organization of their own.

With that in mind, 18 delegates, representing nine veterans' clubs, gathered in Kansas City, Missouri and founded The American Veterans of World War II on Dec. 10, 1944. Less than three years later, on July 23, 1947, President Harry S. Truman signed Public Law 216, making AMVETS, the first post-World War II organization to be chartered by Congress.

Since then, our congressional charter was amended to admit members from subsequent eras of service. Our organization has also changed over the years, evolving to better serve these more recent generations of veterans and their families. In furtherance of this goal, AMVETS maintains partnerships with other Congressionally chartered veterans' service organizations that round out what's called the "Big Six" coalition. We're also working with newer groups, including Iraq and Afghanistan Veterans of America and The Independence Fund. Moreover, AMVETS recently teamed up with the VA's Office of Suicide Prevention and Mental Health to help stem the epidemic of veterans' suicide. As our organization looks to the future, we do so hand in hand with those who share our commitment to serving the defenders of this nation. We hope the 116th Session of Congress will join in our conviction by casting votes and making policy decisions that protect our veterans.

Disabled American Veterans (DAV)

JOY J. ILEM
NATIONAL LEGISLATIVE DIRECTOR

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for this important hearing regarding our views on the Department of Veterans Affairs (VA) suicide prevention efforts and use of a public health model for reducing suicide in the veteran population. We have also been asked to identify any steps DAV is taking as an organization to counter trends in veterans' suicide. Finally, we offer our views on the effectiveness of VA's current mental health programs and suicide prevention efforts and recommendations on what more can be done to ensure veterans have access to critical mental health services when they need them.

As you know, DAV is a non-profit veterans service organization comprised of more than 1 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Many DAV members use VA's specialized mental health services and approved DAV Resolution No. 293 at our last National Convention, which supports mental health program improvements, including: data collection and reporting on suicide rates among service members and veterans; improved outreach through general media for stigma reduction and suicide prevention; sufficient staffing to meet demand for mental health services and enhanced resources for VA mental health programs, including Vet Centers, to achieve readjustment of new war veterans and continued effective mental health care for all enrolled veterans needing such services.

DAV Efforts to Counter Suicide in the Veteran Population

As an organization, we subscribe to VA's perspective-suicide is preventable and that suicide prevention is everyone's business. We believe that membership and participation in a veterans service organization such as DAV, can be a protective factor for vulnerable veterans who may be struggling with serious physical injuries, post-deployment mental health issues, homelessness, or substance use. DAV provides opportunities for comradery, volunteering, serving others, engagement in meaningful activities to include adaptive sports and recreational events, and connecting with other veterans who may be confronting similar challenges.

As an organization, DAV is committed to doing our part in helping to reduce suicide among those who have served. Recently, our entire national service and legislative Washington headquarters staff participated in S.A.V.E training (Signs. Ask. Validate. Encourage/Expedite.) conducted by the local VA Suicide Prevention Coordinator using the same curricula used for non-clinical VHA staff. Our national headquarters office in Cold Spring, Kentucky, also received this training.

DAV has approximately 261 national service officers (NSOs) in 100 offices across the United States and in Puerto Rico and 32 transition service officers that assist service members in filing claims for service-connected disabilities. These are front-line staff that interact with many veterans seeking assistance each day. Within the next couple of weeks, our NSOs will have access to a specific module in DAVs training system-iTRAK on suicide prevention and creating warm handoffs for those in crisis. This will be required training for all NSOs and support staff in each of our field offices.

DAV's communications team works closely with the VA's public affairs office to support the Department's suicide awareness and prevention campaign, #BeThere, on a number of social media sites such as Facebook, Twitter, Instagram and LinkedIn. We promote the Veterans Crisis Line phone number at every opportunity, including it in DAV Magazine articles, web posts, awareness campaigns and collabo-

rative events. We have worked alongside other organizations aimed to prevent veteran suicide such as Vets4Warriors and the Gallant Few. DAV also runs our own suicide prevention and awareness social media campaigns during Suicide Prevention Awareness Month every September. In addition, we recently revised our PTSD booklet, Living With Traumatic Stress, which includes information on VA mental health resources and suicide prevention.

Use of Public Health Model for Suicide Prevention

Suicide is a national tragedy and a complex issue that requires a public-private approach to improve evidence-based prevention and intervention efforts. In its 2018–2022 strategic plan, VA stated that suicide prevention is its highest strategic clinical priority. In fact, VA has worked diligently with other government partners to gain a greater understanding of the epidemiology of veteran suicide and for the first time can more reliably track suicide among veterans and civilians. This required an interagency collaborative effort with the Department of Defense (DoD) and the Centers for Disease Control and Prevention, as well as state governments, to ensure that veteran status was accurately and consistently captured in national statistics.

VA's National Strategy for Preventing Veterans Suicide defines the "public health model" it will use to reduce the rates of suicide for veterans. The four strategic directions identified include:

1. Healthy and Empowered Veterans, Families and Communities;
2. Clinical and Community Preventive Services;
3. Treatment and Support Services; and
4. Surveillance, Research and Evaluation.

Over the past several years, despite intensive efforts to reduce suicide among veterans, rates have not significantly declined even after the Department identified this issue as the top clinical priority of the Administration. VA identified that 14 of the 20 veterans who committed suicide each day were not using VA health care services presenting a number of challenges for understanding and addressing the needs of all potential at risk veterans.[1] Surveillance has been hampered by differing definitions of "veteran" and "death by suicide" (which may or may not include suspicious accidental or violent deaths). In addition, some states' reporting data on suicides, did not require veteran status be reported. We believe future studies should work to standardize definitions and methodologies to help VA understand whether its interventions are having an effect at the population level.

DAV believes the public health approach adopted by VA can be particularly effective in addressing the needs of veterans who do not use VA health care (approximately two thirds of all veterans and 70 percent of those who commit suicide).[2] It can also be used to increase awareness about suicide prevention among members of the public, to include veterans' family members, friends and co-workers-as well as community health care providers with a goal of educating them to recognize the potential risk factors and signs among veterans and accept personal responsibility for getting them help when needed. Effective communication strategies can help to change stereotypes associated with veterans and identify and promote protective factors that may help prevent suicidal ideation such as giving veterans a sense of purpose and connectedness with family and community.

As VHA allows more community care options for veterans under the new MISSION Act, Network community care partners should also receive training and be provided with information about warning signs for suicide, effective screening, and early interventions for veterans. Likewise, as part of its public health model VA must also offer training to its community partners who are more likely to treat the veteran population not using VA health care services. RAND found that community providers are less likely to ask about military service, to screen for conditions such as suicidal ideation common among veterans, and to understand how to manage the care of veterans with these conditions effectively.[3]

VA has developed training tools and modules for both non-clinical and clinical staff and this training is mandatory for all VHA employees. The goal of the training

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[1] Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. VA National Suicide Data Report 2005–2016. September 2018. P. 7

[2] U.S. Department of Veterans Affairs Office of Mental Health and Suicide Prevention (OMHSP) Facts About Veteran Suicide: June 2018

[3] Tanielian, Terri, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, Ready or Not- Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research—reports/RR2298.html. Also available in print form.

is to assist employees in identifying veterans at risk of suicide and help them intervene when a veteran is in crisis.

We have also urged VA to ensure community network providers are properly trained in effective evidence-based mental health treatments and supportive services that are typically not available in the private sector so appropriate referrals can be made back to VA for these services. VA could, in developing training modules for community partners improve and build awareness within the broader health care industry. Unfortunately, the Government Accountability Office (GAO) recently found that VA's awareness efforts-promotion of campaigns such as #BeThere and contact information for veterans and those who care about them-dropped off in 2017 and 2018 and that it had not identified appropriate ways of measuring the success of these efforts. [4]

To deploy an effective public health model, Congress and VA must resource it appropriately with additional funding not those originally programmed for delivery of current mental health services. Likewise, goals for campaigns and strategies must be clearly identified and measured before, during and after the intervention. This continuous measurement and improvement cycle is the key to creating effective public health initiatives and better health outcomes for veterans.

Effectiveness of VA's Mental Health Programs and Suicide Prevention Efforts

We applaud VHA's ongoing implementation of universal screening for suicidality. Recognizing the problem is the first step of successful intervention. As we understand it, almost 2 million veterans have already been screened. [5]

VA also deserves recognition for expanding its Veterans Crisis Line, implementing a predictive analytics model to create a clinical "flag" for those veterans at greatest risk of suicide (REACH–VET), and requiring mandatory training on suicide for both non-clinical and clinical staff in the veterans health care system. The Department has also allowed veterans with other than honorable discharges to seek emergency mental health care and recently announced that all transitioning service members could seek VA health care within the first year of separation from military service-a time frame at which many veterans have been found to be vulnerable to suicide or suicidal ideation. [6] As evidenced by the persistently higher suicide rate among veterans (as compared to civilians) and the recent suicides taking place on VA grounds, however, it is clear much more work must be done.

We are pleased to see that VHA has also deployed an evidence-based practice of early and structured intervention for veterans who have attempted suicide, which promotes safe storage of lethal means strategies to address firearm safety. This includes counseling on safe storage and reducing access to lethal means that could be used as methods of suicide, in addition to employing other coping strategies. When followed by phone calls to assess risk, review safety plans, and encourage treatment engagement, this safety planning intervention almost halved follow-up suicidal behaviors within the first six months after intervention. [7]

We understand this is a very sensitive and controversial topic-but one that cannot be ignored, given that almost 70 percent of veterans' suicides are completed using firearms. [8] As a leading mental health advocate in VA stated, "limiting immediate access to firearms for veterans in crisis can save lives. Safe gun storage is one of the most important ways to prevent suicide." [9] Despite the challenges in addressing this topic, it is clear VA is striving to be a national leader in suicide prevention and pressing forward, creating important community partnerships in an attempt to find new and effective ways to talk about this issue with their veteran patients to ensure they stay safe.

The Rocky Mountain Mental Illness Research Education and Clinical Center is working to identify the effect of provider counseling on safe storage on suicidal be-

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[4] VA HEALTH CARE: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation GAO–19–66: Published: Nov 15, 2018. Publicly Released: Dec 17, 2018.

[5] Department of Veterans Affairs. VA Suicide Risk Identification Strategy: Overview. June 2018/

[6] Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. VA National Suicide Data Report 2005–2016. September 2018. P. 7

[7] Stanley, Barbara, et al. "Association of Safety Planning Intervention with Subsequent Suicidal Behavior Among ER–Treated Suicidal Patients." JAMA Psychiatry: Original Investigation, Vol. 75, Number 9. September 2018. P. 895.

[8] VA National Suicide Data Report: 2005–2016. Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. September 2018, p. 6.

[9] Russell Lemle, PhD, Chief Psychologist at San Francisco VA Health Care System as cited in Women Veterans: The Journey Ahead. P. 30.

haviors in veterans and VA has forged a historic partnership with the National Sports Shooting Foundation and the American Foundation for Suicide Prevention. The collaboration is aimed at developing a program that empowers communities to engage in safe firearm storage practices with an emphasis on reaching service members, veterans and their families. Additionally, VA has a planning tool kit that will be accessible to all veterans-including a workbook, "Your Personal Safety Plan" which provides examples and asks veterans to identify stressors and triggers and warning signs of serious emotional turmoil, in addition to suggesting coping strategies and ideas for staying safe in times of emotional crisis. Veterans are urged to establish a plan that includes a list of safe people and safe places, crisis support and resource contact numbers, who they can talk to if in crisis, and how to ensure a safe environment during a stressful period.

As women veterans' rates of self-directed violence by firearm increase,[10] we want to ensure VA providers are also asking women veterans the same questions about gun storage safety-particularly those who have been identified for being at-higher risk for suicide. What previously might have been an "attempt" using poisoning or asphyxiation can result in an accomplished suicide due to women veterans' increased familiarity with more lethal means. Experts note that civilian women are less likely to use firearms and thus their attempts are often less [11]lethal[12].

Web-based health initiatives have also been proven valuable to younger tech-savvy veterans. Apps and website modules are available to all veterans and service members, as well as family members and friends, managing complex mental health conditions such as PTSD, traumatic brain injury (TBI), MST, or dealing with anger issues and executive function challenges. Veterans report that these web-based initiatives are valuable and help them navigate the challenges of readjustment after military deployment and provide guidance in reconnecting as a friend, parent or spouse.

General Recommendations for VA's Suicide Prevention Efforts

While VA has policy guidance (VHA Directive 1071) creating mandatory suicide risk and intervention training for all VHA employees, there may not be adequate staff or coverage for mental health services at VA facilities to ensure veterans are able to access services when they are most needed-when a veteran is in crisis. According to VA, since 2007, VA's crisis line has handled 3.5 million calls, and responded to almost a million more texts and chat messages. It has dispatched emergency services 93,000 times and referred veterans to suicide prevention coordinators more than 582,000 times.[13] This is strong evidence of veterans' need for immediate crisis intervention.

In addition, many VA primary care clinics have integrated mental health services (PC–MHI) to ensure that veterans identified through primary care screening can receive a warm handoff to a mental health professional and receive immediate attention for any emergent mental health problems. VA indicated that in 2018, about half of veterans using this service had their initial encounter with a mental health professional the same day as their primary care visit.[14] Given the recent tragedies on its own grounds, VA recently sent a reminder to veterans that they can obtain same-day emergency mental health treatment. However, to ensure the timeliness of care and services, VA facilities must have appropriate staffing levels and patient aligned care teams in place to meet demand. For these reasons we recommend that all VA Mental Health Services meet suggested minimum staffing guidelines of 7.72 FTEE per 1000 veteran patients.

One way to increase support for mental health providers is to utilize and train more peer support specialists to work in mental health programs. Properly trained peers embedded with clinical patient aligned care teams can help veterans better understand and manage their mental health and post-deployment health challenges such as substance use, which may put them at higher risk for self-directed suicide. They can also help veteran peers focus on goals for recovery and become more engaged in treatment.

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[10] VA National Suicide Data Report: 2005–2016. Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. September 2018, p. 6.

[11] VA National Suicide Data Report: 2005–2016. Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. September 2018, p. 6.

[12] National Strategy for Preventing Veteran Suicide: 2018–2028. Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. p. 22.

[13] Department of Veterans Affairs. Press Release: VA's Veterans Crisis Line Improves Service with Third Call Center Opening in Topeka, Kansas tps://www.va.gov/opa/pressrel/pressrelease.cfm-id=4070, accessed 4/25/19.

[14] Department of Veterans Affairs. News Release: VA Ensures Veterans Have Same-Day Access to Mental Health. April 16, 2019

Vet Center facilities offering specialized individual and group counseling for post-traumatic stress disorder (PTSD) and the after effects of military sexual trauma (MST), have also proven to be helpful to many at risk veterans. Ensuring that these veterans are connected and engaged in treatment and developing new strategies for coping and reducing exposures to substance use or other behaviors may help to reduce vulnerability to self-directed harm. Nature retreats are another therapeutic option that that allow groups of similar veterans (such as women or veterans returning from recent deployments) to engage with and learn from each other in creating new coping strategies and life goals.

Further reductions in the number of veterans' suicides may also require VA to identify, develop and assess tailored interventions for certain at-risk populations such as veterans recently discharged from military service, LGBTQ veterans and women veterans. Understanding unique differences in their risk factors, protective factors and the effectiveness of different treatments for them could help reduce suicides among these subpopulations of veterans using VHA. Again, data collection, research and analysis must continue to assure that VA is on the right track.

In addition, VA must have the space and facility design to ensure veterans who are in immediate crisis receive treatment in safe environments. Policy guidance (VHA Directive 1167) is available in making mental health environments safe for veterans with suicidal ideation, but we note that GAO has found that environment of care surveys are often incomplete and inaccurate when facilities submit them and recommended VA take concrete steps toward improving its environment of care program. [15] The Committee may want to ask VA to discuss how it intends to make such improvements and how to determine whether the mental health environment of care checklist is being implemented at all of VA's health care facilities with fidelity.

Finally, we understand that VA and DoD are in the final stages of updating their 2013 joint clinical practice guideline on suicide prevention and look forward to reviewing this important document. We are pleased that VA is also building bridges to other federal agencies and working on building coalitions that are better able to connect with veterans who use non-VHA providers for health care.

Overall, VA has done notable work in trying to reduce suicide in the veteran population, but they cannot do it alone, especially when they lack contact with and information about the majority of veterans who do not use VHA services. It will require a large scale strategic plan along with sufficient resources (dedicated funding and staff) to carry out a successful public health/suicide prevention initiative.

In closing, DAV believes effective use of the public health model and implementation of initiatives within its strategy will allow VA to reach beyond its patient population and effect changes in behavior within the greater veteran population and other stakeholder groups. However, we do have concerns about resources and appropriate staffing levels that are necessary to carry out such an expansive effort. Without appropriate resources, skilled professionals to monitor progress through defined and measureable goals and ongoing data collection and analysis, public health initiatives will not be effective. We also note that loss of resources siphoned from VA's existing mental health program could threaten the integrity of the effective programs, services and supportive tools VA has already implemented for suicide prevention and mental health treatment of veterans using VHA.

Mr. Chairman, I appreciate the opportunity to provide DAV's views to the Committee on this important topic, and recommendations for what more can be done to prevent suicide in the veteran population.

Iraq and Afghanistan Veterans of America (IAVA)

Statement of Stephanie Mullen
Research Director

Chairman Takano, Ranking Member Roe, and Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members worldwide, thank you for the opportunity to share our views, data, and experiences on the matter of suicide prevention among veterans.

Suicide prevention is an incredibly important part of our work; it is why it is at the top of our Big Six Priorities for 2019 which are the Campaign to Combat Suicide, Defend Education Benefits, Support and Recognition of Women Veterans, Ad-

[15] VA Should Establish Goals and Measures to Enable Improved Oversight of Facilities' Conditions GAO–19–21: Published: Nov 13, 2018. Publicly Released: Nov 13, 2018.

vocate for Government Reform, Support for Injuries from Burn Pits and Toxic Exposures, and Support for Veteran Cannabis Utilization.

Suicide rates over the past 10 years have been rising at a shocking rate; in 2016, the Center for Disease Control reports that 45,000 Americans died by suicide. And while suicide is an American epidemic and public health crisis, it is severely impacting the veteran population in particular. According to the most recent Department of Veterans Affairs data, 20 veterans and servicemembers die by suicide every day which is over 7,000 veteran and military lives lost to suicide every year. At risk populations include women veterans who are almost twice as likely to die by suicide than their civilian counterparts. And veterans aged 18 to 34, the post-9/11 generation, which has the highest rate of suicide among any generation of veteran.

We've been watching this trendline for years. In our latest member survey, 59 percent of IAVA members reported knowing a post-9/11 veteran who died by suicide; 65 percent know a Post-9/11 veteran who has attempted suicide. In 2014, these numbers were 40 percent and 47 percent respectively.

More alarmingly, our newest data shows that 43 percent of IAVA members report having suicidal ideation since leaving the military, a 12 percent increase since 2014; showing that more and more veterans and servicemembers in IAVA's community are experiencing suicidal ideation—a risk factor for suicide. This information tracks with the final report under the Clay Hunt SAV Act: The VA Mental Health Program and Suicide Prevention Services Independent Evaluation from 2018. The report shows that veterans ages 18 to 45, the post-9/11 generation, had the greatest proportion of suicidal behaviors, including suicidal attempts and ideation, among any age and made up almost 40 percent of the overall suicidal behavior totals.

Our members intimately know the devastation of this loss and despite recent efforts around suicide prevention, an increasing number of our members have a personal connection to this public health crisis. When IAVA planted 5,520 flags on the National Mall on October 3rd, 2018 to represent the 20 military and veteran souls lost to suicide that year to date, many silently wept remembering either those who were lost, or their own personal struggles.

Every day, entire communities are impacted by veteran suicide. Each life lost impacts an entire community: a family, friends, a military unit, and the lives of each and every person that veteran or servicemember touched. We often say one death by suicide is too many, and it is so true, because every life has value and every death has impact far beyond just one moment of crisis.

IAVA is on the front line of this fight. Our groundbreaking Rapid Response Referral Program (RRRP) staffed by masters-level case managers, known as Veteran Transition Managers (VTMs), continues to serve as a safety net for thousands. In 2018, we provided nearly 130 connections to mental health support for veterans and family members around the country, ensuring that those in need of help can easily access the quality support they need.

Importantly, we have a memorandum of understanding (MOU) with VA's Veterans Crisis Line (VCL) which allows us to provide a warm handoff with a trained responder at the VCL, where the at-risk veteran is never left alone or hung up on, literally preventing veteran suicide. In 2018, RRRP connected 39 veterans to the VCL, which means that about every week and a half, VTMs connected a veteran that was either currently suicidal or at—risk of suicide with life-saving support. IAVA's RRRP and the VCL have been in partnership since RRRP launched in 2012, and has connected nearly 260 veterans to this life-saving resource.

Unfortunately, RRRP has seen an alarming increase of more than 50% in referrals to the VCL from 2018 to 2019 to date. RRRP VTMs are highly trained professionals and are pushing hard to detect those at risk of suicide. This sensitive surveillance is one of the factors driving this uptick but these numbers also indicate the ongoing unmet need for mental health care and the urgency in which veteran suicide must be addressed.

While we recognize and appreciate the intent behind today's hearing, we believe that a focus should be on the larger veteran suicide crisis. When a veteran dies by suicide on VA property, it further erodes the foundation of trust between the public and VA; VA is supposed to be where veterans go to get healthy and seek treatment. When this moment of crisis happens at a VA facility, it is heartbreaking and feels preventable. But it is important that we recognize that every death by suicide is different. There are different risk factors, triggers, and moments of crisis in each case, and a death by suicide on VA property is just as tragic and just as great a loss as a death by suicide in a veterans' own home, car or workplace. Regardless, these tragic events should be a call to action; to ensure that all VA policies and procedures surrounding VA emergency mental health care, facility security, and personnel training are up to date, acceptable, and being implemented correctly. A failure in the system should and must be addressed. IAVA recommends that any pro-

posed legislation focus on these procedures and policies at VA facilities that may be able to intervene in a moment of crisis rather than the individual factors surrounding the tragic event itself.

Suicide is a multidimensional problem that demands a range of solutions. In 2014, IAVA launched the Campaign to Combat Suicide. This was a result of our members continually identifying mental health and suicide as the number one issue facing post-9/11 veterans in our annual membership survey. This campaign centers around the principle that timely access to high-quality mental health care is critical in the fight to combat veteran suicides.

The Clay Hunt SAV Act, signed into law in 2015, was a critical piece of legislation to target mental health and suicide prevention, and to bring attention to the growing need for resources in this area. And while the aforementioned final report from the Clay Hunt SAV Act peer support program overall showed that the peer support pilot programs were effective, it highlighted the need for sustained funding and increased dedicated staffing to ensure programmatic success. Since then, we've seen a number of advancements and many pieces of legislation passed addressing the issue. The final third party evaluation of mental health services at VA under the Clay Hunt SAV Act showed that overall, VA's mental health services had a positive impact on the veterans that used them and decreased suicidal ideation and suicide attempts among those using certain services. This is a great indicator that mental health care at VA is effective for those veterans that are able to access it. Expansion of mental health and suicide prevention services have continued since 2015: the Veterans Crisis Line has expanded, community partnerships have expanded, VA has opened up emergency mental health care to those with Other Than Honorable discharges, and VA has started using predictive analytics to reach out to veterans who show risk factors for suicide.

However, we are far from a long term sustainable solution to address veteran suicide. It is critical that VA, Congress, and veterans organizations look to new and innovative solutions to reach every veteran and engage the American public in the veteran suicide crisis. Most veterans do not receive care at VA, and even more receive at least some care in the community. Among IAVA members, only 27 percent receive VA health care exclusively and 25 percent receive private health care exclusively. This means that to effectively address the issue of veteran suicide we must engage with private health care clinicians and insurance companies in the discussion. We must meet veterans where they are - and that is often not inside a VA facility.

We applaud VA for taking a public health approach to the veteran suicide crisis. It will take mobilizing every sector of society to effectively address this crisis. In IAVA's Policy Agenda for the 116th Congress, we lay out a series of recommendations on this issue in particular. To highlight just some of the recommendations, IAVA believes VA should apply existing data at their disposal to implement effective and evidence-based programs for suicide prevention, require all clinicians to have comprehensive mental health care and suicide prevention training including all Primary Care Providers both within VA and the community care program, expand and improve predictive analytics programs that aim to engage a veteran before a moment of crisis, invest in postvention programs targeting veterans impacted by suicide to prevent the risk of suicide contagion, and implement a public awareness campaign around firearms and suicide.

While these may seem like broad and sweeping recommendations, we believe the best next step in addressing this crisis is passage of the Commander John Scott Hannon Veterans Mental

Health Care Improvement Act (S.785) introduced by Sens. Jon Tester and Jerry Moran, which will bring even greater attention and resources to VA to combat the veteran suicide crisis. IAVA is very pleased with the provisions in the bill to provide grants to organizations that provide mental health care services for veterans not receiving VA care, as well to organizations that provide transition assistance to veterans and spouses. S. 785 also invests in a number of studies, including the link between elevation and suicide and an evaluation of Vet Centers' Readjustment Counselors efficacy; it also provides for an increased number of tracking metrics to ensure that VA is providing the best possible mental health care possible. IAVA looks forward to supporting a House companion bill as soon as it is introduced. Thank you for allowing IAVA to share our views.

The American Legion (TAL)

VETERANS AFFAIRS AND REHABILITATION DIVISION

Chairman Takano, Ranking Member Roe, and distinguished members of the Committee on Veterans' Affairs, on behalf of National Commander Brett Reistad and the nearly two million members of The American Legion, we thank you for the opportunity to testify on this deeply troubling issue of the growing number of suicides amongst the veteran community, and on how to prevent such tragedies. As the largest patriotic service organization in the United States with a myriad of programs supporting veterans, The American Legion appreciates the leadership of this committee in focusing on this critical issue.

Background

The latest data on veteran suicide shows more than 6,000 veterans have died by suicide every year from 2008 to 2016, and in 2016, the suicide rate was 1.5 times greater for veterans than non-veteran adults.[1] Veteran Suicide is a national issue and far exceeds the ability of any one organization to handle alone. The American Legion stands behind the Department of Veterans Affairs (VA) in its efforts to collaborate with partners and communities nationwide.

On April 24, 2019, National Commander Brett Reistad teamed up with Dr. Keita Franklin, VA's Executive Director of Suicide Prevention, and penned a letter[2] emailed to nearly 850,000 American Legion members, family, and friends, to let them know that we are working together to adopt a public health approach to suicide prevention. The public health approach looks beyond the individual to involve peers, family members and the community in preventing suicide. Preventing veteran suicide is a top priority for VA, but they need help from dedicated partners to reach veterans outside the VA health-care system. The letter provided links to VA's National Strategy for Preventing Veteran Suicide, a toolkit that includes a guide to online suicide prevention resources, and a resource locator for contacting local VA Suicide Prevention Coordinators.

The best available information and practices should be used to support all veterans, whether or not they are engaging with VA.[3] According to the VA National Suicide Data Report 2005–2016, there are approximately 20 million veterans in the United States. Of these 20 million, only 30 percent receive services from the Veteran Health Administration (VHA).

In April of 2019, three suicides were reported at VA facilities within the span of five days. In February, the Washington Post reported that 19 suicides took place on VA campuses from October 2017 to November 2018, seven of them in parking lots. The American Legion remains deeply concerned by the substantial number of servicemembers and veterans who die by suicide, and is committed to finding solutions to help end this crisis.

One contributing factor to the increase in suicide on VA campuses may be traced to staffing shortages experienced by VA hospitals and clinics. Data released in February 15, 2019, as mandated by the VA Mission Act, reported 48,985 employment vacancies in VA. This number increased by nearly 4,000 since last reported in August 2018.[4] The high rate of employee turnover, insufficient recruitment, retention, and relocation budget, and a drawn-out hiring processes attributes to shortages in VA personnel. These factors inherently lend themselves to overworked staff, poor patient experiences, and lower quality of care.

Another area of concern is the number of potentially harmful medications like benzodiazepines and opioids currently prescribed to veterans. VA has made progress in improving opioid safety through its Opioid Safety Initiative (OIS) and state prescription drug monitoring programs (PDMP); however, room for improvement exists. A study conducted by the VA's Office of Inspector General found several factors that may have contributed to inconsistent adherence to key opioid risk mitigation strategies. These inconsistencies include: the absence of a pain champion (a primary care position required by VHA that can help providers adhere to opioid risk mitigation strategies), limited access to academic detailing, and inconsistent reviews of veteran medical records to ensure provider adherence to these strategies.[5]

Monitoring opioid prescriptions given to veterans using programs outside VA is critical to reducing the risk of veteran overdoses. The Government Accountability Office also found patients who receive opioid prescriptions from non-VA clinical settings are especially at risk. This is due to conflicting guidelines of VA facilities and non-VA facilities as it relates to opioid prescribing and monitoring. Moreover, that

[1] The 2016 VA National Suicide Data Report
[2] https://www.legion.org/commander/245458/legion-va-team-approach-suicide-prevention
[3] National Strategy for Preventing Veteran Suicide 2018–2028
[4] VA Mission Act Section 505 Data released February 15, 2019
[5] Department of Veterans Affairs Office of Inspector General Report No. 17–01846–316

risk is exacerbated when information about opioid prescriptions is not shared between VA and non-VA providers. [6]

We must consider these facts as we try and understand the tragic trend of veteran suicides on the VA facilities, and work to increase the quality of mental health services provided by VA.

Efforts of The American Legion to Reduce Veteran Suicide

In a national effort to reduce veteran suicide, The American Legion established a Suicide Prevention Program (SPP) on May 9, 2018. The program is charged with examining trends of veteran suicide as it relates to traumatic brain injury, posttraumatic stress disorder (PTSD), military sexual trauma (MST), and analyzing the best practices in veteran suicide prevention not currently used by the Department of Defense (DoD) or Department of Veterans Affairs (VA). The objective of the SPP is to then encourage the aforementioned government agencies to adopt best practices not already utilized. [7]

The American Legion's TBI/PTSD Committee met on January 24, 2019, during our annual Washington Conference, and in an effort to increase collaboration with partners and communities nationwide, the committee developed a Mental Health Survey. The survey is designed to collect data that will help The American Legion bring local resources related to TBI, PTSD, and Suicide Prevention to veterans and their families. The survey is scheduled for release in May during Mental Health Awareness Month. Information collected will include current suicide prevention training taken by participants and their perceived effectiveness of that training. This data will help The American Legion determine its current suicide prevention readiness and areas of potential improvement. Data will also be collected on treatment programs for TBI and PTSD, both inside and outside of VA. The information gathered on various forms of treatment experienced by participants will aid in the development of a consolidated list of available resources for veterans. Resources will be categorized by location and vetted to ensure the treatments are evidence based and beneficial for veterans.

Within the American Legion National Headquarters in Washington, D.C., our Executive Director of Government and Veterans Affairs, created a community service policy encouraging employees to get involved with their local communities and work together to save veterans' lives. The policy allows employees additional paid time off to volunteer (40 hours per year) with a suicide prevention program of their choice. This policy encourages good citizenship by supporting local organizations that offer meaningful opportunities for civic engagement in effort to prevent veteran suicide.

In an effort to raise awareness of veteran suicide, The American Legion's Veterans Affairs & Rehabilitation Headquarters Division published a white paper report titled, "Veteran Suicide." This report describes causes, risk factors, and protective factors of veteran suicide, as well as the American Legion's concerns and recommendations regarding this tragic national issue. Publications from The American Legion's TBI/PTSD Committee titled, "The War Within," and "The Road Home," highlight the Legion's research of Post-Traumatic Stress and Traumatic Brain Injury. TBI and PTSD are serious risk factors that put veterans at an increased risk of suicide. The information covered in these publications includes: the symptoms and risk factors of individuals dealing with PTSD and TBI; the treatments and testimonials of those on the road to recovery, and the Resolutions passed by The American Legion in an effort to ease the suffering of these veterans. The Suicide Prevention and Crisis Response Protocol is a toolkit developed by TBI/PTSD Committee to relay the recommendations of the Committee pertaining the veteran suicide and suicide prevention. Information on suicide prevention training, suicide prevention resources, and how to market information pertaining to suicide safely, can all be found in this toolkit.

The American Legion's efforts are also evident at our local posts. Legion Post 102 in Erie, Kansas 102 is partnering with their local elected officials as part of VA's Governor's and Mayor's Challenge to prevent suicide among servicemembers, veterans, and their families. They also recognized the need to help bridge the gap between local communities and VA services, and created position called the Suicide Prevention Officer (SPO). This officer will serve as a liaison to local services for veterans in their communities. The SPO will be trained in peer-to-peer training, have close connections with local mental health providers, police departments, first responders, EMT services, schools, primary health care providers, other veteran service originations, and VA programs.

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[6] GAO report 18–380

[7] Legion Resolution #20, 2018 Spring NEC

The Florida Department Chaplain is developing training for ministers and clergy on the characteristics of veterans' trauma. In addition, Legionnaires in Florida created a 2.2-mile "ruck" walk, called Challenge 22, designed to raise awareness for veteran suicide. The event's motto, 22 Until Zero, was adopted in recognition of the number of veterans that die by suicide each day. The event raised $31,000 in 2017, and $33,000 in 2018. This year's event is scheduled to take place November 16, 2019, with a goal to raise $100,000 in support of local programs for veterans with PTSD including: PROJECT VetRelief, Kine9line, Warrior Beach Retreat, Veterans Counseling Veterans, Camaraderie Foundation, and Florida 4 Warriors.

Moving Suicide Prevention to a Public Health Model

The public health approach to preventing veteran suicide has four components as defined by the Center for Disease Control (CDC). These components include population approach, primary prevention, commitment to science, and multidisciplinary strategies.[8] The public health model uses a population approach to improve health on a large scale. A population approach means focusing on prevention approaches that impact groups or populations of people, as opposed to treatment of individuals.[9] The American Legion supports the population approach component of the public health model and understands that reducing veteran suicide will involve looking beyond individuals' suffering, to those willing to support them.

Using a population approach is a proactive strategy to increase suicide prevention readiness because it draws on the power of the collective, as opposed to the reactive strategy of focusing on the individual. The first line of defense in preventing veteran suicide is the veteran's primary social circle - close friends and family. Those individuals closest to the veteran are the most likely to notice small changes in mood and behavior. They are also best equipped to approach the veteran with concerns of suicide due to their established level of trust.

The primary prevention component of the public health model focuses on preventing suicidal behavior before it occurs and addresses a broad range of risk and protective factors.[10] The American Legion supports the primary prevention component of the public health model and recognizes the importance of addressing the risks of suicide before they become critical. Individuals with knowledge of suicidal warning signs and risk factors can help curve this alarming trend. Furthermore, individuals who identify at-risk veterans, must have available resources and tools to mitigate the risk of suicide.

The commitment to science component of the public health model is centered on scientifically increasing the understanding of suicide prevention and developing new and better solutions. The American Legion's support of this component of the public health model can be found in Resolution No. 160 which states, ".The American Legion urge Congress to provide oversight and funding to the Department of Veterans Affairs (VA) for innovative, evidence-based, complementary and alternative medicine (CAM) in treating various illnesses and disabilities." Treatments addressing the comorbidity of symptoms of PTSD, TBI, and suicide, are powerful protective factors contributing to suicide reduction.[11] The American Legion recognizes the only way to consolidate safe and effective treatments for the comorbidity of symptoms relating to PTSD, TBI, and suicide is to build upon evidence established by the scientific community.

The multidisciplinary strategies component of the public health model advocates for collaboration, bringing together many different perspectives to engineer solutions for diverse communities.[12] The American Legion supports this component of the public health model and has endeavored to collaborate with local communities in an effort to reduce veteran suicide.

Solutions

The American Legion urges Congress to pass legislation to improve VA's tedious hiring process and increase VA's recruitment, retention and relocation budget. It will allow VA to retain quality mental health providers, incentivize exemplary performance, and increase employee morale. Improvements in these areas will lead to increased customer satisfaction and overall quality of care for veterans. The American Legion recommends state-level prescription drug monitoring program databases

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[8] Centers for Disease Control and Prevention, Enhanced Evaluation and Actionable Knowledge for Suicide Prevention Series. Suicide Prevention: A Public Health Issue (n.d.). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/ASAP—Suicide—Issue2-a.pdf

[9] National Strategy for Preventing Veteran Suicide 2018–2028

[10] Id.

[11] Resolution No. 160

[12] National Strategy for Preventing Veteran Suicide 2018–2028

share data (Resolution No. 160: Resolved, The American Legion urges legislation that would improve pain management policies for the Department of Defense (DoD) and VA.). Implementing a strategy for state-level prescription drug monitoring programs to share data will reduce the unknowing prescription of risky drug combinations, and the overprescribing of potentially dangerous medication.

Conclusion

In closing, The American Legion appreciates the leadership of this committee and remains committed to eradicating veteran suicide. Further, The American Legion is committed to working with the Department of Veterans Affairs and this committee to ensure that America's veterans are provided with the highest level of support and healthcare. Chairman Takano, Ranking Member Roe, and distinguished members of this committee, The American Legion thanks this subcommittee for holding this important hearing and for the opportunity to explain the views of the nearly 2 million members of this organization. For additional information regarding this testimony, please contact Mr. Larry Lohmann, Senior Legislative Associate of The American Legion's Legislative Division at (202) 861–2700 or llohmann@legion.org

Vietnam Veterans of America (VVA)

Submitted by
John F. Rowan
National President

Chairman Takano, Ranking Member Dr. Roe, and other distinguished members of this very important committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views for the record on "Suicide Prevention Among Veterans," with particular emphasis on, as Chairman Takano has written, "the heartbreaking trend of veteran suicide on the grounds of VA facilities." First, though, we want to thank the committee for your consistent and unwavering concern about the mental health care afforded our veterans.

Suicide is not an easy subject to discuss. It is a topic that most of us would prefer not to think about. Considering the purpose of this hearing, it should be noted that accurate statistics on deaths by suicide, despite the intense focus during the wars in Afghanistan and Iraq by both the VA and Defense Department, do not, and cannot, paint a true picture because many incidents are not reported, are misreported, or just fall through the cracks.

Two salient statistics stand out when considering, and confronting, the loss of too many of those men and women who have served in a combat zone. One: of the 20 or so veterans who are estimated to take their life each day, the vast majority, some 70%, are over the age of 55. They are, for the most part, Vietnam-Era veterans. We don't have solid statistics about who among them was afflicted with PTSD or depression borne of their experiences in the military that have plagued them, nor of the problems caused or exacerbated by their repeated long absences from home due to deployments. Although these experiences may have altered the arc of their life (and of their family relationships), more immediate concerns may have led them into the abyss: the loss of a job or a house or a spouse or a child; or a malady that is too painful or debilitating or inevitably fatal.

And two: During the fighting in Afghanistan and Iraq, of the 20 or so veteran suicides a day, 14 were not patients at a VA or clients at a Vet Center. So when a veteran immolates himself in the parking lot of a VA medical center, this naturally gets immediate attention via the media. Or if he puts a gun to his head and pulls the trigger, or if she downs half a bottle of sleeping pills and was recently back from a combat zone - or whose unit was about to be sent back into the fray - such an action will likely attracts attention.

Certainly, whenever a veteran returned from the war takes his or her own life, this is a very real public health concern for our military and veteran communities. Because we know, from more than a few studies, e.g., a 12-year study published in the June 2007 issue of the journal Epidemiology and Health, that the risk of suicide among male veterans, after adjusting for a host of potentially compounding factors, including age, time in service, and health status, is more than two times greater than that of the general population. A report released more than a decade ago by the VA Inspector General noted that "veterans returning from Iraq and Afghanistan are at increased risk for suicide because not all VA clinics have 24-hour mental care available . . . and many lack properly trained workers."

Under the glare of publicity, much of it focusing on how the VA and Defense Department, despite spending hundreds of millions of dollars searching for answers as

to why troops and veterans choose oblivion over life, you in Congress, and we in the VSO and MSO communities, have grappled with the problem without much success. You must acknowledge, however, that the VA has found ways to deter an uncounted number of veterans from making that final, fatal decision.

In the early years of the Global War on Terror, DOD to its discredit, hid suicides on official casualty lists as "accidental non-combat deaths," even lying to the parents of dead soldiers. The Army insisted that they could not to find a connection between PTSD, between the stresses of combat and the type of combat waged in Iraq, and suicide.

We as a nation have come a long way in acknowledging the connection between PTSD and suicide. One of the characteristics of PTSD is that the onset of symptoms is often delayed, sometimes for decades, triggered by stories and images of combat and the casualties of combat, and aggravated by other personal losses, hurts, or issues.

VVA's position on suicide is clear: one suicide of a veteran, or an active-duty troop, is one too many, and there have been far too many. We need to focus not on why veterans take their life; this is no great mystery. We need instead to concentrate on what we, collectively, can do to get more at-risk veterans the counseling that might save their life.

And we urge you not to be taken in by the assertion of some that we need more expertise from entities having little or no connection with the military or with veterans.

One significant first step that needs to be done is to do a complete analysis of all aspects of the suicide soldier or veteran's life, including medical, psychiatric, familial, social, spiritual, and financial situation. For example, if married, is it a solid marriage- Has there been a marital separation or other negative event in the family's life- Is there a steady stream of income that is adequate to cover the basic needs of the family- Is there a VA claim for compensation that is currently held up or recently denied- Are they behind on their VA guaranteed mortgage-

VVA will send you a more complete explication of what we strongly believe should be included in such an analysis, and what efforts of the entire VA team may allow us collectively to intervene in time for some suicidal service member or veteran in the future. It was clear in the Roundtable on Suicide sponsored earlier by Chairman Takano and Ranking Member Dr. Roe that neither VA nor DOD was even thinking in these terms. Since that Roundtable VVA and the major VSOs participated in a discussion with the current Executive in Charge of Veterans Health Administration (VHA) and the current head of the Suicide Prevention office that not only are they not doing such a thorough analysis, but that the Suicide Prevention people were not even thinking in an action oriented modality of how can we discern key triggers, and then as a total team at VA/DOD, with assistance from the Veterans Service Organizations/Military Service Organizations move swiftly to save future lives.

It's too easy, at this point in time, to create commissions or task forces to give the impression that we are taking this issue seriously. Instead, we need to focus on the lessons we, and specifically the VA, know works, what suicide prevention initiatives and programs have saved lives, and what other interventions show promise. In other words, while more data will be helpful, it is action that is needed rather than further cogitation.

It is up to all of us, with your leadership, to do the very best that we can to provide enough help and guidance to the men and women who need it most.

VVA thanks you for the opportunity to share our views on this issue.

Wounded Warrior Project (WWP)

Introduction

Chairman Takano, Ranking Member Roe, and distinguished Members of the Committee on Veterans' Affairs - thank you for inviting Wounded Warrior Project (WWP) to submit this statement for the record of today's hearing on veteran suicide prevention. Suicide prevention is the Department of Veterans Affairs' highest clinical priority and among the greatest challenges WWP is working to address in the community we serve. For these reasons, we appreciate the Committee's continued commitment to bringing veteran suicide into greater focus with this hearing.

Framing WWP's Approach to Suicide Prevention

Wounded Warrior Project is transforming the way America's injured veterans are empowered, employed, and engaged in our communities. Since our inception in 2003, we have grown from a small group of friends and volunteers delivering

backpacks filled with comfort items to the bedsides of wounded warriors here in our nation's capital, to an organization of nearly 700 employees spread across the country and overseas delivering over a dozen direct-service programs to warriors and families in need. Our foundational principle to ensure that today's generation of warriors and families successfully transition into civilian life and thrive in their communities guides all that we do internally and what we fund externally.

Wounded Warrior Project is constantly striving to be as effective and efficient as possible and we are in continual communication with the warriors and caregivers we serve to ensure that we are constantly adapting our programs and approach to their unique challenges and needs. To learn more about their physical, social, economic, and mental health needs, WWP has conducted the nation's largest and most comprehensive survey of post-9/11 veterans who have sustained both physical and hidden injuries while serving the nation. Since its first edition in 2010, this annual survey has helped us identify trends and needs among registered warriors, to compare their outcomes with those of other military and veteran populations, and to measure the impact of continual programmatic engagement - all to determine how we can better serve veterans, service members, and their families.

Wounded Warrior Project released the results of its 2018 Annual Survey to a gathering of congressional staff in December 2018. Over 33,000 warriors completed this edition of the Annual Survey and, for the fourth year in a row, post-traumatic stress disorder (PTSD) was the most frequently reported health problem from service (78.2 percent), followed closely by depression (70.3 percent), anxiety (68.7 percent), and even sleep problems (75.4 percent), an issue frequently linked to mental health challenges. Accordingly, mental health programs are WWP's largest programmatic investment - in 2018, WWP spent $63.4 million on our mental health programs - and we hope the lessons we have learned as the leading provider and funder of mental health programming in the veteran service community can help guide Congress and the Department of Veterans Affairs (VA) to reverse the haunting trends in veteran suicide.

Complementing VA Efforts to Prevent Veteran Suicide

In September 2018, WWP testified that our approach to addressing veteran suicide is encompassed by our belief that suicide prevention must move beyond the healthcare/crisis management model towards an integrated and comprehensive public health approach focused on resilience and prevention. A multi-disciplinary approach to treatment - whether clinical, community-focused, or a combination - is required. We also recognize that our efforts are part of a community approach being driven in large part by VA:

"In the Department of Veterans Affairs FY 2018–2024 Strategic Plan, we have identified preventing Veteran suicide as our highest clinical priority, one that will require all of government, as well as public-private partnerships, to achieve. [.]

VA has embraced a comprehensive public health approach to reduce Veteran suicide rates, one that looks beyond the individual to involve peers, family members, and the community. Yet we know we cannot do it alone, as roughly half of all Veterans in the U.S. do not receive services or benefits from VA. This means we must collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they're engaging with VA."

Dr. Carolyn Clancy, Executive-in-Charge, Veterans Health Administration
VA National Strategy for Preventing Veteran Suicide 2018–2028 (2018)

In this context, VA has recently adopted a public health model to address veteran suicide prevention - a move WWP has encouraged and supported in a variety of both direct and complementary ways. As the Committee looks to address VA's recent shift towards prevention as part of a public health model, we offer this statement through the lens of that model and offer perspective on how WWP approaches its mission to honor and empower wounded warriors through the model's four foundational pillars: (1) population approach, (2) commitment to science, (3) primary prevention, and (4) multidisciplinary strategies.

Population Approach

As stated by the Centers for Disease Control (CDC), "while suicide is often thought of as an individual problem, it actually impacts families, communities, and society in general. The long-term goal of public health is to reduce people's risk for suicidal behavior by addressing factors at the individual (e.g., substance abuse), family (e.g., poor quality parent-child relationships), community (e.g., lack of connectedness to people or institutions), and societal levels (e.g., social norms that sup-

port suicide as an acceptable solution to problems; inequalities in access to opportunities and services) of the social ecology."

Whether because of psychological ("invisible wounds") or physical ("visible wounds") trauma or a combination of both, every warrior who registers with WWP is provided with a unique path of individual and collective recovery that he or she can pursue through our direct services and other support networks. While there is no predetermined path for each warrior registering with WWP, a warrior's first engagement with our organization is often through our Alumni Program. While in the military, many service members form bonds with one another that are as strong as family ties. WWP helps re-form those relationships by providing wounded warriors opportunities to connect with one another through community events and veteran support groups housed within this program. WWP also provides easy access to local and national resources through outreach efforts and with the help of partners like The Mission Continues, Team Red White & Blue, Team Rubicon, and over 30 funded partner organizations. While most events are warrior focused, WWP also hosts a variety of family-based activities.

Additionally, WWP-sponsored Peer Support Groups are led by, and designed for, warriors who want to discuss personal challenges and lend support to one another. Peer Support Groups can lead to new friendships, provide a renewed sense of community, strengthen bonds through shared experiences, and introduce new solutions to challenges. WWP trains Peer Support Group leaders to facilitate productive discussions and maintain a safe, judgment-free environment for warriors. These groups not only serve as "force multipliers" for our organization but also assist WWP with identifying individuals in crisis.

While engagements may range from recreational activities and sporting events to professional development opportunities and community service projects, the Alumni Program was formed with an appreciation for the fact that a desire for post-service camaraderie is what often brings veterans to our organization. In this context, our Alumni Program focuses on engagement and connection and not simply the activity or event itself. We diversify our connection-focused offerings in regions to attract a wide variety of warriors and families, and it is through these events that they develop a relationship with the organization and trust WWP to help resolve more challenging and personal obstacles in their rehabilitation and recovery. Our organization averages more than 11 engagements like this every day.

While not specifically focused on suicide prevention, the Alumni Program's value becomes clearer when we conceptualize WWP "membership" and engagement as a possible first step in recovery for those seeking or in need of help. Obstacles to seeking mental health care support may be difficult to overcome, especially when amplified by stigmatizing messages. In many ways, these obstacles can be challenging to overcome and serve to further isolate those who may already feel marginalized. A possible first step to overcome those hurdles is engagement with peers. During such peer engagement warriors may be exposed to peer testimonies and guided towards seeking mental health treatment and expose them to WWP programs that can lead them towards paths to career fulfillment, financial security, physical wellness, and other protective factors against suicide. Warriors may attend an engagement event to spend time with fellow veterans but may leave with newly acquired psychoeducational information and new friendships that empower them to take an additional step in their recovery.

Suicide prevention should not be limited to saving an individual life when they are in crisis; it must be about creating a life worth living - and providing coping skills and resiliency for dealing with future stressors. Meaningful relationships are vital to the success of warriors' transitions back into civilian life, and suicide is best combated through preventive measures such as providing mental health programs, connection opportunities, and pathways to build confidence and a sense of purpose. We must be proactive when engaging warriors and showing them how their lives matter in their homes and communities. Offerings like WWP's Alumni Program and Peer Support Groups provide avenues to recurring engagement and a way to stay connected prior to a crisis.

POLICY CONSIDERATION - Encourage and enable VA to improve collaboration with private sector programs and services assisting veterans: As Congress and VA work to expand VA's clinical footprint through the MISSION Act, there remains great opportunity to integrate not only medical services, but also to build from that foundation, linking to existing referral networks of non-clinical community supports. The creation of a network bridging non-profit with governmental - clinical with non-clinical - could help veterans better navigate the many services that are available to them. If done correctly, this has the potential to be transformative; non-clinical supports are in many cases as essential for a veteran's success as high quality clinical care. Section 201 of the Commander John Scott Hannon

Veterans Mental Health Care Improvement Act of 2019 (S. 785) embraces this concept and we encourage the Committee to consider similar legislation.

Primary Prevention

The CDC states that "public health emphasizes efforts to prevent violence (in this case, toward oneself) before it happens. This approach requires addressing factors that put people at risk for, or protect them from, engaging in suicidal behavior." At WWP, we recognize that mental health treatment works, but every individual has unique needs, and there is no one-size-fits-all solution. We take a comprehensive approach to mental health care that is focused on improving the levels of resilience and psychological well-being of warriors. Our end goal is continual engagement until the warrior is far enough in their recovery to "live our logo" (i.e., help carry a fellow warrior) - the last step in what we refer to as our Mental Health Continuum of Support.

Our Mental Health Continuum of Support is comprised of a series of programs, both internal to WWP and in collaboration with external partners and resources, intended to assist warriors and their families along their journey to recovery. The Mental Health Continuum of Support provides diverse programming and services to better meet their needs. At WWP, we understand that warriors have individualized paths of recovery and that engaging all warriors with the same program or even in a linear fashion may not be optimal. WWP's Mental Health Continuum of Support addresses and meets warriors where their needs are at their current stage of recovery. Warriors are engaged with the appropriate mental health program (i.e., the program that can best address current levels of psychological well-being and resiliency). This allows for warriors to be empowered by programs that can best address their needs and increase both psychological resilience and psychological well-being.

Recovery is not accomplished in a vacuum - life may present challenges that derail or hamper the recovery process. The continuum was designed to address such challenges and to allow for nonlinear progress through programs. Warriors sometimes need to take foundational steps (for example, to learn and hone coping skills) before proceeding forward into the next program in the continuum. By focusing on such an approach, we can reach warriors with relevant programs at time-sensitive and critical moments. By the third quarter of fiscal year 2018, programs that comprise the mental health continuum had over 67,000 engagements through Mental Health and Wellness programs. This includes outreach and referrals along with WWP programs known as Talk, Project Odyssey, and Warrior Care Network. Engagements are interactions of varying depth and scale that drive impact within each focus area.

Wounded Warrior Project has built its Mental Health Continuum of Support with a recognition that some veterans will not reach out to VA for help; however, WWP also recognizes that some veterans may not reach out for help at all because of stigma. WWP as an organization challenges these stigmas and tries to normalize the help-seeking process as all programming engagements, particularly within our Continuum of Support, are ultimately focused on normalizing mental health. For instance, in September 2018, WWP launched a social media campaign to bring awareness to veteran suicide. As our organization reaches millions of individuals across several platforms including Facebook (3.2 million), Twitter (190,000), Instagram (88,700), and LinkedIn (94,000) - we are hopeful to raise meaningful awareness across the country. Recently, and for the third year in a row, WWP facilitated a live Facebook discussion in conjunction with DoD, VA, and the Bush Institute Warrior Wellness Alliance to address veteran suicide, the challenges warriors face transitioning to civilian life, and the resources available to help with those challenges. Metrics taken 36 hours after the stream reported 128,121 unique views, which is an encouraging sign that such initiatives are reaching individuals. Internally, WWP has organization-wide Applied Suicide Intervention Skills Training (ASIST). In September 2018 alone, our organization trained 228 individuals in ASIST as part of our goal to have all program staff - as well as external partners and communities - trained with the appropriate skills and tools needed to enhance the effect of suicide awareness as well as interactions with suicidal warriors.

POLICY CONSIDERATION - Using value-based reimbursement models to enhance mental health care quality: Section 101(i) of the MISSION Act allows VA to incorporate value-based reimbursement principles to promote the provision of high-quality care, and this permission can and should be used to help encourage innovative models in physical and mental health treatment. While the health care industry has embraced bundled payment approaches to address episodes of care for hip surgery, diabetes, stroke, cancer treatment, and others, VA lags behind, and the expanded migration of this practice to mental health would allow VA to be a pioneer

in an area where veterans are catastrophically suffering and drive the wider mental health care industry towards better quality and more cost-effective outcomes.

Commitment to Science

As framed by VA, "public health uses science to increase our understanding of suicide prevention so we can develop new and better solutions." Such an approach involves tracking suicide trends and identifying risk and protective factors for suicidal behavior. This information helps frame suicide prevention strategies that can be developed and evaluated to identify the most effective interventions and then bring successful models of intervention to scale.

Although the WWP Mental Health Continuum of Support is comprised of several programs designed to meet warriors where they are in their recovery, the Warrior Care Network and Project Odyssey stand out as models for best practices and integration across multiple entities committed to improving outcomes for veterans with mental health needs. Both are also carefully tracked to measure their effectiveness and guide improvements where they are needed. Through the implementation of the Connor Davidson Resiliency and the VR12 Rand Quality of Life scales, WWP measures outcomes of services and provides the most effective programming based on the needs of warriors and their families. And while we highlight these two specific programs, it is the combination of programs across our continuum that provides our warriors and their families with a successful path to follow to increase resilience and improve their psychological well-being.

Warrior Care Network

Within the Continuum of Support, warriors needing intensive treatment for moderate to severe PTSD can take part in the Warrior Care Network. This innovative program is a partnership with WWP and four national academic medical centers (AMCs): Massachusetts General Hospital, Emory Healthcare, Rush University Medical Center, and UCLA Health. Warrior Care Network delivers specialized clinical services through innovative two- and three-week intensive outpatient programs that integrate evidence-based psychological and pharmacological treatments, rehabilitative medicine, wellness, nutrition, mindfulness training, and family support with the goal of helping warriors thrive, not just survive.

Through these two- to three-week cohort-style programs, participating warriors receive more than 70 direct clinical treatment hours (e.g. cognitive processing therapy, cognitive behavioral therapy, and prolonged exposure therapy) as well as additional supportive intervention hours (e.g. yoga, equine therapy). Each academic medical center has specific programming for caregivers and family members at some point during the intensive outpatient program, including family weekend retreats, psychoeducation, or telehealth communications. For example, UCLA's Operation Mend PTSD track includes three weeks for both veterans and caregivers to go through treatment and psychoeducation sessions. This provides caregivers with clinical outlets, as well as in-depth knowledge of PTSD symptoms, effects, and recovery process. Family and caregiver support is extremely important to WWP, and our Warrior Care Network includes support for these groups because if a treatment program does not offer a family or caregiver component, and warriors go through clinical processes then return home, it may leave the family or caregiver to feel left in the dark about what occurred.

Providing warriors with best in class care that combines clinical and complementary treatment is still only part of the Warrior Care Network's holistic approach to care. While AMCs provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, a Memorandum of Agreement (MOA) between WWP and VA has been structured to further expand the continuum of care for the veterans we treat. In February 2016, VA signed this MOA with WWP and the Warrior Care Network to provide collaboration of care between the Warrior Care Network and VA hospitals nationwide. Four VA employees act as liaisons between each site and VA, spending 1.5 days per week at their respective sites to facilitate coordination of care and to meet with patients, families, and care teams. Each VA liaison facilitates national referrals throughout the VA system as indicated for mental health or other needs, but also provides group briefings about VA programs and services, and individual consultations to learn more about each patient's needs. In November 2018, that MOA was renewed with a growing commitment from VA - VA has created full-time billets for liaisons at each AMC to enhance their contribution to the partnership. All told, this first-of-its-kind collaboration with VA is critical for safe patient care and enables successful discharge planning. At WWP, we believe cooperation and coordination like this can serve as a great example of "responsible choice" in the VA health care system.

Measuring Results:

Warriors who complete the Warrior Care Network program are seeing results. Prior to treatment, over 83 percent of patients reported PTSD symptoms at the severe to moderate range based on the PCL–5 clinical assessment, with the aggregate average being 51.1 (severe PTSD). Following treatment in the intensive outpatient programs, PTSD symptoms decreased 19.4 points to 31.7 (minimal PTSD)[1]. A similar pattern was seen for symptoms of depression, with a mean score of 16.0 at intake and a decrease to 10.2 at follow-up on the PHQ–9 assessment. These changes translate into increased functioning and participation in life, based on the decrease of psychological distress caused by severe to moderate levels of PTSD and depression.

It is also worth noting that, although effective if completed, many who begin evidence-based mental health treatment (cognitive processing therapy and prolonged exposure) in non-intensive outpatient (IOP) formats - including highly controlled and selective clinical trials[2] - discontinue care before completion. While drop-out rates in those formats are between 30 and 40 percent[3], the IOP model used by Warrior Care Network has a completion rate of 94 percent. When combined with clinically significant decreases in mental health symptoms, this figure is illustrative of the successful approach the Warrior Care Network has taken - and patients agree. Ninety-six percent (96.3 percent) of warriors reported satisfaction with clinical care received, and 94 percent of warriors indicate they would tell another veteran about WCN, a possible indication of reduced mental health stigma.

Lastly, and perhaps most important to the discussion on suicide prevention, a recent study of veterans at risk for suicide[4] evaluated the link between PTSD symptoms and suicidal ideation (SI) by using evidence-based treatments, specifically Prolonged Exposure therapy (an approach embraced and used at Warrior Care Network AMCs), to reduce PTSD symptoms and monitor subsequent changes in SI. The study indicated that a reduction in PTSD symptoms led to reduced SI among patients although the reduction followed the PTSD symptom reduction and did not occur simultaneously. Thus, reduced PTSD symptoms were predictive of later reduced SI among patients. Researchers also hypothesize that this correlation between PTSD symptoms and SI could be the result of a reduction in generalized distress. The study concluded that inclusion of evidence-based treatments in PTSD treatment are advisable to both reduce PTSD symptoms and prevent suicide.

Project Odyssey

Aside from clinical treatment, warriors may also need additional resources to improve resilience and cope with PTSD. WWP provides Project Odyssey, a 90-day program consisting of a multi-day adventure-based mental health workshop that helps warriors find resiliency in their transition from military to civilian life and continued follow-up over the weeks thereafter to build upon the lessons learned at the workshop. This non-clinical intervention takes place in locations across the country. Each workshop includes psychoeducational activities or evidence-based exercises that provide information and support to those who live with mental health issues. Project Odyssey has both warrior specific (male and female exclusive cohorts) and warrior/partner programming (i.e., Couples Project Odyssey). Each warrior cohort learns how to accept and process emotions in a productive way to build resiliency instead of avoidance and control techniques. Couples Project Odyssey focuses on friendship as the core of any relationship, with trust and commitment as the main support. Being able to better the relationship as a couple allows for a built-in accountability partner to better the individual in terms of bouncing back from life's challenges.

Project Odyssey provides specific coping mechanisms that can be practiced in daily life as stressors return. Prior to the end of the workshop, each participant establishes SMART goals - an acronym for specific, measurable, attainable, relevant,

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[1] Note: A change in score greater than 5 is indicative of clinically significant change rather than statistical change.

[2] Imel, Z., Laska, K., Jakcupcak, M., Simpson, T. (2013). Meta-analysis of Dropout in Treatments for Post-traumatic Stress Disorder. Journal of Consulting and Clinical Psychology, 81(3), 394–404.

[3] Kehle-Forbes, S., Meis, L., Spoont, M., Polusny, M. (2015). Treatment Initiation and Dropout From Prolonged Exposure and Cognitive Processing Therapy in a VA Outpatient Clinic. Psychological Trauma: Theory, Research, Practice, and Policy, 8(1), 107–14.; Gutner, C., Gallagher, M., Baker, A., Sloan, D., Resick, P. (2015). Time Course of Treatment Dropout in Cognitive-Behavioral Therapies for Posttraumatic Stress Disorder. Psychological Trauma: Theory, Research, Practice, and Policy, 8(1), 115–21.

[4] Keith S. Cox, et. al., Reducing Suicidal Ideation Through Evidence-Based Treatment for Posttraumatic Stress Disorder, 80 J. PSYCHIATRIC RES. 59, 59–62 (2016).

and timebound - which are set with the intention of supporting the individual or couple while they implement the resiliency skills learned into their daily routines. WWP works directly with the participants through a 90-day follow-up program to help them achieve their goals, connecting them with additional resources as needed. A common resource WWP provides is a referral for outpatient therapy so that the warrior or family member can continue building their coping skills. WWP has external partners that provide individual, family, or couples therapy delivered by a culturally competent therapist in the closest possible geographic location.

Measuring Results:

One crucial goal of Project Odyssey is to increase resiliency. Increased levels of resiliency may help in a warrior's psychological hardiness and in his or her ability to navigate future challenges that may cause psychological distress. When warriors successfully cope with stressors, it empowers them and may serve to lessen current and future distress. WWP uses the 10-item version of the Connor-Davidson Resilience Scale (CD–RISC) to assess resilience as one measure to determine the impact of programming. Over the last several years we have had over 10,000 participants in our Project Odyssey program with almost 3,000 in this year alone. We conducted an internal review of over 2,000 participants and found that after attending Project Odyssey, both warriors ($t(2,293)=-9.62$, $p<.001$) and family members ($t(500)=-3.46$, $p<.001$) on average experienced statistically significant increased levels of resilience. Moreover, 92 percent of warriors and family members rated the resiliency skills learned as very useful and 83 percent said the skills were still useful 90 days after completing the Project Odyssey.

In addition, preliminary analysis of PTSD symptoms (i.e., PCL–5) seem to indicate that Project Odyssey, a non-clinical intervention, is having clinical results in lowering the severity of PTSD symptoms. Our goal is to further analyze this data to confirm these initial findings and statistically covary potential influential variables.

POLICY CONSIDERATION - Embrace innovation in care delivery and payments: Section 152 of the MISSION Act authorized - and VA has since established - a Center for Innovation for Care and Payment to develop new, innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of and access to care furnished by VA. As the steward of taxpayer dollars dedicated to the health and well-being of veterans, Congress has a vested interest in tracking the developments of this center and encouraging action and partnership with the private sector on successful, scalable models of both care and payment.

POLICY CONSIDERATION - Increase studies of Vietnam Era veterans: According to VA data from 2015, rates of suicide were highest among younger veterans (ages 18 to 34) and lowest among older veterans (ages 55 and older). However, 58.1 percent of all veteran suicides in 2015 were among older veterans. While Congress should strive to reduce suicide rates and volume among all veteran demographics, it should consider directing more research on Vietnam Era veterans to gain a clearer understanding of the underlying psycho-social and biological challenges that tend to be exacerbated with age. Scientific studies may provide valuable insight into issues that are plaguing older veterans. That insight may also provide greater awareness into an aging population of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans so that essential, time-sensitive resources can be better focused as younger veterans - both current and future - begin to age.

Multidisciplinary Strategies

Lastly, the public health model advocates for multidisciplinary collaboration, convening many different disciplines across multiple sectors. While WWP's top programmatic spend was on direct mental health programs, other programming investments are delivering results along similar lines.

Research has long found that mental health and physical health tend to be intertwined to form a wholistic index of health. At WWP, the Physical Health & Wellness (PH&W) team promotes the notion that by enhancing the physical health of warriors, mental health tends to also be improved. The PH&W program targets at-risk warriors in the categories of obesity, impaired mobility, and poor nutritional quality. A host of complementary issues often accompany warriors entering the program: substance abuse, sleep disruption, low self-esteem, depression, and an elevated risk for diabetes, heart disease, cancer, and all-cause mortality.

The team's coaching program begins with a multi-day onsite experience, educating participants in the practices of bodyweight resistance training, high-quality nutrition, recovery strategies, bettering the sleep environment, a mobility assessment,

and SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goal setting. Participants are then followed for 90-days, interacting with their coach biweekly, maintaining accountability and adherence to their self-determined goals.

There is a recognition that the veteran does not achieve success alone. The family and community play a role in behavior modification and ongoing mechanisms of motivation and support. Pilot programs continue to run, assessing the impact on the inclusion of the family member throughout the coaching process. Community resources are leveraged to provide warriors with fitness, nutrition, and mindfulness-related outlets within their home area. For instance, WWP has recently been collaborating with VA's Whole Health office by providing a platform for VA to present its initiative to warriors attending the multi-day PH&W coaching program. As warriors become familiar with VA resources and the agency's holistic approach to wellness, we are helping raise awareness for a program spotlighted in the Joint Action Plan promulgated after the January 9, 2018 Executive Order addressing mental health and suicide prevention for separating and recently separated service members - and one which we hope will attract more veterans to the VA health system.

Testing outcomes pre- and post-program, 50% of warriors demonstrate improvements in physical and psychological wellbeing (VR–12 Quality of Life), lose an average of 11 pounds, 50% meet the physical standard for weekly activity (150 minutes of moderate intensity work), 54% experience improved nutritional quality, while the great majority achieve better mobility, sleep quality, self-esteem, mood, and the symptoms of stress, anxiety, and depression. The evidence is clear - a continued-care and physically-focused approach dramatically improves mental health outcomes.

A final point of consideration is the crossover between mental health and preparation for separation from service. The transition between the military and civilian culture can be stressful, as warriors are forced to change roles and how they self-identify. The resulting acculturation or transition stress may be an integral time to target interventions with warriors; however, transition is not often a time when service members are thinking about their long-term mental and physical health. As transitioning warriors are focused on their departure, their career prospects, and opportunities for post-service education, community stakeholders should be more educated on the resources available to veterans that talk about the importance of engagement, camaraderie, counseling, and physical activity as a protective factor - in essence, reaching them before they are in active crisis.

POLICY CONSIDERATION - Pursue postvention programming with family members: While VA is appropriately dedicating considerable resources to veteran-centric pursuits to reduce suicide, much can be gleaned from working with survivors to identify better approaches to identifying warning signs and empowering families to intervene effectively. A partnership WWP helps fund between Massachusetts General Hospital and the Tragedy Assistance Program for Survivors (TAPS) that created a 2-week intensive clinical program for traumatized families of the fallen and helped develop an after-care network that is saving lives by raising awareness about suicides among veterans and active duty service members. [5]

POLICY CONSIDERATION - Maintain focus on improving military transitions: As highlighted by DoD's Defense Suicide Prevention Office, service members transitioning out of DoD are at a higher risk of suicide within the first 90 days of separation - a trend consistent over a 14-year period. Over that period, approximately 50 percent of suicide deaths occurring in the first three months of separation happened within the first 17 days of separation. As Congress continues to work with the executive branch to improve and monitor military-to-civilian transition, WWP encourages the committees to review The Veterans Metric Initiative (TVMI) study commissioned by the Henry Jackson Foundation - and funded, in part, by WWP - which focuses on post-military well-being. The TVMI study's findings regarding vocation, finances, health, and social relationships may provide compelling evidence to guide future initiatives.

Conclusion

Wounded Warrior Project thanks the House Committee on Veterans' Affairs, its distinguished members, and all who have contributed to the policy discussions surrounding today's discussion about veteran suicide. We share a sacred obligation to serve our nation's veterans, and Wounded Warrior Project appreciates the Committee's effort to identify and address the issues that challenge our ability to carry out that obligation as effectively as possible. We are thankful for the invitation to sub-

[5] Brian McQuarrie, I Couldn't Be the Only One Having this Experience, BOSTON GLOBE (Feb. 23, 2019) available at https://www.bostonglobe.com/metro/2019/02/22/couldn-only-one-having-this-experience/Mx8wUfUEVV2RaSgvPsQ9eM/story.html.

mit this statement for record and stand ready to assist when needed on these issues and any others that may arise.

Center For Diseasse Control (CDC)

Written statement on behalf of the Centers for Disease Control and Prevention

Thank you to the Committee for the opportunity to discuss suicide prevention in the United States, the federal response, and the Centers for Disease Control and Prevention (CDC)'s role. The Trump administration has made addressing Veteran suicide a top priority which was emphasized by the issuance of an executive order on March 5th to empower Veterans and end a national tragedy of suicide. As directed in the executive order, the Department of Health and Human Services (HHS) will join a federal task force charged with developing a comprehensive public health approach to better understand the underlying factors of suicide and the tools needed to empower Veteran communities and provide needed services.

CDC shares the Administration's commitment to preventing suicide, which is exacting a toll on individuals, families, and communities across the country. As the Nation's public health agency, CDC is uniquely poised to help prevent suicide amongst all populations especially those most at risk, including Veterans and active duty personnel. The latest data tell us that approximately 47,000 people died by suicide in 2017[1] (an increase of 33 percent since 1999), which includes roughly 6,500 Veterans and active duty service members[2]. There is no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental and social influences that interact with one another, often over time. In the first ever Vital Signs report CDC published on suicide, CDC reported that more than half of people who died by suicide did not have a known diagnosed mental health condition[3]. Many of these deaths were preceded by economic losses, relationship issues, substance misuse, physical health problems, and housing stress. This underscores the importance of strategically including a focus outside of the realm of mental health to help prevent suicide. Successful suicide prevention requires a coordinated approach that engages multiple sectors, including public health. CDC's unique role is to lead the Nation's prevention efforts by reducing factors that contribute to suicide and suicidal behavior and by using data to inform action.

CDC assists states and communities in tracking and monitoring suicide injuries and deaths and identifying factors that may have contributed to suicides; this tracking is done through the National Violent Death Reporting System (NVDRS). NVDRS is the only state-based surveillance system that pools information from multiple data sources into a usable, anonymous database. This unique system combines multiple types of data including medical examiner reports, coroner reports, law enforcement notes, and vital statistics records. It allows CDC to better understand the individual circumstances surrounding a death, and helps to determine how it could have been prevented. With the increase in appropriations in fiscal year (FY) 2018, CDC was able to expand this system to all 50 states, Washington DC, and Puerto Rico. This recent expansion will allow CDC, states, and communities to better understand the characteristics of violent deaths and inform prevention strategies.

In the past, CDC worked with the Department of Defense (DoD) to link NVDRS data to Department of Defense Suicide Event Reports (DoDSER) among active duty Army personnel. This linkage allowed scientists from the DoD and CDC to see more comprehensive details on suicide incidents than one system alone could provide. This was one of the earliest studies to provide evidence on how the combination of health, relationship, and environmental related risk factors can precipitate suicide in the military. In addition, CDC used NVDRS data to map the military and Veteran suicide deaths by U.S. county to show which counties shoulder the greatest burden. Currently, CDC is working with both the DoD and the Department of Veterans Affairs (VA) to expand this project to help agencies not only identify where

[1] Hedegaard H, Curtin SC, Warner M. Suicide mortality in the United States, 1999–2017. NCHS Data Brief, no 330. Hyattsville, MD: National Center for Health Statistics. 2018.

[2] Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018 and Department of Defense, Defense Suicide Prevention Office. Quarterly Suicide Report, 4th Quarter, CY2017, October 2017.

[3] Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates - United States, 1999–2016 and Circumstances Contributing to Suicide - 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624.

suicides for each population are concentrated but also the service gaps in the high burden locales.

Also, Colorado conducted an analysis of their VDRS data to better understand suicide deaths among first responders, categorized as traditional fire, EMS, and police/law enforcement occupations, as well as security, corrections, and dispatchers (related to emergency service). Colorado's VDRS data showed that suicide victims who were first responders were more likely to have been Veterans, compared to the general population of suicide victims in their state. These findings helped Colorado direct their outreach services, and led them to enhance an online suicide prevention program for men and to promote resources focused on positive mental and physical health for first responders, active military personnel, Veterans, and their families.

In addition, CDC recognizes a need to provide near real-time data on suicide-related behavior, or suicide attempts. These data can enable states and communities to respond more quickly to changes in trends or suicide methods and deliver prevention and intervention resources where they're needed.

Being able to plan for a surge capacity response, for example, in the wake of high profile suicides can help save lives. To that end, CDC will begin piloting the use of emergency department data from the National Syndromic Surveillance Program to collect data on suicide risk behavior in near real-time. This system will allow CDC, states, and communities understand what is happening in the community to determine if there is an increase in suicides or a suicide cluster so the community can respond quickly.

Many states and communities want to do more to prevent suicide and look to CDC expertise and leadership for assistance. In the last year, CDC has been asked by multiple states to provide epidemiologic assistance or Epi-Aids to respond to suicide clusters. Epi-Aids are investigations of an urgent public health problem in which CDC provides a rapid, short-term, onsite examination of data in order to determine the best action to prevent and control the problem. For example, in 2018 Stark County and Ohio state health officials requested a CDC Epi-Aid to guide immediate programmatic action to prevent suicide, following an uptick of youth suicide in the area. A survey on connectedness, social media, mental health, suicidal ideation, and resiliency was administered to over 15,000 students in 7th-12th grade. Over half of the students experienced loneliness and 25 percent of the students experienced 3 or more adverse childhood experiences (ACEs), including verbal and emotional abuse, depression, and substance use in the home. Eighty percent of youth who had 3 or more ACEs and used opioids disclosed suicidal ideation. Based on key findings across data sources, CDC provided Stark County with a number of recommendations including increasing access to health and psychological care for youth, training community members to identify people at risk, collaborating with local news sources to promote safe suicide reporting, and regularly assessing the wellbeing of students through ongoing surveys. The Stark County community will use these recommendations to guide future prevention strategies and direct resources to areas of greatest need.

One of the strongest tools CDC has released to help states and communities take advantage of the best available evidence to prevent suicide is Preventing Suicide: A Technical Package of Policy Programs, and Practice. The technical package includes seven strategies focused on preventing the risk of suicide in the first place as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society. The seven strategies are:

- Strengthening economic supports
- Strengthening access and delivery of suicide care
- Creating protective environments
- Promoting connectedness
- Teaching coping and problem-solving skills
- Identifying and supporting people at risk
- Lessening harms and preventing future risk

In 2018, as part of the Governor's Challenge, seven states (Arizona, Colorado, Kansas, Montana, New Hampshire, Texas, and Virginia) convened to develop an implementation plan for the National Strategy for Preventing Veteran Suicide, utilizing the evidence-based CDC Preventing Suicide technical package strategies. In addition, since 2009, The Arizona Coalition for Military Families public/private partnership has utilized evidence-based strategies from the technical package to leverage existing resources in a sustainable effort to address active military service members, Veterans, and their families to prevent suicide through capacity-building, outreach, increased connectedness and support among Arizona communities and all branches of military service.

One critical need in the area of Veteran suicide prevention is to help Veterans at risk for suicide who are not accessing or using Veterans Health Administration (VHA) services. An estimated 20 Veterans die by suicide each day on average. Of those 20, approximately 14 of them were not using VHA services[4]. CDC has been applying a Veteran-centered approach along with a public health lens to better understand how to reach young Veterans not accessing VHA services. This project also helped to gain insights from the Veterans' perspectives on how to prevent suicide among this population as they are transitioning out of military service. Through that effort, CDC gathered insights directly from Veterans in six different, highly affected communities across the United States (Columbus, Ohio; Houston, Texas; Raleigh, North Carolina; Denver, Colorado; Colorado Springs, Colorado; Atlanta, Georgia). This deep level of engagement with Veterans and their communities helped CDC gain additional ideas for how public health might play a unique and complementary role in Veteran suicide prevention. CDC is testing out one of those new ideas by funding an evaluation demonstration project among Veteran-serving organizations. Specifically, CDC is partnering with the CDC Foundation to directly fund five Veteran-serving organizations that are implementing programs that align with an upstream suicide prevention approach-including America's Warrior Partnership, Arizona Coalition of Military Families, The Mission Continues, The Warrior Alliance, and Stack Up. CDC is providing resources and technical assistance to build these organizations' evaluation capacity and their ability to measure the impact of their programs. Ultimately, this project is contributing to an increased understanding of what works to prevent Veteran suicide at the community-level.

We know that suicide is preventable; therefore, a comprehensive public health approach is needed to reduce suicides. The National Center for Injury Prevention and Control (NCIPC) at CDC has prioritized this important public health issue. CDC brings a unique and important perspective to suicide prevention by tracking and monitoring suicide trends, identifying risk and protective factors, and evaluating suicide prevention programs, policies, and practices to determine impact. With CDC's help, states and communities can support people at risk of suicide; teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns; promote safe and supportive environments at the workplace and at home; and lessen harms and prevent future risk. CDC is committed to identifying the best evidence and partnering with other federal agencies and organizations to limit the devastation communities feel and ultimately, save lives.

Veterans Of Foreign Wars Of The United States (VFW)

CARLOS FUENTES, DIRECTOR
NATIONAL LEGISLATIVE SERVICE

Chairman Takano, Ranking Member Roe, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide recommendations on suicide prevention.

Eliminating suicide among our nation's veterans continues to be a top priority for the VFW. The most recent analysis of veteran suicide data from 2016 found suicide has remained fairly consistent within the veteran community in recent years. An average of 20 veterans and service members die by suicide every day. While this number must be reduced to zero, it is worth noting that the number of veterans who die by suicide has remained consistent in recent years, while non-veteran suicides have continued to increase.

Congress must ensure sufficient resources are available and used for effective Department of Veterans Affairs (VA) suicide prevention efforts, including to identify veterans at increased risk of suicide, adopt new interventions, and effectively treat those with previous suicide attempts. Programs such as the Veterans Crisis Line, the placement of suicide prevention coordinators at all VA medical centers and large outpatient facilities, integration of behavioral health into primary care, and joint campaigns between the Department of Defense and VA must continue to be improved and expanded. The VFW also supports the recent executive order to establish the Veteran Wellness, Empowerment, and Suicide Prevention Task Force to co-

[4] U.S. Department of Veterans Affairs, Office of Suicide Prevention. Suicide among Veterans and other Americans 2001–2014. Viewed March 23, 2017 at https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf. 2016.

ordinate suicide prevention efforts at the national and local levels, and expanding efforts with community partners like the VFW.

The Government Accountability Office has identified several key barriers that deter veterans from seeking mental health care. These include stigma, lack of understanding or awareness of the potential for improvement, lack of child care or transportation, and work or family commitments. Early intervention and timely access to mental health care can greatly improve quality of life, promote recovery, prevent suicide, obviate long-term health consequences, and minimize the disabling effects of mental illness.

The VFW is proud to have partnered with VA, and community and corporate partners to raise awareness of mental health conditions, foster community engagement, improve research and provide intervention for those affected by invisible injuries and emotional stress through the VFW Mental Wellness Campaign. Since Fall 2016, nearly 300 VFW posts around the world and 13,000 volunteers have successfully reached 25,000 people in the past three "Day to Change Direction" events, hosted in partnership with Give an Hour's Campaign to Change Direction.

The focus of the VFW's Mental Wellness Campaign is to teach veterans and caregivers how to identify when they or their loved ones are experiencing the signs of emotional suffering—personality change, agitation, being withdrawn, poor self-care, and hopelessness. In an effort to destigmatize mental health, participants are informed that mental health conditions such as post-traumatic stress disorder (PTSD) are common reactions to abnormal experiences.

The goal is to also reduce the number of veterans who die by suicide each day without having made contact with VA health care services. Research indicates that veterans who do not use VA for their health care are at an increased risk of suicide. This comes as no surprise to the VFW, as our members have continuously informed us that they prefer VA health care because of the high-quality and veteran-centric care VA provides. To better assist all veterans, veterans service organizations, VA, and Congress must know more about the two-thirds of veterans who die by suicide each day without any contact with VA. The VFW urges VA to analyze the demographics, illnesses, socioeconomic status, and military discharges of the 14 veterans and service members who die by suicide every day and do not use VA health care. There are questions that need to be answered in order to properly address this epidemic. Did those 14 use private sector care- Were they eligible to use VA- Were they among the many who were discharged without due process for untreated or undiagnosed mental health disorders- Were they discharged for unjust and undiagnosed personality disorders due to transgenderism or during the era of "Don't Ask, Don't Tell- Have they used other VA benefits such as the GI Bill-

However, VA must stand ready to assist veterans who take the bold step of seeking assistance when they are suffering from suicidal ideation. Over the past decade, the VA Office of Mental Health Services has developed a comprehensive set of services to treat the approximately 1.7 million veterans who received VA mental health services in fiscal year (FY) 2018, which is a significant increase from the 927,000 veterans who received such care in FY 2006. Since 2016, VA has strived to provide same day access to veterans who need urgent and emergent health care. While this and other suicide prevention initiatives have resulted in VA saving the lives of veterans in crisis, it must do more to ensure veterans who need help receive it.

It is unconscionable for veterans who experiencing mental health care crises to be turned away. For example, the VFW was informed of a veteran who presented to a VA mental health clinic with suicidal thoughts and asked to be seen immediately because she feared she would take her own life. The front desk clerk informed her that she could not be seen immediately because she had just completed a mental health care appointment the previous day and the next available appointment was in a week. Luckily, the veteran was able to cope with her crisis without VA assistance, and is alive and well.

Too many veterans have died because VA has turned them away in their time of need or failed to identify the seriousness of their health conditions. For example, it is unacceptable for a veteran who is in a VA waiting room to complete suicide without someone noticing the veteran needed immediate assistance. VFW commends VA for looking into ways to protect its employees and patients at VA medical facilities. However, enhanced safety procedures at VA medical facilities will not address the underlying problem. VA employees have become desensitized to veterans with mental health concerns. I have personally witnessed a VA employee disregard a veteran as "just another crazy veteran." Such mentality must stop. VA must train its employees to identify and assist veterans in crisis. VA must also encourage its employees to take action when they identify a veteran in crisis, without fear of reprisal.

Another reason VA is required to turn veterans away is eligibility for VA health care. The VFW lauds Congress and VA for recent action to expand VA mental

health care services to recently discharged veterans and veterans with Other Than Honorable discharges. VA also has the ability to treat any veteran who is not eligible for VA care through its humanitarian care authority under section 1784 of title 38, United States Code (U.S.C.). However, VA is required to charge veterans the full cost of urgent or emergent mental health care. It is understandable for VA to bill other health insurance for such care, but VA must not be required to place an undue burden on veterans who have survived a mental health crisis, particularly because financial instability is often a contributing factor to mental health crises.

The VFW is working with a veteran who was rushed to a VA hospital during a mental health crisis caused by untreated bipolar disorder and depression. The veteran was admitted to the medical center's inpatient mental health care clinic for two weeks, despite not being eligible for VA health care. VA saved his life, but now he has a $20,000 bill. His mental health crisis was exacerbated by unemployment and his inability to provide for his family. With proper treatment he has been able to return to work, but still lacks the resources to pay the VA bill. The VFW is working on having his bill waived, but he will never return to VA if he has another mental health crisis.

The fear of being turned down or billed for care should never prevent a veteran from seeking the urgent or emergent VA mental health care they need. Congress must amend section 1784 of title 38, U.S.C., to exempt those who have worn our nation's uniform who receive urgent or emergent mental health care under VA's humanitarian care authority from having to pay the full cost of such care.

The Office of Inspector General (OIG) report determining Veterans Health Administration (VHA) staffing shortages continues to list psychiatry clinics as having the most need, with the fourth being psychology. Out of 141 facilities surveyed, 98 had a shortage for psychiatrists and 58 had a shortage for psychologists. By not adequately staffing VA, the capacity to serve veterans and provide the necessary access to mental health care needed by so many veterans will continue to be limited. With the entire nation experiencing a critical shortage of mental health providers, such need cannot be sufficiently addressed by simply increasing use of community care. VA must utilize the tools it was given by the VA MISSION Act to hire more providers with enhanced recruitment and retention incentives, train more mental health providers with increased Graduate Medical Education opportunities, and maximize its current capacity with its anywhere to anywhere authority.

The VFW is proud to be part of the solution. Through Project Advancing Telehealth through Local Access Stations (ATLAS), the VFW has worked with VA and Philips to leverage VA's anywhere to anywhere authority to expand telehealth options for veterans who live in rural areas. In this partnership, VA has identified highly rural areas where veterans must travel far distances to receive VA health care. The VFW identifies posts in those areas to serve as access points for VA health care. Once the post is modified to VA's specifications, it is equipped with Philips-donated telehealth technology to provide veterans access to VA health care at a convenient veteran-centric location. More than 20 VFW posts have been identified as possible telehealth centers. The primary use for the first Project ATLAS site in Eureka, Montana, will be for mental health care. Veterans in Eureka are required to travel more than 70 miles to the nearest VA clinic for mental health care. Soon they will have the ability to receive VA health care closer to home.

VA is making concerted efforts to ensure it appropriately uses pharmaceutical treatments when providing mental health care. Under the Opioid Safety Initiative, VA has reduced the number of patients to whom it prescribes opioids by more than 22 percent. Prescribed use of opioids for chronic pain management has unfortunately led to addiction to these drugs for many veterans, as well as for many other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of PTSD and SUD to ensure better health outcomes. However, many veterans report being abruptly taken off opioids they have relied on for years to cope with their pain management, without receiving a proper treatment plan to transition them to alternative therapies. Doing so leads veterans to seek alternatives outside of VA or to self-medicate. VA must continue to expand research of non-traditional medical treatments, such as medical cannabis and other holistic approaches, for mental health care conditions.

In the past several years PTSD and traumatic brain injury (TBI) have been thrust into the forefront of the medical community and the general public in large part due to suicides and overmedication of veterans. Medical cannabis is currently legal in 33 states and the District of Columbia. This means veterans are able to legally obtain cannabis for medical purposes in more than half the country. For veterans who use medical cannabis and are also VA patients, they are doing this without the medical understanding or proper guidance from their coordinators of care at VA. This is not to say VA providers are opting to ignore this medical treatment, but that

there is currently a lack of federal research and understanding of how medical marijuana may or may not treat certain illnesses and injuries, and the way it interacts with other drugs.

This is regardless of the fact that many states have conducted research for mental health, chronic pain, and oncology at the state level. States that have legalized medical cannabis have also seen a 15–35 percent decrease in opioid overdose and abuse. There is currently substantial evidence from a comprehensive study by the National Academy of Sciences and the National Academic Press that concludes cannabinoids are effective for treating chronic pain, chemotherapy-induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia—all of which are prevalent in the veteran population.

The VFW urges Congress to pass legislation to require VA to conduct a federally funded study with veteran participants for medical cannabis. This study should include participants who have been diagnosed with PTSD, chronic pain, and oncology issues.

The VFW has also long advocated for the expansion of VA's peer support specialists program. VA peer support specialists are healthy and recovered individuals with mental health or co-occurring conditions who are trained and certified by VA standards to help other veterans with similar conditions and/or life situations. Veterans who obtain assistance from peer support specialists continuously sing their high praises. Peer-to-peer programs are also critically important for minorities, LGBT and women, or any group within the veteran community that is ostracized or misunderstood. This is instrumental in helping veterans avoid loneliness, which can lead to suicidality.

Aside from veterans receiving support from fellow veterans who have recovered from similar health conditions, and experiencing the bond and trust veterans share, peer support specialists also greatly assist in destigmatizing mental health conditions such as PTSD. For a veteran to become a peer support specialist, they must have actively gone through treatment, and be living a relatively healthy lifestyle. This allows veterans who may be struggling to see that their condition is treatable, manageable, and not something that has to negatively impact or control their lives.

The Independent Fund

Thank you for the opportunity to provide this testimony to the Committee on Suicide Prevention.

Operation RESILIENCY

The Independence Fund recently embarked on one of the most ambitious suicide prevention programs, in partnership with the VA. Called, "Operation RESILIENCY", this program brings together tactical combat units who suffered high casualty rates during those deployments, and then suffered high suicide rates upon redeployment. The concept is to bring the company or battalion sized units together in reunion retreats, build upon the strong unit cohesion borne of battle, and leverage that cohesion to renew a sense of belonging amongst the military veterans, as well as to build accountability amongst the unit members.

Inaugural Retreat

The Independence Fund recently hosted the first of these retreats April 4–7, 2019, in Charlotte, NC, with members of Bravo Company, 2nd Battalion, 508th Parachute Infantry Regiment (B Co., 2/508 PIR), from their 2009–2010 combat deployment to Afghanistan. Of the 115 surviving members of the Company, 95 participated, some of them still active duty or reserve component, but most discharged or retired veterans. This unit suffered more than a 50% Purple Heart award rate, lost two members Killed in Action, and dozens Wounded in Action. Equally troubling, since that deployment, of the approximately 300 members of the Battalion, six members died from suicide.

During this four-day reunion, while members of B Co. enjoyed unit building activities such as white- water rafting, Top Golf outings, unit physical training, and bonfires, they also participated in clinical group and individual therapy sessions facilitated by mental health professionals from the VA's Office of Suicide Prevention, and led by Dr. Keita Franklin. The clinical therapy sessions focused on connectiveness and reigniting the bonds these Paratroopers have. On the final day, after more unit physical training, a Resource Fair was held with representatives from local Congressional offices, Veteran and Military Service Organizations, mental health providers, and various Veterans Benefits Administration, Veterans Health

Administration, and other federal government agencies, as well as local governments, to provide a "whole of society" approach to addressing the panoply of contributors to veteran behavioral health and suicide prevention.

In addition to the representatives of the VA's Suicide Prevention Office, local VA medical facility and VISN officials, as well as representatives of various benefits offices, participated in the weekend.

Members of the North Carolina Congressional delegation, the Afghan Ambassador to the United States, and VA and Independence Fund officials all participated in various programs with the unit members.

Post Reunion Retreat Engagement

Together with the VA, the participants of the retreat complete a VA designed pre-retreat, post-retreat, and 30-day follow-on post-retreat survey, a copy of which is attached. This survey is used to measure individual changes in participants' individual Resilience Score, using the Connor-Davidson Resiliency Scale (CD–RISC). The VA conducts these surveys and collects this data as this program is a pilot program for the VA, in large part to determine the efficacy of this approach in improving individual resilience.

Furthermore, the VA is conducting follow-on engagement calls for all participants, with the initial contact completed by May 3, 2019. The participants will also receive a post-retreat survey via e-mail by May 8, 2019, as well as additional follow-on calls at 60- and 90-day points after the retreat, and at six and 12 months. The calls will be used to determine if the participants connected to resources identified during the retreat weekend, and if The Independence Fund and the VA can provide them additional support obtaining these resources. An additional purpose of the calls is to remind them of the connection with their accountability partners within the unit, and possibly identify those in or approaching crisis who may need immediate intervention.

Another key goal of the retreat is to get those participants who need it into therapy with the Department of Defense or VA, as appropriate. Since the retreat, three participants started therapy, and another three presented themselves as in crisis, where The Independence Fund and the VA were able to get them into immediate care.

For those present, the impact on the participants was palpable. The reconnection with battle buddies, assurance from unit leadership that seeking behavioral health assistance was normal and acceptable, and resiliency training all appeared to have a visible and quick impact on the participants. As one participant stated post-retreat, "This retreat saved lives. Maybe not today or tomorrow, but lives will be saved because of what happened here."

Additional Reunion Retreats

The Independence Fund will host at least two additional retreats in 2019 and plans to host four to six retreats per year moving forward. From May 8–11, 2019, the Independence Fund will host the 3rd Battalion of the 67th Armored Regiment, who deployed to Fallujah, Iraq, at a reunion retreat in Houston, TX. From September 26–29, 2019, the Independence Fund will host a retreat for Bravo Company, 2nd Battalion, 504th Parachute Infantry Regiment, in Nashville, TN.

Members of this Committee and both Committee and personal office staff are more than welcome to join us at these retreats. Local Congressional offices are also invited to set up booths at the retreats' Resource Fairs on the last day to advise constituent participants on the services those Congressional offices can provide active duty, reserve component, and veteran participants. Further, if Members of the Committee know of other military units, active or reserve component, who fit these criteria and might benefit from an Operation RESILIENCY retreat, please contact us and we will work with you to support those units.

Operation RESILIENCY Summits

Building on the "whole of community" approach championed by the VA through their Governors' Challenge and Mayors' Challenge, The Independence Fund is also hosting a series of regional Operation RESILIENCE Summits to support the local community planning to execute these veteran suicide prevention efforts. The Independence Fund hosted the first Summit April 23, 2019 in Charlotte, NC supporting Mecklenburg County, and focusing on student veteran suicide. In addition to the support of national leadership of Student Veterans of America, representatives of eight regional colleges and universities joined local government officials and The Independence Fund with workshops and panel discussions such as "Pre/Post Military Stress for Student Veterans", "Invitation to a Tribe: Connecting in the Community", "Student Veteran with Healthcare Needs - Navigating and Collaborating with

VA and Community Resources", and "Working Through Obstacles and Creating Support for Veteran Resiliency & Success". The Independence Fund will work with SVA, Mecklenburg County and other participants to continue to engage Student Veterans in the weeks and months following.

In July 2019, the Independence Fund will host a second Summit in Houston, TX, which will focus on older veteran suicide. Specific goals of these summits are to "Invitation to a Tribe: Connecting in the Community", "Senior Veteran with Healthcare Needs - Navigating and Collaborating with VA and Community Resources", and "Working Through Obstacles and Creating Support for Veteran Resiliency & Success". We are currently reviewing other communities in which to host further Summits this year and following years. The Independence Fund plans to host four to six of these Summits per year. If Members of this Committee know of suitable partner communities where we could host future Summits, we would very much appreciate the opportunity to work with your offices to coordinate that.

Legislative & Policy Proposals

The Independence Fund fully supports the whole of community approach presented in the President's PREVENT Executive Order, and believe including non-governmental community organizations, along with State and local governments, in such veteran suicide prevention programs is the only way to fully address the issue of veteran suicide. As both this Committee, the Senate Veterans Affairs Committee, and the Administration are all proceeding with similar community engagement grant programs, The Independence Fund would appreciate the opportunity to present what we believe should be governing principles as these legislative, regulatory, and Executive Branch actions move forward.

Keep a Behavioral Health Focus: While many factors can contribute to an individual's death by suicide, it is ultimately a behavioral health issue. Factors such as employment, finances, housing, and personal relationships can all contribute to suicide and suicidal ideation. But many other veterans suffer setbacks in all those areas without looking at suicide as a response. The decisions which lead to suicide are cognitive and are best treated by proper behavioral health. The Independence Fund is concerned government grant and community engagement programs will be diluted below a level of minimum capability if these programs attempt to address too many non-behavioral health issues.

Strengthen the Behavioral Health Capabilities of Community Care Providers: With most veterans dying by suicide not enrolled in the VA system, it is doubtful expanding VA behavioral health capabilities alone will adequately address veteran suicide rates. Government to community engagement programs and grants should seek to broaden, strengthen, and deepen the capabilities of community care behavioral health capabilities to reach as many veterans as possible. This Committee should also remain aware there is still deep mistrust of the VA within many parts of the veterans community, which will require exorbitant levels of marketing and engagement to overcome. The Independence Fund believes those funds would better be spent on community care programs where those issues of mistrust are not as prevalent.

Grants Should Provide Sufficient Funds to Run a Meaningful Programs: Too often government grant programs seek to meet broad demographic, policy, and geographic diversity goals, which then may lower the amount awarded in individual grants below a level where the program can be efficiently executed and unnecessarily raising per capita costs. The Independence Fund believes it is better to award a smaller number of larger grants than a larger number of smaller grants in order to prevent funds provided will be consumed by overhead and administrative expenses and not address the key behavioral health issues.

Maximize Community Partner Engagement in the Government Processes: Current regulations allow grant making agencies to have stakeholders serve on grant selection committees. This Committee should encourage the VA and the PREVENT Task Force to bring such veteran suicide prevention stakeholders into the process for determining the grant criteria and to have such stakeholders serve on the grant-making committees. Further, this Committee should encourage the Administration to establish an advisory subcommittee of the PREVENT Task Force where veteran suicide prevention stakeholders and community partners can effectively serve.

The Independence Fund appreciates this opportunity to testify before the Committee and looks forward to the opportunity to work with you further in preventing veteran suicide.

Questions For The Record

Representative Lauren Underwood to National Institute of Mental Health (NIMH)

Questions:

1. In your written testimony for this hearing, you outlined the effectiveness of the REACH–VET suicide risk identification system.

a. Please provide information on the specific patient characteristics that REACH–VET analyzes.

b. Please provide more detailed information on how REACH–VET's effectiveness is evaluated.

c. Has there been any effort to export the predictive system used by the REACH–VET model for use by other health care providers?

2. Your written testimony includes a section addressing several research studies supported by the VA that have uncovered benefits from an intervention called "caring communications." Please provide a summary of the current status of implementation of caring communications intervention methods, including the number of facilities using the methods, any research analyzing their effectiveness, and any plans or proposals for expanding use of the methods.

Answer to Question 1:

The U.S. Department of Veterans Affairs' (VA) Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment (REACH–VET) program highlights the potential of identifying people at suicide risk using electronic health records (EHRs).

Building on the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)[1], the largest study of mental health risk and resilience ever conducted among military personnel, VA initiated efforts to develop predictive models of suicide risk among veterans receiving VA healthcare.[2] The VA also worked with Michael Schoenbaum, Ph.D. from the National Institute of Mental Health (NIMH) and later Ronald C. Kessler, Ph.D. from Harvard Medical School. Suicide data used in the REACH–VET analyses were National Death Index results from the VA/DoD Suicide Data Repository and predictors were measured from Veteran Health Administration (VHA) clinical records. The predictive model incorporated demographic measures (e.g., age, gender, race/ethnicity, marital status, urban or rural residence, and geographic region), contextual factors (e.g., military service-connected disability, homelessness, and previous self-directed violence), mental health measures (e.g., receipt of any mental health or substance abuse diagnoses and specific diagnoses), and medical measures (e.g., specific diagnoses, including common conditions, and pain-related diagnoses). This analysis demonstrated the feasibility of developing algorithms to identify patients within the VA system whose predicted suicide risk was 20–30 times higher than average.

The analysis described above led directly to the development of the VA's REACH–VET program, which currently applies an algorithm each month to the VA patient care population to identify a small fraction (0.1 percent) of patients with the highest predicted suicide risk. NIMH defers to the VA to provide information on the administration and evaluation of the effectiveness of the REACH–VET program. It is our understanding that the REACH–VET algorithm examines an individual's EHRs for the following model predictors: demographics, prior suicide attempts, diagnoses, VHA use, medications, and interactions.[3] REACH–VET coordinators work with mental health and primary care providers to re-evaluate care, provide a suicide-focused clinical assessment, and consider ways to enhance treatment for veterans identified at high-risk for suicide. It is also NIMH's understanding that the VA Serious Mental Illness Treatment Resource and Evaluation Center conducts ongoing evaluation regarding REACH VET effectiveness. This includes assessment of REACH VET program effects on measures of care processes, treatment utilization, and mortality outcomes, using difference-in-difference techniques.

While the VA was the first healthcare system in the United States to use data from EHRs to help identify people with suicide risk, other healthcare systems are now using similar data to develop and validate suicide prediction tools to use with

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4286426/
[2] https://www.ncbi.nlm.nih.gov/m/pubmed/26066914/
[3] https://www.hsrd.research.va.gov/for—researchers/cyber—seminars/archives/3527-notes.pdf

civilian populations. For example, seven of the 13 healthcare systems across the United States that are part of NIMH's Mental Health Research Network (MHRN) examined data from EHRs and responses to self-report questionnaires to predict suicide attempts and deaths.[4] The MHRN model predictors include demographic and clinical characteristics, prior suicide attempts, mental health and substance use diagnoses, medical diagnoses, psychiatric medications dispensed, inpatient or emergency department care, and routinely administered depression questionnaires. MHRN researchers found that prediction models incorporating both EHR data and responses to self-report questionnaires outperform existing suicide risk prediction tools that do not use EHR data.[5]

Answer to Question 2:

Multiple agencies, including the NIMH and the VA, are supporting several research studies that have uncovered benefits from [6]"caring[7] communications[8]."[9] Caring communications includes a wide range of interventions in which patients are sent follow-up written communication - by postcard, letter, or text message - in the weeks and months after they are identified with suicide risk. Such communications, which provide regular and supportive contact with the patient during a critical period when they transition between structured healthcare settings and the community, have been found to reduce suicidal behaviors.

NIMH-supported researchers have also shown that caring communications is a very high-value intervention; that is, it is a relatively low-cost intervention compared to its benefits.[10] The researchers found that sending caring postcards or letters following an emergency visit is more effective and less expensive than usual care. While telephone or written follow-up communications can be provided by the hospital where the patient was identified, from a centralized facility coordinated by the health system, or by staff from Crisis Line programs such as the National Suicide Prevention Lifeline or the Veterans Crisis Line, this type of proactive follow-up is not yet part of standard practice.

NIMH continues to support research to identify how and why these follow-up interventions work, and how these methods can be scaled up for broader implementation. NIMH will continue to work with our federal and public partners to inform evidence-based care and prevent suicide. NIMH defers to the VA regarding the current status of implementation of caring communications methods within the VA healthcare system, including the number of facilities using the methods, and any plans or proposals for expanding use of these methods for veterans and military personnel.

Representative Lauren Underwood to Dr. Richard Ston , Dr. Shelli Avenevolie

1. Your written testimony mentions a national network of Women's Mental Health Champions created by VA. Please provide a brief written overview of the Women's Mental Health Champions Program, including any evidence-based practices that have influenced the development of that program, and a list of program participants located in Illinois.

2. Given the recent incidences of veteran suicides at VA medical facilities, has VA enacted any new policies or procedures to reduce the number of on-site suicides?

a. Have any internal reviews have been conducted with regard to improving onsite security and threat screening?

b. If so, when will those review findings become available?

3. In your written testimony you highlighted VA as a national leader in providing "telemental" health services. Please provide data regarding the efficacy of "telemental" health programs as a useful means of reaching, retaining, and providing effective mental health care to patients.

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[4] https://www.ncbi.nlm.nih.gov/pubmed/29792051
[5] https://www.ncbi.nlm.nih.gov/pubmed/29792051
[6] https://www.ncbi.nlm.nih.gov/pubmed/30758491
[7] https://projectreporter.nih.gov/project—info—description.cfm-aid=9687746
[8] https://clinicaltrials.gov/ct2/show/NCT01473771
[9] https://clinicaltrials.gov/ct2/show/NCT01829620
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750130/

4. In Dr. Shelli Avenevoli's written testimony for this hearing, she outlined the effectiveness of the REACH–VET suicide risk identification system.

a. Please provide information on the specific patient characteristics that REACH–VET analyzes.

b. Please provide more detailed information on how REACH–VET's effectiveness is evaluated.

c. Has there been any effort to export the predictive system used by the REACH–VET model for use by other health care providers?

5. The written statement provided by Disabled American Veterans for this hearing praised the utility of a personal workbook distributed by VA, "Your Personal Safety Plan," to identify stressors and to create a strategy for veterans for staying safe in times of emotional crisis. Given the elevated risk factors among the veteran population, has VA considered proactively providing the "Your Personal Safety Plan" workbook to all veterans as a presumptive positive intervention method?

6. Dr. Avenevoli's written testimony includes a section addressing several research studies supported by the VA that have uncovered benefits from an intervention called "caring communications." Please provide a summary of the current status of implementation of caring communications intervention methods, including the number of facilities using the methods, any research analyzing their effectiveness, and any plans or proposals for expanding use of the methods.

7. In your written testimony you highlighted several times the need to better understand and target prevention efforts towards the 14 veterans who die by suicide each day who were not recent users of VA health services. Please provide an overview of any current methods to identify the demographics of 14 veterans.

a. Please provide information on what data is being collected on these individuals, including their character of service; medical history; and access to VA, military, or private sector care, etc.

8. The written statement provided by Veterans of Foreign Wars referenced an August 2018 report from the Department of Veterans Affairs Office of Inspector General (Report #17–05248–241) detailing the VA's staffing shortages in the area of mental health care. Please provide a roadmap with specific and measurable goals toward reducing the shortage of mental health staff in VA facilities, along with an outline of the resources you need to successfully implement the plan.

9. In her testimony during the hearing, Dr. Keita Franklin stated, "If it were up to me, we'd train the entire VA on how to talk about lethal means." Are there any existing barriers that would hinder VA from expanding lethal means training for its staff?

10. Dr. Franklin also highlighted official partnerships between the VA and outside organizations to promote firearm safety. Please provide an overview of VA's current partnerships with organizations (such as firearm dealers and firearm ownership groups) aimed at reducing veteran suicide rates. Please include data on any funding provided, the number of involved organizations, and the number of veterans reached by these efforts.

To Dr. Shelli Avenevoli:

1. In your written testimony for this hearing, you outlined the effectiveness of the REACH–VET suicide risk identification system.

a. Please provide information on the specific patient characteristics that REACH–VET analyzes.

b. Please provide more detailed information on how REACH–VET's effectiveness is evaluated.

c. Has there been any effort to export the predictive system used by the REACH–VET model for use by other health care providers?

2. Your written testimony includes a section addressing several research studies supported by the VA that have uncovered benefits from an intervention called "caring communications." Please provide a summary of the current status of implementation of caring communications intervention methods, including the number of facilities using the methods, any research analyzing their effectiveness, and any plans or proposals for expanding use of the methods.

Chairman Mark Takano to Department of Veterans Affairs (VA)

Regarding the Public Health Model (Generally)

Question 1: How does VA collect and use data on veteran suicides to inform its prevention efforts?

VA Response: Data informs all of our suicide prevention efforts. VA is using data to tailor the best possible targeted prevention strategies to reach all Veterans - not just those who are identified as being at elevated risk. To better understand Veteran suicide as a whole, we look at trends among both the broader Veteran population, as well as sub-groups of Veterans, over time. This helps us identify areas of particular concern, to develop appropriate programs and resources and to better measure our progress.

Question 1a: For example, how does VA examine various factors (e.g. location of the suicide, last contact with a VA health care provider) and use this information in all of its suicide prevention programs (not just REACH VET)?

VA Response: VA analyzes data about risk factors and completed suicides and uses this information to develop targeted programming and align resources to the areas that need it most. Additionally, VA is examining the association between suicide risks and factors including no-show medical appointments and high-risk flags.

Based on data findings on suicide rates for never federally activated members of the Guard and Reserves, VA developed a toolkit of resources for this population; published an Executive in Charge memo to the field encouraging facility staff to provide gunlocks, conduct community outreach, and use the humanitarian/emergency care authority in 38 United States Code (U.S.C.) 1784 to provide mental health and suicide prevention services; and began working with Guard and Reserve leadership on strategies to provide resources to this population.

VA's data showed that transitions in care are a critical time-period for suicide prevention. This led to a pilot program called Caring Contacts, where suicidal patients received text messages or letters with brief, non-demanding expressions of care over a year or more. Veterans overwhelmingly found these expressions to be helpful, and VA is exploring options to bring this pilot to other facilities.

When a suicide or suicide attempt occurs at a VA Medical Center (VAMC), staff will complete a Root Cause Analysis (RCA) to review a larger systems issue, or a Peer Review, to focus on a specific aspect of a Veteran's care. An RCA is a multidisciplinary approach to study health care-related adverse events and close calls, which involves a systematic process for identifying "root causes" of problems or events, as well as an approach for responding to them. The goal of the RCA process is to find out what happened, why it happened, and how to prevent it from happening again. The Patient Safety Manager is responsible for identifying RCA team members to complete the RCA process, including Facility Suicide Prevention Coordinators (SPC) and VA Police, as needed.

VA also realized that Veterans with Lesbian, Gay, Bisexual, Transgender (LGBT) or related identities may be at increased risk for suicide. To help provide comprehensive care to this population, VA developed a toolkit of resources that helps VA providers and their patients have open, culturally appropriate conversations about issues related to LGBT health care. We also recently launched the Connect. It can save a life. campaign to encourage VA providers and their patients to talk about gender identity and sexual orientation as part of routine health care.

Additionally, based on our data findings regarding suicide deaths by firearms and other lethal means, VA implemented a nationally-standardized Suicide Prevention Safety Planning Template that ensures that Veterans receive high-quality suicide prevention safety plans that address feasible steps to reduce access to lethal means.

We have also analyzed data on employment rates and homelessness to ensure that we have the right partners and capabilities in place to target these risks.

Question 1b: How does VA collect and use data to "target groups" like female veterans?

VA Response: VA compiles data from multiple sources, including VA, the Department of Defense (DoD), and public records systems (e.g., the Centers for Disease Control and Prevention's (CDC) National Death Index (NDI)), to understand Veteran suicide. Each data source and measure provide new information that can help characterize risk for a Veteran subgroup. Ongoing monitoring enables longitudinal assessments. In these ways, for example, we know that suicide rates among female Veterans are particularly elevated compared to non-Veteran women.

Once we identify this data point, we work with VA's Women Health Services office to share findings and develop specific programming. We also engage with other offices to develop pilot projects and programming tied to this risk. An example of this is a new pilot project with the Army, Navy, and Marine Corps on a women's health transition program. This pilot is currently in the testing phase with the Air Force.

Question 2: How do VA and DOD share data with each other to help prevent veteran suicides?

VA Response: VA's most comprehensive source of Veteran suicide mortality data on the entire Veteran population, including those not receiving care from the Veterans Health Administration (VHA), is the Joint VA/DoD Suicide Data Repository (SDR). Data for the SDR are obtained from the CDC's NDI, considered the national "gold standard" for mortality data. The NDI includes indicators of date, state, and cause of death.

Question 2a: Are there any challenges with collecting and/or accessing data across agency lines?

VA Response: Yes, there are several challenges, including the need to improve mortality surveillance by the inclusion of additional fields available on the death certificate such as address of residence and county of death. Current resources used by VA, such as the CDC's NDI, do not currently have this information.

An additional challenge is that the timing of current data availability prevents near real time monitoring of suicide data to appropriately assess program efforts. NDI releases death records for request approximately 11 months after the end of the calendar year, at which time a coordinated VA/DoD search of millions of records is completed, leading to the identification of the matching death records and cause of death for Veteran decedents, followed by follow-on analyses within our VHA data systems and then developing the report and the dissemination of this information. This coordinated, multiagency process leverages the best available data to report and track Veteran mortality and can take up to 18 months for completion. DoD and VA both pay CDC for this data as well - close to 3 million dollars in total, and there are hurdles with making sure that the vehicle is in place to make the payment in order to receive the data in a timely matter.

Regarding REACH VET Predictive Analysis Modeling

Question 1: Has VA monitored whether all VISNs and VAMCs have successfully implemented REACH VET in all required patient care settings?

VA Response: Yes. Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment (REACH VET) is fully implemented in VHA and identifies approximately 30,000 at risk Veterans for care review, enhancement, and outreach. The target for the program for fiscal year (FY) 2019 is 90 percent of those identified receiving review and outreach within two weeks and that target was reached in March 2019.

Question 2: How has VA ensured that VHA providers responsible for conducting VA's new standardized suicide risk screening and assessment processes have been properly trained in this process?

VA Response: Prior to the implementation of the Universal Screening Protocol in May 2018, an informational memo was distributed to the field outlining the new protocol. A Suicide Risk Screening and Assessment SharePoint was established, a single technical assistance email group was established, and all facilities identified a Facility Champion/Point of Contact for training and questions. Educational webinars were held throughout August and September, which were made available on the Talent Management System (TMS) for sites to utilize. Weekly technical assistance calls were also held during this period.

The assignment and management of training and education is done locally. There are no national metrics to track training as facilities must determine appropriate staff based on scope of practice. Local facilities may assign training to appropriate staff and track this training through TMS.

Virtual training remains available and provides details and guidance on VA's new, national three-stage screening and evaluation process. Three courses are available in TMS, including Suicide Risk identification Strategy - Overview (TMS item number VA 36829), Primary and Secondary Screening Tools (TMS item number VA 36816), and Comprehensive Suicide Risk Evaluation (CSRE) (TMS item number VA 36830). VA's Suicide Risk Identification SharePoint training documents folder includes training resources such as Frequently Asked Questions, Suicide Risk Identi-

fication Clinical Reminder Flowchart, and Suicide Risk Stratification Table. In addition, the SharePoint hosts a discussion board for questions.

The VA Suicide Risk Identification Technical Assistance Group hosts a weekly technical assistance phone call. Questions can be emailed to the VA Suicide Risk Identification Technical Assistance Group at vhariskIDsupport@va.gov.

To ensure that facilities are made aware of updates related to national memos, release of educational materials, changes to requirements or guidance documents and any other information related to the risk ID process, each facility was required to identify a Facility Champion/Point of Contact. The Facility Champion receives updated information as it becomes available and disseminates the information to the local facility.

The Suicide Risk Management Consultation Program is available to consult on a specific case or talk about suicide risk management strategies more generally.

Regarding the Executive Order on a National Roadmap to Empower Veterans and End Suicide

Question 1: As part of the March 5th Executive Order on Suicide Prevention, the President calls for the creation of a task force that will, among other things, develop a plan to be known as the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide, or PREVENTS, within one year of March 5, 2019. It has been more two months since the issuance of the order and details have been scarce.

Question 1a: Could you inform the Committee who has been assigned to represent the various agencies and organizations listed as part of this task force?

VA Response: VA is working closely with the White House on efforts associated with the Executive Order. Task Force work has already started three lines of effort (LOE): Research, State and Local Action, and Enabling Supports. Each LOE is comprised of working groups with representation from the Task Force identified agencies as well as a variety of other organizations.

The Research LOE is responsible for developing a research strategy which will advance the efforts to improve quality of life and reduce suicide among Veterans by better integrating existing efforts of governmental and non-governmental entities and by improving the development and use of metrics to quantify progress of these efforts. The State and Local Action LOE is responsible for developing the legislative proposal that establishes a program for awarding grants to local communities to enable them to increase their capacity to collaborate with each other, to integrate service delivery to Veterans and to coordinate resources for Veterans. The Enabling Supports LOE is responsible for completing essential activities to support determination and implementation of professional development and to engage and coordinate with national, state, and local stakeholders and partners.

The Task Force is co-chaired by the Secretary of Veterans Affairs and the Assistant to the President for Domestic Policy and is comprised of the following cabinet members or their designees:

(i) the Secretary of Defense;
(ii) the Secretary of Labor;
(iii) the Secretary of Health and Human Services;
(iv) the Secretary of Housing and Urban Development;
(v) the Secretary of Energy;
(vi) the Secretary of Education;
(vii) the Secretary of Homeland Security;
(viii) the Director of the Office of Management and Budget;
(iv) the Assistant to the President for National Security Affairs; and
(x) the Director of the Office of Science and Technology Policy.

A formal Task Force Kick-Off is planned for June 2019 and cabinet members will identify their designees for Task Force membership at that time.

Question 2: The March 5th Executive Order on Suicide Prevention requires the development of (1) a grant-based system to assist in the coordination of federal, state and local resources available to veterans, (2) a research strategy and metrics to quantify the progress of research to prevent suicides, and (3) a legislative strategy to support the steps associated with greater coordination and research.

Question 2a: Given the importance of research, does the administration intend to assign a representative from VA's Office of Research Development to the taskforce as a designee of the taskforce?

VA Response: Yes, our formal VA Office of Research & Development (ORD) Task Force member will be Dr. Rachel Ramoni, Chief Research & Development Officer. VA appointees to manage the Research LOE will be Dr. Wendy Tenhula, Deputy Chief Research & Development Officer and Dr. Terri Gleason, Director, Clinical Science Research & Development Service.

Regarding the Support Systems (State and Local) Needed as Part of the Public Health Approach

Question 1: The Arizona Coalition for Military Families has spent the last decade developing the BE CONNECTED Program. For those that are not aware, this program connects veterans in need of resources such as financial counseling, legal assistance, or transportation to both VA and Community-based regionally specific resources. I understand the intent of the EO on Suicide Prevention is to expand this pilot program nationwide.

Question 1a: Because the resources are specific to a region, such as a county or zip code, it seems most effective to set up state-based agencies or organizations like Arizona's Coalition to collect, review, organize, and oversee these resources. What barriers do you foresee to its expansion nationwide?

VA Response: VA is taking a public health approach to suicide prevention by working across sectors in communities nationwide to reach Veterans with lifesaving resources and support. At VA, we know that successful interventions in one location may not work in all communities, and suicide prevention interventions on the local level must consider the needs of each individual community. We intend to work with local entities to fulfill this mission and do not foresee any barriers on implementing best practices nationwide at this time.

In March 2018, VA and the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered to launch the inaugural Mayor's Challenge to prevent suicide among Service members, Veterans, and their families. Now in its second year, this initiative brings together interagency teams from twenty-four cities to develop local action plans tailored to their individual communities to prevent Veteran suicide. Based on the success of the Mayor's Challenge, VA and SAMHSA launched the Governor's Challenge in February 2019, replicating the goals of the Mayor's Challenge with seven states.

During the Mayor's and Governor's Challenges, leaders from the participating states, cities, and counties created tailored plans for their communities to implement the National Strategy for Preventing Veteran Suicide, which provides a framework for identifying priorities, organizing efforts and contributing to a national focus on Veteran suicide prevention.

Community and state teams can share best practices and innovative approaches through the Mayor's and Governor's Challenge work. This cross-team communication about programs such as the BE CONNECTED program allows teams to adapt and tailor such programs based on their community's unique needs and resources.

Executive Order (EO) 13861, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide, also referred to as PREVENTS, will allow for communities to access grants that will help them better connect Veterans with resources such as employment, housing, benefits, recreation, education, and more. VA is looking forward to Congress providing VA with grant making authority which is needed to comply with EO 13861 PREVENTS. The Administration included a legislative proposal for grant making authority tin its FY 2020 Budget. We would welcome working with Congress to have you and other members sponsor the legislation. In the meantime, VA is working to develop the infrastructure needed to issue the grants for suicide prevention once we are provided that authority.

Regarding the Budget for Suicide Prevention

Question 1: In 2018, the President signed an Executive Order focused on creating a seamless transition between DoD and VA mental healthcare for transitioning servicemembers. This EO required the development of a Joint Action Plan and status update 6 months following the development of the Joint Action Plan. The development of these strategic planning documents has allowed veterans, stakeholders, and Congress to more easily envision the ultimate goal of the EO, as well as to track the agency's progress toward the completion of the EO's goals. As part of your 2020 budget request, you've asked for a 63% increase in funds for "implementation of the National Strategy on Preventing Veterans Suicide."

Question 1a: In an effort to better assist veterans and stakeholders understanding of your "ultimate goal" and to assist Congress in oversight, would you commit to developing an "Action Plan" that lays out each of the 14 goals, reliable metrics by which you intend to judge success, and targets, including dates, that reflect what that "success" looks like?

VA Response: We have an "Action Plan" for this effort. A Joint Action Plan was submitted and accepted by the White House on May 3, 2018 and is publicly available at: https://www.va.gov/opa/docs/Joint-Action-Plan-05–03–18.pdf. The Joint Action Plan outlined the strategy and associated 14 tasks to implement the actions mandated in the EO. This effort is governed by a cross agency working group that met biweekly/monthly for over a year and monitored the implementation of each task. The work is also overseen by the Joint Executive Committee. Since the action plan was submitted there continues to be progress in all lines of work. An updated plan was developed and is used to track the metrics.

We have developed comprehensive measurement strategies, including assessment of numerous reliable metrics for each line of effort to track and measure the impact of activities on suicide reduction.

The following list focuses on some of the metrics associated with VA's suicide prevention priorities that are regularly tracked to monitor trends to include our enhanced care delivery, education and training, and outreach and awareness interventions:

- Lethal Means and Safety Planning:
  - Suicide Risk Identification using a 3-step approach to ensure universal suicide risk screening for all Veterans seen in clinics throughout VHA;
  - High Risk for Suicide Flag (HRF) patient record flag for patients assessed to be at high risk for suicide - VA tracks numerous metrics tied to the HRF program to ensure compliance and appropriate follow up for these vulnerable Veterans;
  - Number of gunlocks we deliver;
  - Pounds of medication disposed of by Veterans through the Pharmacy Medication Disposal Program;
  - Suicide safety planning throughout VHA;
  - Operation S.A.V.E. training compliance among VA staff, tracked through the TMS training portal (Operation S.A.V.E. consists of five components: Signs of suicide, Asking about suicide, Validating feelings, Encouraging help, and Expediting treatment);
  - Operation S.A.V.E. trainings provided externally in the community; tracked through various means including the Suicide Prevention Application Network (SPAN), that is used by SPC to track external presentations, through the TRAIN.ORG training portal (connected to TMS and tracked by VA's Employee Education System), through the YouTube views, and through PsychArmor (the non-profit that assisted in the creation of the Operation S.A.V.E. video training), which, in all cases, we regularly collect and track usage/completion; and
  - Veterans Crisis Line (VCL) use and metrics associated with efficient and effective VCL efforts.
- Partnerships, Outreach, and Awareness:
  - Awareness campaigns - Online interaction with our campaign materials to gauge how effectively we are reaching the right people with the right information: site usage patterns, traffic to site, time on site, number of pages visited, public service announcement views, impressions and distribution, broadcast and billboard efforts;
  - Engagements with other key resources-downloads of campaign materials, uses of Operation S.A.V.E. training, views of our educational videos, and Public Service Announcements;
  - Outreach events completed by VHA staff within their communities and number of participants in attendance at these outreach events;
  - The number of community partners, and assessing the gaps in sectors to ensure VA is developing partnerships across all areas that intersect with suicide; and
  - Action plans and efforts from Mayor's and Governor's Challenge partners.
- Enhanced Health Care Services:
  - Mental Health and Suicide Prevention Coordinator staffing metrics;
  - Number of Veterans identified by predictive analytics that receive the recommended interventions;
  - New mental health appointments within 30 days;
  - Same day access to mental health appointments;

- Mental Health appointments delivered by telehealth; and
- Post discharge follow up from inpatient care, emergency department, residential facilities, substance abuse, etc. to engagement in outpatient care.

Metrics related to our enhanced care delivery interventions have been developed through several automated dashboards to identify Veterans at highest risk for suicide to aid providers in improved decision making and safety planning. These include:

- Suicide Prevention Quarterly Dashboard - reports quarterly metrics on core suicide prevention priorities, tracking trends, needs, successes and gaps for quality improvement, and is adaptable to track new priorities. This dashboard tracks and reports metrics mentioned above;
- REACH VET, which identifies patients at statistical risk of death by suicide in the next month;
- The Stratification Tool for Opioid Risk Mitigation (STORM), which identifies patients at statistical risk of overdose or suicide-related health care events or death in the next year;
- The Suicide Prevention Population Risk Identification and Tracking for Exigencies (SPPRITE) - unifies information from the following: HRF, STORM, REACH VET, Post-Discharge Engagement (PDE), positive secondary suicide risk screens (C–SSRS), and intermediate or above risk levels captured by the comprehensive suicide risk evaluation (CSRE) to identify and reduce care gaps and ensure high levels of care for patients identified at high risk for suicide; and
- SPAN - a database that allows SPC to report suicides and suicide attempts, manage treatment plans, follow patient progress, and provide outreach. SPAN is designed to capture the number of suicides and non-fatal suicide attempts among the Veteran population. This information is calculated monthly and continuously updated.

VA developed the Strategic Analytics for Improvement and Learning Value (SAIL) Model to measure, evaluate, and benchmark quality and efficiency at medical centers to promote high quality, safety, and value-based health care. SAIL assesses 25 Quality measures including specific metrics assessing mental health care. These metrics are reviewed and utilized for decision making and technical assistance to close gaps to offer the best care. These reports are publicly available on VA's Web site: https://www.va.gov/qualityofcare/measureup/strategic—analytics—for—improvement—and—learning—sail.asp.

Question 2: Over the last few years, VA has shifted towards a "public health" approach to suicide prevention. You've described community engagement as a central part of this new approach. However, you've only requested an increase of $275,000 for "Local Facility and Community Outreach and Activities."

Question 2a: How does VA intend to leverage this additional $275,000 to begin creating the community support that will be integral to the "public health" approach that is currently being pursued by VA?

VA Response: The additional $275,000 under line item "Local Facility and Community Outreach and Activities" is specifically for funding that the National Suicide Prevention Program sends to local SPC for September's Suicide Prevention Month. This funding, used at the local level, is spent on local outreach, communication efforts, and programming focused on engaging Veterans, families, and communities around suicide prevention.

Our outreach and community engagement efforts extend beyond just this line item. We've also requested an increase in the line item "National Suicide Prevention Strategy Implementation" where our communications and paid media funding is captured as well as our ongoing collaboration with the Department of Health and Human Services' SAMHSA for the Governor's and Mayor's Challenges, as examples.

Regarding Trans Veterans

Question 1: As a result of the President's April 12 ban on transgender people serving in the armed forces, we have heard from advocacy groups and health care providers about the increased likelihood the ban will trigger increased suicidality amongst trans veterans.

Question 1a: What is the VA doing to reach out to these veterans who are particularly vulnerable?

VA Response: Every VA facility has an LGBT Veteran Care Coordinator (VCC). The role of the VCC is to create a welcoming environment for Veterans with LGBT or related identities, to provide education and clinical consultation for VA health care providers, to provide resources and information for Veterans with LGBT or related identities, and to build community partnerships. LGBT VCCs conduct community outreach to transgender Veterans by holding collaborative public events with community LGBT organizations. To help provide comprehensive care to this population, VA developed a toolkit of resources that helps VA providers and their patients have open, culturally appropriate conversations about issues related to LGBT health care.

Question 1b: What interventions have been developed that are specific to this population?

VA Response: VA health care includes services that are particularly important for Veterans with LGBT or related identities, including hormone treatment, substance use/alcohol treatment, tobacco use treatment, treatment and prevention of sexually transmitted infections, intimate partner violence reduction and treatment of after effects, heart health, and cancer screening, prevention, and treatment. Information about LGBT Veteran health services are available on every VAMC Web site.

Additionally, the LGBT Health Program of VA's Patient Care Services provides ongoing educational programs for VHA staff about LGBT health care. Many of the trainings are available on-demand for providers who work with Veterans outside of VA. VA also offers consultation to providers related to transgender-specific health care via regional e-consultation teams.

The Suicide Prevention Program (SPP) worked closely with the LGBT Health Program in Patient Care Services to launch the Connect. It can save a life campaign. The campaign encourages Veterans and their providers to talk about sexual orientation and gender identity as part of routine health care so that providers can give Veterans with LGBT or related identities the highest-quality care.

Regarding Native American Veterans

Question 1: American Indians and Alaska Natives (AI/AN) have a disproportionately high rate of suicide-more than 3.5 times those of racial/ethnic groups with the lowest rates, according to a 2019 CDC study. And the rate has been steadily rising since 2003.

Question 1a: What is VA doing to ensure tribal veterans have access to suicide prevention outreach?

VA Response: Community building to address the needs of Veterans in tribal communities presents unique opportunities and challenges. We recently began working (in FY 2018) with Dr. Nate Mohatt on a program, partnered with two VA facilities and the VHA Office of Rural Health, to develop a model and program to guide Native community engagement on suicide prevention. Additionally, the VA Office of Tribal Government Relations works to strengthen and build relations between VA, tribal governments, and other key federal, state, private, and non-profit partners to more effectively and respectfully serve Veterans.

Regarding Women Veterans

Question 1: Dr. Franklin: Women veterans die by suicide at twice the rate of non-veteran women. What are some of the factors unique to women veterans that put them at greater risk of suicide?

VA Response: Multiple factors contribute to the higher rates of suicide deaths among women Veterans as compared to non-Veteran women. As compared to their civilian peers, women Veterans experience higher rates of psychiatric and psychosocial suicide risk factors, and these differences may partially account for the relatively higher rates of death by suicide observed in women Veterans. For example, there is a well-established link between mental illness and suicide risk. Women Veterans, as compared to their civilian peers, experience higher rates of mental illness and substance use disorder (Ilgen et al., 2010).

Women Veterans are also at higher risk than non-Veteran women of experiencing adverse life effects associated with heightened suicide risk. For instance, women Veterans are at higher risk than non-Veteran women for intimate partner violence (Dichter, Cerulli, & Bossarte, 2011). The experience of intimate partner violence is associated with known suicide risk factors, including mental and physical health conditions, hopelessness and social isolation (Iovine-Wong et al., 2019), as well as suicidal ideation and attempts (Cavanaugh et al., 2011; Simon et al., 2002). Women Veterans are also at greater risk for experiencing sexual trauma, including military

sexual trauma (Kimerling et al., 2016; Monteith et al., 2015; Rosellini et al., 2017). For both women and men, sexual trauma is associated with suicidal ideation, suicide attempts, and death by suicide. Research also suggests that sexual trauma, unlike other types of trauma, may directly increase risk for suicide, above and beyond the effects of related mental health conditions (Davidson et al., 1996; Gradus et al., 2012).

Finally, women Veterans are more likely than non-Veteran women to use firearms as a method of suicide; they are also more likely to have access to firearms as a result of living in a household with firearms. It is likely that the higher rates of suicide among women Veterans are, at least in part, due to women Veterans' more frequent use of this highly lethal means when attempting suicide (Department of Veterans Affairs, April 2019).

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Question 1a: How is VA improving peer-support programs for women veterans?

VA Response: VA requested and the Office of Personnel Management verbally approved a waiver to allow VA to recruit for and hire only female Peer Specialists for peer support positions established as part of Section 506 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSON Act), which requires female peer specialists be available in all 30 facilities mandated to expand peer support in primary care. In addition to those facilities participating in this section, we are encouraging each medical center to employ women peer specialists and to make them available for women Veterans.

Regarding Peer Support Specialists

Question 1: VA has found peer support specialists to be an integral part of increasing access to VA's mental health programs. These specialists also often offer assistance accessing other parts of VA such as VBA and even NCA services.

Question 1a: Does VA intend to expand this program and the training associated with it to service lines outside of Primary Care and Mental Health

Care- For example, to Community Living Centers, Substance Abuse Programs, Long and Short-Term Rehabilitation Programs, and Women's Health Care?

VA Response: Expanding peer support services beyond Mental Health is part of the overall strategic plan for the Office of Mental Health and Suicide Prevention (OMHSP). Therefore, VA recognizes the importance and the impact of peer support and is exploring expanding peer support into other areas as well, including, Community Living Centers (CLC), traumatic brain injury programs, and spinal cord injury programs; however, there is no immediate plan other than the Mission Act for such staffing currently. Decisions to support increasing the peer workforce are made at the local level and based on balancing local resources and clinical needs. OMHSP continues to encourage VISNs and facilities to expand peer support.

Question 2: In response to the President's 2018 Executive Order on Transitioning Servicemembers, it was suggested that veterans should receive "peer support for life." Why was this never fully realized- What barriers did you run into and what were some of the issues with the provision of peer support as described?

VA Response: As part of the executive order there were barriers with executing one peer support number for service members and veterans that started when a service member joined the military and extended throughout the life of a veteran. DoD wanted to offer the peer support for just the first year after service members leave the military through their existing capability - Military One Source. This is what was completed. Subsequently VA began actions to develop a call center for "peer support for the life of the Veteran" - and those plans are well underway for completion.

While VA strongly believes in the transformational power of peer support, we believe that any treatment option should be provided only as long as the Veterans with mental health conditions need that treatment. In a recovery-oriented health care system, the ultimate goal is to help the Veterans develop self-sufficiency so that they rely less on institutional care and more on the support of the community in which they live, which includes many formal and informal peer networks. While they may re-engage with peer support services when the need arises, providing "peer support for life" would be contrary to the concepts of recovery-oriented care. In addition, it would require a significant investment in additional staff, and such an investment would be better used to expand peer support to programs outside Mental Health.

Regarding VA's Transformation towards Whole Health Programs

Question 1: As part of the VA's response to the President's 2018 Executive Order to assist transitioning veterans in accessing seamless care, VA began offering "Introduction to Whole Health" sessions to newly transitioning veterans. However, the Whole Program has not been fully implemented at all facilities.

Question 1a: How is VA serving veterans interested in Whole Health that may not have access to a facility that offers all components of Whole Health such as Yoga, Mindfulness, or Financial Counseling?

VA Response: VHA Directive 1137 outlines specific requirements for the provision of complementary and integrative health services. This directive requires all facilities to offer evidence based Complementary and Integrative Health (CIH) approaches as part of standard medical benefits, when clinically appropriate, and includes acupuncture, biofeedback, clinical hypnosis, guided imagery, massage therapy, meditation, tai chi/qi gong, and yoga. These services need to be available either in house, in the community, online or via telehealth.

Telehealth modalities are continuing to grow to facilitate a smoother Provider and Veteran experience of Whole Health and CIH. The most recent innovation is the VA Video Connect modality which is popular among both group and one-on-one TeleWholeHealth encounters such as Tele Coaching, Tele Facilitated Groups and TeleWholeHealth Clinical Care encounters. With this modality, Veterans can access their Health Coach or Provider from anywhere they have an internet connection. The provider and Veteran enter a virtual medical room where they can complete the encounter.

VA's Whole Health System does not include non-health care benefits such as financial counseling.

Regarding Surveillance as Part of the Public Health Approach

Question 1: Researchers from various organizations and companies often reach out to our offices seeking access to the wealth of data VA collects regarding veteran's healthcare and healthcare outcomes. It would seem, according to these scientists that VA is a VERY data rich environment. However, we still know very little about veterans and military personnel that complete suicide - especially the nearly 70% of those that never entered VA's healthcare system.

Question 1a: How can we ensure VA, DoD, DHS, and HHS are sharing data in real-time so that the development of effective interventions is not further delayed?

VA Response: Multiple data sets are available for suicide prevention by researchers funded by ORD. One specific highlight has been the development of a Memorandum of Agreement (MOA) between ORD and OMHSP for ORD researchers to access data from the Suicide Prevention Data Repository maintained by OMHSP and include DoD data that have been accessed by OMHSP. This MOA is an agreement by ORD to support OMHSP's ongoing work in the acquisition of vital status and cause of death data from the CDC National Death Index Plus.

In collaboration with DoD, OMHSP has established the VA/DoD Suicide Data Repository (SDR) (also known as the Military Mortality Database), and, as authorized by the SDR's Board of Governance, has made these data available for all approved VA research projects. The SDR consists of results from VA/DoD searches of the NDI, with information regarding date and cause of death for Service members and those who have separated from the military, as well as data from DoD and the Veterans Benefits Administration (VBA). Support from ORD, which is committed to supporting this important OMHSP work that has important benefits for VA research and development, will now promote broader use of these data among ORD investigators.

Additionally, analyses of these data will permit the identification and examination of Veterans who completed suicide and were not in VA's healthcare system. The strong collaboration between ORD and OMHSP is reflected in our continued sharing of the SDR data. During the period of October 2017 to April 2019, OMHSP has completed 84 requests for data from ORD from 70 investigators.

Other activities of note include close collaboration with DoD on the Study to Assess Risk and Resilience in Service Members—Longitudinal Study, as well as new funding opportunities that focus on at-risk Veterans in transition out of the military and on empowering them by funding public health and community interventions, based on rigorous surveillance and epidemiological data.

Question 2: Hypothetically, if VA had access to the complete records of every veteran and military personnel that has completed suicide in the past 10 years, would VA have the technology necessary to fully analyze that data in-house?

VA Response: Yes, we do have this capability in house, and in addition, VA and DoD have partnered with the Department of Energy Oak Ridge National Laboratory (ORNL) to enable use of advanced supercomputing to develop advanced analytics to assess and utilize information from VA and DoD data sources.

Question 2a: If not, how can we allow VA access to such technology so that its researchers and investigators are well versed in its use once that magnitude of data is obtained?

VA Response: The technology is available via partnership with ORNL. The partnership with ORNL is not a core funded resource and requires ongoing funding from VA and DoD that potentially limits sustainability.

Regarding the Development of Interventions as Part of the Public Health Approach

Question 1: How are you using assessments performed by both internal and external sources to guide your path forward?

VA Response: The Institute of Defense Analyses (IDA) is currently examining our organizational relationships within Central Office and the field, especially as it relates to suicide prevention, and to identify opportunities for improvement. The goal is to improve support for frontline work done by local staff and the engagement of facilities with their local communities. IDA is a Federally Funded Research and Development Center that works in support of the government agencies.

Pursuant to Title VII, Subtitle C, § 726(c) of the National Defense Authorization Act of 2013, Public Law (P.L.) 112–239, Congress included a mandate for the Na-

tional Academies of Sciences, Engineering, and Medicine (the National Academies) to conduct a study to assess the VHA's mental health care services and provide recommendations to assist VHA with improving its services. The National Academies appointed the Committee to Evaluate the Department of Veterans Affairs Mental Health Services assigned to comprehensively assess the quality, capacity, and access to mental health care services for Veterans who served in the Armed Forces in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND). Findings of the committee included:

- The majority of OEF/OIF/OND Veterans report positive experiences with VA Mental Health Services;
- VA has a strong history of implementing innovative practices to expand reach and spread care to all Veterans;
- VA can improve awareness of how to connect with mental health care and streamline access for ease and expediency;
- VA can better use social media and telehealth to improve access and help seeking behavior while reducing stigma and barriers to mental health care; and
- VA can improve quality across facilities and subpopulations including recruiting adequate staff at facility that struggle to fill positions.

OMHSP is actively engaged in review of the Committee's recommendations for inclusion in its strategic plan. VA is already engaged in active recruitment and incentives in hard to fill areas. As directed by EO 13822, VA is actively working to improve the transition experience and expedite connections of discharging service members to VA healthcare.

Pursuant to the 2015 Clay Hunt Suicide Prevention for American Veterans Act (Clay Hunt SAV Act) P.L. 114–2, VA's mental health care and suicide prevention programs are evaluated annually. The first evaluation sent to Congress in December 2018 stated in key findings that "Most of the mental health programs that could be evaluated demonstrated a positive impact on psychological well-being or functioning of the veterans who use them."

The Clay Hunt SAV Act was enacted to ensure that Veterans at highest risk of suicide have access to effective mental health and suicide prevention services provided by VHA. Although there was a small reduction in number of deaths from 2015–2016 in the most recent VA suicide data report, and despite the general effectiveness of VA mental health program, we have not yet produced the reduction in suicide among Veterans that we are so strongly dedicated to achieving.

VA is aggressively working to do more, and VA has directed the team to work with the contractor who developed the annual report to determine how the next annual report can be restructured to more directly look at the impact of our mental health and suicide prevention programs on reducing and eliminating veteran death by suicide.

Question 2: What are some of the most effective interventions VA currently utilizes? Have they been adopted nationwide? How are you tracking their successful implementation?

VA Response: Some of VA's most effective nationally-available interventions include:

Suicide Risk Identification Strategy

OMHSP has implemented a national, standardized process for suicide risk screening and evaluation, using high-quality, evidence-based tools and practices.

- The Primary Screen is a single item intended to broadly screen for individuals who may be at increased risk for suicide in all clinics. Those who screen positive receive the second level screen.
- The Secondary Screen is conducted using the C–SSRS. The C–SSRS consists of three to eight additional questions that specifically query about suicidal thoughts, plan, intent, and behavior. Those who screen positive receive the VA CSRE.
- The VA CSRE was developed by a team of subject matter experts to include evidence-based factors that may be used to determine acute and chronic risk levels and inform a risk management plan.
  - This plan is developed to meet the individual needs of the Veteran and can be initiated at the time the Veteran is being seen and reporting suicidal ideation or behavior, regardless of setting type.
  - Using one instrument across all VA settings will result in standardization of evaluation and management, thereby improving quality of care for at-risk

Veterans and helping reduce stigma associated with discussions about suicide.
- Metrics are tracked weekly, monthly and quarterly, including numbers of Veterans screened at all 3 levels and in which settings.
- Since October 1, 2018, in ambulatory care more than 2.3 million Veterans have received a standardized risk screen, with over 70,000 receiving the secondary screener, with one-half of one percent being referred for a full clinical assessment. Over 90,000 Veterans in all settings have completed the CSRE, the full clinical risk assessment.

Patient Record Flag (PRF) - High Risk for Suicide and Enhanced Care

- Providers identify Veterans at potential high-risk for suicide, with a flag activated in the electronic medical record alerting all providers that see this Veteran, and refers the Veteran to the facility Suicide Prevention Coordinator (SPC) team for enhanced care that included the following:
  - Completion of a Suicide Prevention Safety Plan including restriction of lethal means;
  - Four follow-up appointments within 30 days of activation of the PRF or discharge;
  - Ensuring follow-up for no-shows to scheduled mental health appointments
  - Making personal contact;
  - Establishing United States Postal Service mail contact; and
  - Collaborating with the mental health provider and ensuring review and update of the PRF every 90 days.
- Numerous metrics are tracked and reported regularly, locally and nationally, to ensure compliance with directive, and trouble shoot barriers.

Dashboards to Aid Providers in Real Time

- REACH VET uses predictive (statistical) modeling to identify Veterans at risk for suicide and other adverse outcomes. The patients identified by the model are at increased risk for outcomes including suicide attempts, deaths from accidents, overdoses, injuries, all-cause mortality, hospitalizations for mental health conditions, and medical/surgical hospitalizations.
  - Each facility has a REACH VET coordinator focused on implementing the program, engaging providers, and ensuring that providers are aware of which of their patients are at risk. Providers for Veterans identified are asked to review the care Veterans receive and to enhance as appropriate.
- STORM uses a predictive model to identify patients at-risk for opioid overdose and suicide-related adverse events or death, specifically patients with active opioid prescriptions and patients with an opioid use disorder diagnosis in the past year. STORM provides patient-centered opioid risk mitigation strategies by displaying:
  - Estimates of individual risk of opioid drug overdose or suicide based on predictive models;
  - Risk factors that place patients at-risk;
  - Risk mitigation strategies, including non-pharmacological treatment options, employed and/or to be considered; and
  - Patients' upcoming appointments and current providers to facilitate care coordination.
- SPPRITE dashboard unifies critical patient-level information for patients identified at high-risk for suicide through clinical determination and predictive models, specifically: HRF, STORM, REACH VET, PDE, positive C–SSRS and intermediate or above risk levels identified by the CSRE, so providers can:
  - Engage in integrated case management of high-risk patients at their facility/on their patient panel;
  - Enhance care coordination and communication with providers in other settings/programs;
  - Facilitate outreach efforts;
  - Track suicide risk screening and evaluation results: and
  - Identify and reduce care gaps and ensure high levels of care for patients identified at high-risk for suicide.

VA Opioid Education and Naloxone Distribution Program (OEND)

- This program aims to reduce harm and risk of life-threatening opioid-related overdose and deaths among Veterans.

- Key components of the OEND program include education and training of providers and Veterans regarding opioid overdose prevention, recognition of opioid overdose, opioid overdose rescue response, and issuing naloxone kits.
- The Opioid Safety Initiative Toolkit, developed in conjunction with the National Pain Management Program Office, contains resources and presentations that can aid staff in clinical decisions about starting, continuing, or tapering opioid therapy, and other challenges related to safe opioid prescribing.
  - The toolkit is available at www.va.gov/painmanagement/opioid—safety—initiative—osi.asp.

Operation S.A.V.E. Training

- In early 2017, VA implemented mandatory, annual Operation S.A.V.E. training for all VHA non-clinical staff. The Operation S.A.V.E. Training is an online suicide prevention video that was developed by VA in partnership with PsychArmor Institute and is publicly available to help everyone play a role in preventing Veteran suicide.
- Since its launch, 93 percent of VHA non-clinical staff are compliant with their assigned Operation S.A.V.E. or refresher Operation S.A.V.E trainings, and the video has been viewed over 18,500 times on the PsychArmor website and social media platforms.
- VHA clinicians also engage in mandatory, initial training on suicide prevention/risk management and take yearly refreshers, with more than a 94 percent completion rate.

Suicide Prevention Coordinators

- As an integral part of Veterans' care teams implementing VA suicide prevention programs, SPC are experts on suicide prevention best practices. SPC work closely with other providers to ensure that Veterans living with mental health conditions and experiencing di-cult life events receive specialized care and support.
- Over 400 SPC nationwide support Veterans in VHA care who are at risk for suicide or who have attempted suicide. SPC also play an integral role in helping build networks of support outside of VA, by providing education, outreach, and engagement to Veterans, providers, and partners in the community. In 2017, SPC engaged over 1.5 million people at over 14,000 suicide prevention outreach events nationwide.

Regarding the Targeting of Interventions as Part of the Public Health Approach

Question 1: How is VA ensuring the modernization of the Electronic Health Records includes data collection necessary to the further development of effective interventions?

VA Response: The native design of the VA's new electronic health record (EHR) solution will enable VA to capture an increased amount of discrete patient data. This increase in measurable and reportable data collected by the EHR solution, combined with the various commercial reporting and analytics tools integrated in the EHR's capabilities suite, will support VA in effectively intervening on behalf of at-risk Veterans. Cerner's extensive report writing tools allow access to all data captured within the EHR solution and will support VA's clinical, operational, and outcome reporting needs. The reporting interface will enable VA to run a variety of reports and identify opportunities for intervention.

VA is currently configuring Cerner's population health and analytics platform, which will provide VA new data collection and aggregation methods and support improved outcomes not only for individual patients at the point of care, but for larger Veteran populations. Clinicians will have a comprehensive view of Veterans' health history, as the new EHR solution collects data from legacy EHR sources, claims data, pharmacy dispense data, and open source data. The platform cleans, normalizes, and reconciles the data, allowing clinicians to identify patients with care needs, assess risk, build a plan of care, and empower individuals, their families, and care providers to act in support of our Veterans.

Question 2: How is VA ensuring the new EHR incorporates systems that will allow frontline providers and support staff to target those effective interventions to veterans that need them most?

VA Response: VA's new EHR solution includes subsystems, capabilities, and solutions that provide decision support, recommendations, and alerts at the point of care enabling front-line personnel to provide effective interventions to Veterans in

need. The EHR solution will increase the measurable data captured within Veterans' health records, support the data analysis process, and increase visibility of at-risk individuals. Capabilities embedded in the EHR solution allow VA to insert advanced decision support directly into care teams' workflows. Clinicians will be able to identify, score, and predict health risks of Veterans to implement targeted interventions. Care providers will be able to monitor both population-wide interventions as well as Veteran-specific interventions using one EHR solution. Recommended interventions will be embedded within the user's workflow, prompting the clinician to take the requisite action before or during a Veteran's appointments. Clinicians will also have the ability to generate lists of patients with outstanding interventions in order to proactively engage those Veterans and assist in facilitating the necessary care. VA administrators can leverage EHR tools to analyze, monitor, and create targeted engagement strategies for populations of Veterans with similar needs.

Regarding Limiting Access to Lethal Means

Question 1: Sixty nine percent of Veterans completed suicide via firearm. However, it has come to my attention [by staff from APA] that VA staff have been directed to stop using the term "lethal means" even though it is a standard phrase used throughout the mental health industry. Is this true? If so, what is your reasoning?

VA Response: OMHSP has not stopped using the term "lethal means." Current guidance on discussing lethal means with patients and stakeholders does include an observance of terminology on the part of the provider and avoiding terms that could potentially create opportunity for the patient to become defensive, as discussions related to firearms, specifically, can be harder to manage on the part of a provider, especially in times of higher risk.

There is ongoing discussion in the field of lethal means as to which terms are best used in research, intervention, and messaging, with a focus on ensuring patients and stakeholders remain open to dialogue. For example, VA, in partnering with the National Shooting Sports Foundation (NSSF) and the American Foundation for Suicide Prevention (AFSP), is moving away from the term "firearm safety" when discussing lethal means and is now using the term "safe firearm storage," as that is more direct and accurate in the goals of lethal means safety discussions. Currently, "lethal means" continues to be the terminology of choice.

Question 2: During Committee Staff's recent trip to the Phoenix VA Medical Center, VA staff stated that approximately 800-gun locks are given away to veteran patient's each week. These locks are not issued by staff, but rather placed in areas such as primary care, mental health, and women's health clinics, as well as, in the Emergency Room so that veterans can take them without fear of being judged or tracked.

Question 2a: What is other ways VA is ensuring veterans are fully aware of the staggering amount of suicides completed via firearm? And what resources, besides gun locks and video training, does VA offer to veterans that may choose to limit their access to firearms?

VA Response: VA has implemented a new, nationally-standardized Suicide Prevention Safety Planning Template that ensures Veterans receive high-quality suicide prevention safety plans through collaboration with their providers and will facilitate the reporting and analysis of utilization, completion, and timing of safety planning. Access to lethal means are addressed within the safety plan. Safety plans are meant to be innovative, individualistic, and geared toward feasible actions that can be taken to reduce access to lethal means. Not all Veterans have access to the same opportunities, whether in their homes or in the community. For example, some states allow gun shops to store firearms from individuals, while others do not. When developing safety plans with Veterans, VA providers focus on being collaborative and innovative, with an emphasis on realistic actions that put time and space between suicidal thought and actions.

Safety Planning is mandated for all Veterans who have a PRF High Risk for Suicide flag and recommended for Veterans who have made a recent suicide attempt, express suicidal ideation, or have otherwise been determined to be at high or intermediate acute or chronic risk for suicide, based on a comprehensive suicide risk assessment.

VA is working to provide suicide prevention training throughout all offices. For example, we are working with the Office of Geriatrics and Extended Care on how to have conversations around firearm safety with Veterans and their family members with dementia. We recently hosted a training for SPCs about lethal means

safety and how to have conversations with Veteran patients about safe storage. This training will be available to all VA providers through our internal training platform.

VA has also partnered with AFSP and NSSF to develop a program guided by a toolkit to facilitate community engagement in suicide prevention and firearm safety to decrease risk for firearm suicide among service members and Veterans. The program aims to:

- Educate the community about the significance of safely storing firearms when not in use and motivate engagement in safe storage practices;
- Increase awareness that suicide is preventable and endorse the role of safe storage to reduce firearm injury; and
- Educate firearm owners, family members, and friends about ways they can help prevent suicides by firearm.

Regarding Interventions for the Aging Veteran Population

Question 1: Male veterans age 55 and older had the highest count of suicide according to the 2016 National Suicide Data Report. Kaiser Health News and PBS NewsHour also found that an alarming number of seniors, not only veterans, are committing suicide in Long Term Care Facilities. The article suggests that depression, debility, access to deadly means, and disconnectedness are the main risk factors for senior suicide.

Question 1a: How is VA working to track these risk factors in its Community Living Clinics? How are CLC staff being trained to deliver interventions in response to veterans that exhibit these risk factors?

VA Response: As part of the VHA Suicide Risk Identification Strategy, Veterans admitted to a CLC must be screened for suicide risk within 24 hours of admission and 24 hours before discharge from the CLC. Those screening positive must be engaged in secondary screening and, if positive, a comprehensive suicide risk evaluation must be completed within that same 24-hour timeframe. In order to support CLC teams in addressing this requirement, guidance entitled VHA Suicide Risk Screening and Evaluation Standards: Guidance Regarding Application to Community Living Center Practice was developed and disseminated nationally. An educational webinar devoted to this topic was also developed.

In addition, every employee is required to take Operation S.A.V.E. Training for Employees which focuses on recognizing and addressing signs of suicide risk (Signs of suicidal thinking should be recognized; Ask the most important question of all; Validate the Veteran's experience; Encourage treatment and Expedite getting help). Every employee is also required to take an annual refresher in this training.

Question 2: How does VA track suicide attempts and death by suicide in its Community Living Clinics?

VA Response: Each CLC is required to report suicide attempts and completed suicides to the leadership of the Medical Center, the Veterans Integrated Service Network, and to VA Central Office.

Question 3: What is the readmission policy surrounding previously suicidal veterans once they have been treated for their mental health concerns?

VA Response: If a CLC resident becomes acutely suicidal, he/she will be transitioned to an inpatient mental health care setting with an environment of care designed for safety of individuals at risk for suicide. Once that individual has stabilized, he/she may be re-admitted to the CLC with a clear plan for monitoring risk and supporting the Veteran's safety.

Question 4: Does VA intend to offer peer support in its Community Living Clinics?

VA Response: Expanding peer support services beyond Mental Health is part of the overall strategic plan for OMHSP. While peer support has, to date, been primarily focused on mental health settings, it has expanded to Primary Care as a result of an Executive Action in 2014, which required Peer Specialists in the Patient Aligned Care Teams (PACT) in 25 facilities. The MISSION Act now requires Peer Specialists in PACT in 30 facilities. There have also been discussions to expand peer support into the CLCs, however, there is no immediate plan for such staffing at this time.

Question 5: Does VA intend to offer the Whole Health Program at its Community Living Clinics?

VA Response: VA CLCs offer Whole Health Programs to the residents who live there. As stated above, the medical benefits package includes, as clinically appropriate, biofeedback, clinical hypnosis, guided imagery, meditation, yoga, Tai Chi/Qi Gong, massage therapy, and acupuncture. VHA has also identified optional approaches that are generally considered to be safe, such as aromatherapy. As VA continues to implement Whole Health throughout the system, CLCs are participating and included in this effort.

Question 6: How is VA ensuring aging veterans enjoy a high quality of life at its Community Living Clinics?

VA Response: VA CLCs have focused for many years on creating a culture of individualized, Veteran-Centered care to address each resident's values and preferences. The resident is asked on admission about his/her daily routine and preferences in care. These are incorporated as much as possible into the resident care plan and goals for their stay in the CLC. The resident and/or family is part of the interdisciplinary care team that establishes the plan while the resident lives in the CLC.

For residents with dementia-related distress behaviors (e.g., agitation, aggression), the Staff Training in Assisted Living Residences (STAR–VA) program has trained teams in a majority of CLCs to provide resident-centered, interdisciplinary behavioral care that emphasizes each Veteran's individualized needs and preferences; the STAR–VA intervention includes a focus on integrating individualized "pleasant events" into each Veteran's daily life.

Question 7: More broadly, given that depression presents differently in older adults, how has VA adjusted its screenings for this cohort?

VA Response: VHA's primary depression screening tool, the Patient Health Questionnaire (PHQ) 2, has been demonstrated to be a valid screening tool for major depression in older adults. The full PHQ–9, which includes the PHQ–2, is integrated into the Resident Assessment Instrument Minimum Data Set 3.0 questions for every new CLC resident, as required in all nursing homes in the United States. For residents who are unable to complete self-report on this instrument due to moderate/severe cognitive impairment, there is a staff observation version, "Staff Assessment of Resident Mood."

In addition, the Geriatric Depression Scale, a validated tool for screening for depression among older adults, is available for use by VA clinicians via an electronic health record template.

Gaps in Medical Training

Question 1: Dr. Avenevoli or Dr. McKeon, could one or both of you elaborate on the existing gaps in formal medical training for suicide risk assessment and management and the impact that has, as America as a whole, adopts this public health approach to suicide? (NOTE: THIS IS NOT A QUESTION FOR VA TO ANSWER).

Question 1a: Dr. Stone, would you agree that VA plays a significant role in educating America's future medical workforce?

VA Response: Yes. VA conducts the largest education and training effort for health professionals in the United States. In 2018, 120,890 trainees received some or all of their clinical training in VA. VA's physician education program is conducted in collaboration with 145 of 152 Liaison Committee Medical Education accredited medical schools, and 34 out of 35 Doctor of Osteopathic granting schools (American Osteopathic Association accredited medical schools). In addition, more than forty other health professions are represented by affiliations with over 1,800 unique colleges and universities. Among these institutions are Minority Serving Institutions such as Hispanic Serving Institutions and Historically Black Colleges and Universities. Over 60 percent of all U.S.-trained physicians, and 70 percent of VA physicians have had VA training prior to employment. Approximately 50 percent of U.S. psychologists and 70 percent of current VA psychologists and optometrists have had VA training prior to employment.

VHA conducts education and training programs to enhance the quality of care provided to Veterans within the VA health care system. Building on the long-standing, close relationships among VA and the Nation's academic institutions, VA plays a leadership role in defining the education of future health care professionals that helps meet the changing needs of the Nation's health care delivery system. Title 38 U.S.C. § 7302 mandates that VA assist in the training of health professionals for its own needs and those of the Nation.

Question 1b: In that case, what is VA doing to ensure the 70 percent of medical professionals who spend time at VA receive adequate training and exposure to suicide risk assessment and management?

VA Response: It is VHA policy that all VHA employees must complete their required suicide risk and intervention training module (either Suicide Risk Management Training for Clinicians or Operation S.A.V.E. training for non-clinicians) and, for providers/clinicians, pass the post-module test within 90 days of entering their position. It is also policy that all employees must complete the appropriate annual refresher training specific to their position (Operation S.A.V.E. Refresher Training for non-clinicians or Suicide Risk Management Training for Clinicians). VHA has also developed a Suicide Risk Management Training for Registered Nurses that may be assigned annually as an alternative training option to Suicide Risk Management Training for Clinicians, understanding that the roles may be different in some cases.

Staffing

Question 1: A number of VA OIG reports on VA's efforts to reduce veteran suicide found issues, weaknesses, or mistakes by Suicide Prevention Coordinators. Our Suicide Prevention Coordinators are central to so many of VA's efforts to reduce veteran suicides.

Question 1a: In your opinions Dr. Stone and Franklin, do the workloads and responsibilities of these Coordinators align with the resources they are provided?

VA Response: The National Suicide Prevention Program (SPP) recognizes that SPC are the "frontline" in the fight to end Veteran suicide, however SPC are not adequately resourced currently. To support that effort, SPP has been pushing the Secretary's Mental Health Hiring Initiative (MHHI), currently ongoing since July 2017, which addresses increasing the number of SPCs in the field, as well as retention of SPCs.

Question 1b: Currently, how many vacancies are there in these roles across VA?

VA Response: SPC occupy a variety of mental health occupations and data is tracked by occupational series. Currently, there are 2,696 vacancies (10.5 percent rate) for all Mental Health occupations.

Question 1c: Given the nature of the work, are these roles susceptible to high turnover rates?

a.If yes, what do the exit surveys tell us about why these critical staffers are leaving? And what is being done to address these findings?

VA Response: The turnover rates for the mental health occupations are typical of other VHA occupations. We do not have data to report if turnover is high for SPC nor do we have exit surveys for this specific cohort, as SPC occupy a variety of mental health occupations and this data is tracked by occupational series; however, turnover is not high for mental health occupations. The attached table shows detailed vacancy and onboard data for all mental health occupations. Tab 1 shows onboard as of April 30, 2019, and loss rates for FY 2018 and Tab 2 shows vacancies and vacancy rates as of December 31, 2018.

Reasons for leaving VA for all mental health occupations cannot be determined currently. We do have information on psychologists. The top two reasons psychologists leave are advancement opportunity (44 percent of respondents endorsed) followed by personal/family reasons (24 percent of respondents endorsed). Psychologists have been shown to be extremely positive in their assessment of their VA employment experience.

Family & Provider Support

Question 1: Following the tragic loss of a veteran from suicide, thoughts and prayers are sent to their loved ones. I suspect it is particularly distressing for the psychiatrists, psychologists, social workers and nurses in mental health who provided direct care. Naturally, the process of case review for completed suicides may pose a particular challenge for these team members. Many are interested in better understanding potential missteps or ways to better engage their patients in care.

Question 1a: Dr. Stone, could you outline how VA creates an environment of support, free of judgement, for frontline staff impacted by a patient's suicide?

VA Response: Facility Suicide Prevention Staff, Chaplain Services, and Clinic Coordinators offer support to VA staff impacted by a Veteran suicide. The VA Suicide Risk Management Consultation Program offers postvention consultation and support to staff members affected by a Veteran suicide. In addition, employees are encouraged to use the Employee Assistance Program and local community resources if further assistance is needed processing the suicide after the initial crisis period. VA also has suicide postvention teams that assist with the notification of suicides and provide support for affected staff. Postvention educational materials are underway.

Uniting for Suicide Postvention (USPV) was created to offer a community of shared healing to connect family members, friends, co-workers, providers, and workplace supervisors who have been touched by suicide loss. The USPV website will house infographics, films, and resources designed to support ANYONE who has lost someone to suicide with anticipated completion in summer of 2019. The USPV podcast series is available to learn more about suicide postvention topics, visit https://www.mirecc.va.gov/visn19/education/media/#PostventionPodcasts

Question 2: I think we can all agree it is important to surround a vulnerable individual, such as a suicidal veteran, with support. Often, we find support amongst our family, friends, and colleagues.

Question 2a: How is VA ensuring that those closest to veterans are prepared to identify risk factors and empowered to connect that veteran with the resources he or she may need - such as a mental health professional or the veteran's crisis line?

VA Response: Every day, more than 400 VA SPC and their teams, located at every VAMC, connect Veterans with care and educate their surrounding communities about suicide prevention programs and resources. VA is partnering with hundreds of organizations and corporations at the national and local levels - including Veterans Service Organizations, professional sports teams, and major employers - to raise awareness of VA's suicide prevention resources and educate people about how they can support Veterans and service members in their communities.

Some specific resources include:

- The VCL connects Servicemembers, Veterans, and their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1–800–273–8255 and Press 1, chat online, or send a text message to 838255 to receive confidential crisis intervention and support 24 hours a day, 7 days a week, 365 days a year. More information is available at https://www.veteranscrisisline.net/.
- The #BeThere campaign emphasizes that everyday connections can make a big difference to someone going through a difficult time and that individuals don't need special training to safely talk about suicide risk or show concern for someone in crisis. Learn more at VeteransCrisisLine.net/BeThere.aspx.
- Make the Connection provides Veterans, their family members and friends, and other supporters with information on and solutions to issues affecting their lives. Visit MakeTheConnection.net/Conditions/Suicide.
- Coaching Into Care is a national telephone service from VA that aims to educate, support, and empower family members and friends who are seeking care or services for a Veteran. Call (888) 823–7458 to learn more.
- PsychArmor Institute's Operation S.A.V.E. online training describes how to talk with Veterans who may have suicidal thoughts and provides specific recommendations for what to do and say during these critical conversations. Watch the Operation S.A.V.E. video at psycharmor.org/courses/s-a-v-e. This training is also available directly on YouTube.
- Walgreens has partnered with VA to help reduce the stigma about mental health and help seeking behaviors among Veterans and has worked to trained staff at their health clinics in the warning signs of suicide.
- The Warrior Wellness Alliance, part of the George W. Bush Institute, is organizing best-in-class peer support and mental health providers, including VA, to find innovative ways that post 9/11 Servicemembers and Veterans can reach peer support services and mental health services nearest to where they live. CaringBridge is a global nonprofit social network dedicated to helping family and friends communicate with and support loved ones during any health journey through the use of free personal websites. A CaringBridge Web site can be used to share updates and coordinate support for Servicemembers, Veterans, their caregivers and families during any health journey including mental health and substance use. Through the partnership with VA and CaringBridge, a tai-

lored destination page www.caringbridge.org/military-service/ to directly focus on the needs of Servicemembers, Veterans, caregivers and their families is now available.

Question 2b: What barriers have you identified that would prohibit the distribution of information and access to training for these families, friends and colleagues?

VA Response: We do not see any barriers. Preventing Veteran suicide is VA's top clinical priority. However, not all Veterans receive services from VA. To accomplish its goal of reducing suicide rates among all Veterans, the SPP is using innovative strategies and partnerships to serve Veterans who do not-and may never -seek services within the VA health care system. VA's public health approach to suicide prevention is driven by data and best practices and looks beyond the individual to involve peers, family members, and the community. This comprehensive view considers the full range of factors, including those unrelated to mental health, that contribute to risk for suicide. Using the public health approach, the Suicide Prevention Program can deliver resources and support to Veterans earlier -before they reach a crisis point. No single group can effectively prevent Veteran suicide. To save lives, multiple systems must work in a coordinated way to reach Veterans where they are.

Operation S.A.V.E. Training is available for anyone who cares about, or interacts with, Veterans and can be taken on the PsychArmor Web site at psycharmor.org or directly on YouTube. This training provides an understanding of the problem of suicide in the United States; how to identify a Veteran who may be at risk for suicide; and, finally, teaches what to do if they identify a Veteran at risk.

- VA has partnered with Objective Zero Foundation which is a nonprofit organization that uses technology to enhance social connectedness and improve access to mental health resources. The Objective Zero mobile application connects Servicemembers, Veterans, their families, and caregivers to peer support through videoconferencing, voice calls, and text messaging. Users also get free access to resources on mental health and wellness. Volunteer ambassadors sign up for the application, receive training including VA's own Operation S.A.V.E. Training course to then be on the receiving end of those in need of connecting. Objectize Zero aims to be more upstream than the Veterans Crisis Line and allows Servicemembers, Veterans their families and caregivers to both volunteer and connect to others when they need it most. You can download the free Objective Zero mobile application at https://www.objectivezero.org/app .
- Through its suicide prevention partnership with The Independence Fund, VA is helping to provide wellness and mental health education to Servicemembers and Veterans who are reunited with their former military units to enhance social connection and prevent suicide.

Questions from Congresswoman Julia Brownley

Question 1: Drs. Stone and Franklin: As you know, a 2018 VA OIG report found that 49 percent of military sexual trauma-related claims were incorrectly denied, meaning that women and men were perhaps not receiving the benefits they were owed. Obviously, MST is linked to the topic of this hearing. Can you provide information on what the VA is doing to correct these mistakes? Are each of these denied claims being reviewed to ensure accuracy and that veterans receive the care they are owed?

VA Response: VBA implemented a plan to conduct a review of denied military sexual trauma (MST)-related claims decided between October 1, 2016, through June 30, 2018, and take corrective actions based on the review if an incorrect decision was made. On November 14, 2018, VBA began the first phase of its plan at the Columbia Regional Office (RO) to validate the process established for the review. The second phase of the review began in March 2019. VA has added the Muskogee, Cleveland, Huntington, and Portland ROs to the review. All reviews are expected to be completed by September 30, 2019.

VBA released and mandated two training courses for those employees who have been designated by their ROs as MST processors. The first, "MST Checklists" - TMS #4483955 - was mandated for completion by October 31, 2018. The second, "Military Sexual Trauma (MST): Claims Development and Rating" - TMS 4500994 - was released on April 12, 2019, with a mandated completion date of May 31, 2019. VBA also teaches "MST - Soft Skills Training" - TMS #4177413 - as part of the Veterans Service Representative / Rating Veterans Service Representative after-Challenge training curriculum.

On November 2018, VBA required stations to designate specially trained VSRs and RVSRs to process MST-related claims. Additionally, VBA updated its adjudica-

tion manual specifying that all rating decisions on MST claims are subject to a second signature review until the specialized RVSR demonstrates an accuracy rate of 90 percent or greater based on a review of at least 10 MST cases.

VBA is planning to conduct a special focus quality review of denied MST claims during FY 2019. This review will be completed by October 2019. Errors found during this review will be returned to field offices to take corrective action.

Receipt of MST-related health care is separate from the disability and compensation claims process. Veterans do not need for their MST-related conditions to be service-connected to receive free MST-related care. Nor do they need (as a condition precedent) to be enrolled in VA's health care system or eligible for other VA care. For example, the minimum length of active-duty service requirements does not apply to those covered by the special MST-treatment authority. Nor do Veterans need to have reported their MST experiences while still in the Armed Forces or have other service documentation to receive a request for MST-related care.

Question 2: Drs. Stone and Franklin: During your testimony, you discussed a national network of Women's Mental Health Champions. Can you provide more background on this program, the duties and responsibilities of these champions, and the practices they use to support women's mental health?

VA Response: VA has a national network of Women's Mental Health Champions at every VAMC. The Women's Mental Health Champion position was developed in 2016 to ensure at least one point of contact for Women's Mental Health within each VA healthcare system. The Women's Mental Health Champion role is a collateral position which means they perform these responsibilities outside of their clinical assignment. A minority of Champions receive some protected time for this position. None is full-time.

Champions disseminate information, facilitate consultations and support the development of women's mental health resources at their local facility. Specific duties vary by site, local priorities, and resources.

All Women's Mental Health Champions undergo specialized training in women Veterans' mental health, including completion of a Women's Mental Health Mini-Residency. The Women's Mental Health Mini-Residency is an intensive, three-day clinical training during which nationally recognized experts lead sessions on a broad range of topics related to the treatment of women Veterans, including gender-tailored psychotherapies and pharmacotherapies, with a focus on the influence of hormonal changes and the reproductive cycle. As part of the mini-residency curriculum and requirements, all Champions are required to apply new learning by developing and implementing an Action Plan to improve women's mental health clinical resources at their local facilities. Collaboration with local stakeholders is strongly encouraged and all plans are reviewed by facility mental health leadership prior to initiation. Action Plans commonly include the development of gender-sensitive mental health intake processes, screening strategies and/or new treatment options. Gender-sensitive intake and screening strategies, for example, include standardized processes to better identify disordered eating, sexual trauma-related sexual dysfunction, and exacerbations of mental health problems during perimenopause. Gender-sensitive treatment approaches include gender-tailored pharmacotherapy considerations (e.g., when working with women who are pregnant or planning to become pregnant) and psychotherapy approaches that target women's unique mental health treatment needs, such as Skills Training in Affective and Interpersonal Regulation (STAIR). STAIR addresses areas of functioning that are often disrupted in female survivors of severe interpersonal traumas, such as sexual assault, including teaches skills for managing strong emotions and building healthy interpersonal relationships (including parenting relationships).

Question 3: Studying suicide and developing medications to prevent it has been challenging. To prevent suicides, one successful approach so far has been treating related mental health conditions. Do you think that suicide prevention should focus on treating underlying conditions such as Schizophrenia, Bipolar, Depression and PTSD or is there another approach you favor?

VA Response: There is no single cause of suicide. Suicide is often the result of a complex interaction of risk and protective factors at the individual, community, and societal levels. Certain mental health conditions are risk factors for suicidal behavior, and efforts should be made to treat these conditions in Veterans with evidence-based approaches. The mental illnesses identified are impairing and a significant cause of morbidity and mortality, warranting treatment independent of the impact on death from suicide.

Other risk factors for suicide include prior suicide attempt history, access to lethal means, and stressful life events, such as divorce, job loss, or the death of a loved one. Suicide prevention efforts should focus on minimizing risk factors and promoting protective factors that help to offset these risk factors. Some protective factors for suicide include access to mental health care, feeling connected to other people, and positive coping skills.

Question 4: PTSD is a major factor in many Veteran suicides, but a recent VA report found that "most [PTSD] patients are treated with medications or combinations for which there is little empirical guidance regarding benefits and risks," and there is "no visible horizon for advancements in medications that treat.PTSD." This is a big challenge. How is the VA positioning itself to reduce barriers to partnerships on clinical trials and big data research and work with companies of all sizes to encourage new therapies and diagnostics for PTSD?

VA Response: VA Research has been positioning itself to develop partnerships for supporting our efforts on advancements in medications for posttraumatic stress disorder (PTSD), beginning with a published statement at https://doi.org/10.1016/j.biopsych.2017.03.007 that we need attention on this issue. The VA PTSD Psychopharmacology Initiative has since conducted an industry day, outreach with partners, and investigator training. We have launched multiple new medication trials as a result, with a goal to be supporting 12 clinical trials of medications for PTSD by 2020. In addition to medications, we are focused on the potential testing of new therapies and diagnostic approaches.

Questions from Congressman Chris Pappas

Question 1: Dr. Franklin: I appreciate your response to my question on providing care for transgender veterans in light of the implementation of the ban on their serving openly in the Armed Forces. Could you please elaborate on what specifically VHA/VA is doing to ensure a "positive handoff" of these service members from DOD to VA, recognizing their increased risk for suicidal ideations?

VA Response: Through the Joint Action Plan developed under EO 13822, "Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life," all transitioning Servicemembers are receiving mental health screening by DoD prior to military separation. Data sharing logistics of this mental health screening between VA and DoD are currently in process with a plan to share all data to allow for appropriate referrals to VA mental health care for eligible Veterans and DoD's inTransition program. Those Servicemembers who have had contact with mental health care in the year prior to transition are contacted by inTransition coaches within 30 to 90 days prior to separating from the military. The inTransition coaches initiate contact with Servicemembers via phone to offer assistance with transitioning into VA mental health care, as appropriate. These efforts benefit all transitioning Servicemembers and Veterans in the effort to ensure access and capture all Servicemembers and Veterans in need of mental health services, including those who are transgender.

Chairman Mark Takano

Regarding the Public Health Model (Generally):

1. How does VA collect and use data on veteran suicides to inform its prevention efforts?

a. For example, how does VA examine various factors (e.g. location of the suicide, last contact with a VA health care provider) and use this information in all of its suicide prevention programs (not just REACH VET)?

b. How does VA collect and use data to "target groups" like female veterans?

2. How do VA and DOD share data with each other to help prevent veteran suicides?

a. Are there any challenges with collecting and/or accessing data across agency lines?

Regarding REACH VET Predictive Analysis Modeling:

1. Has VA monitored whether all VISNs and VAMCs have successfully implemented REACH VET in all required patient care settings?

2. How has VA ensured that VHA providers responsible for conducting VA's new standardized suicide risk screening and assessment processes have been properly trained in this process?

Regarding the Executive Order on a National Roadmap to Empower Veterans and End Suicide:

1. As part of the March 5th Executive Order on Suicide Prevention, the President calls for the creation of a task force that will, among other things, develop a plan to be known as the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide, or PREVENTS, within one year of March 5, 2019. It has been more two months since the issuance of the order and details have been scarce.

a. Could you inform the Committee who has been assigned to represent the various agencies and organizations listed as part of this task force?

2. The March 5th Executive Order on Suicide Prevention requires the development of (1) a grant-based system to assist in the coordination of federal, state and local resources available to veterans, (2) a research strategy and metrics to quantify the progress of research to prevent suicides, and (3) a legislative strategy to support the steps associated with greater coordination and research.

a. Given the importance of research, does the administration intend to assign a representative from VA's Office of Research Development to the taskforce as a designee of the taskforce?

Regarding the Support Systems (State and Local) Needed as Part of the Public Health Approach:

1. The Arizona Coalition for Military Families has spent the last decade developing the BE CONNECTED Program. For those that are not aware, this program connects veterans in need of resources such as financial counseling, legal assistance, or transportation to both VA and Community-based regionally specific resources. I understand the intent of the EO on Suicide Prevention is to expand this pilot program nationwide.

a. Because the resources are specific to a region, such as a county or zip code, it seems most effective to set up state-based agencies or organizations similar to Arizona's Coalition to collect, review, organize, and oversee these resources. What barriers do you foresee to its expansion nationwide?

Regarding the Budget for Suicide Prevention:

1. In 2018, the President signed an Executive Order focused on creating a seamless transition between DoD and VA mental healthcare for transitioning servicemembers. This EO required the development of a Joint Action Plan and status update 6 months following the development of the Joint Action Plan. The development of these strategic planning documents has allowed veterans, stakeholders, and Congress to more easily envision the ultimate goal of the EO, as well as to track the agency's progress toward the completion of the EO's goals. As part of your 2020 budget request, you've asked for a 63% increase in funds for "implementation of the National Strategy on Preventing Veterans Suicide."

a. In an effort to better assist veterans and stakeholders understanding of your "ultimate goal" and to assist Congress in oversight, would you commit to developing an "Action Plan" that lays out each of the 14 goals, reliable metrics by which you intend to judge success, and targets, including dates, that reflect what that "success" looks like?

2. Over the last few years, VA has shifted towards a "public health" approach to suicide prevention. You've described community engagement as a central part of this new approach. However, you've only requested an increase of $275,000 for "Local Facility and Community Outreach and Activities."

a. How does VA intend to leverage this additional $275,000 to begin creating the community support that will be integral to the "public health" approach that is currently being pursued by VA?

Regarding Trans Veterans:

1. As a result of the President's April 12 ban on transgender people serving in the armed forces, we have heard from advocacy groups and health care providers

about the increased likelihood the ban will trigger increased suicidality amongst trans veterans.

a. What is the VA doing to reach out to these veterans who are particularly vulnerable?

b. What interventions have been developed that are specific to this population?

Regarding Native American Veterans:

1. American Indians and Alaska Natives (AI/AN) have a disproportionately high rate of suicide-more than 3.5 times those of racial/ethnic groups with the lowest rates, according to a 2019 CDC study. And the rate has been steadily rising since 2003.

a. What is VA doing to ensure tribal veterans have access to suicide prevention outreach?

Regarding Women Veterans:

1. Dr. Franklin: Women veterans die by suicide at twice the rate of non-veteran women. What are some of the factors unique to women veterans that put them at greater risk of suicide?

a. How is VA improving peer-support programs for women veterans?

Regarding Peer Support Specialists:

1. VA has found peer support specialists to be an integral part of increasing access to VA's mental health programs. These specialists also often offer assistance accessing other parts of VA such as VBA and even NCA services.

a. Does VA intend to expand this program and the training associated with it to service lines outside of Primary Care and Mental Health Care? For example, to Community Living Centers, Substance Abuse Programs, Long and Short-Term Rehabilitation Programs, and Women's Health Care?

2. In response to the President's 2018 Executive Order on Transitioning Servicemembers, it was suggested that veterans should receive "peer support for life." Why was this never fully realized? What barriers did you run into and what were some of the issues with the provision of peer support as described?

Regarding VA's Transformation towards Whole Health Programs:

1. As part of the VA's response to the President's 2018 Executive Order to assist transitioning veterans in accessing seamless care, VA began offering Intro to Whole Health sessions to newly transitioning veterans. However, the Whole Program has not been fully implemented at all facilities.

a. How is VA serving veterans interested in Whole Health that may not have access to a facility that offers all components of Whole Health such as Yoga, Mindfulness, or Financial Counseling?

Regarding Surveillance as Part of the Public Health Approach

1. Researchers from various organizations and companies often reach out to our offices seeking access to the wealth of data VA collects regarding veteran's healthcare and healthcare outcomes. It would seem, according to these scientists that VA is a VERY data rich environment. However, we still know very little about veterans and military personnel that complete suicide - especially the nearly 70% of those that never entered VA's healthcare system.

a. How can we ensure VA, DoD, DHS, and HHS are sharing data in real-time so that the development of effective interventions are not further delayed?

2. Hypothetically, if VA had access to the complete records of every veteran and military personnel that has completed suicide in the past 10 years, would VA have the technology necessary to fully analyze that data in-house?

a. If not, how can we allow VA access to such technology so that its researchers and investigators are well versed in its use once that magnitude of data is obtained?

Regarding the Development of Interventions as Part of the Public Health Approach:

1. How are you using assessments performed by both internal and external sources to guide your path forward?

2. What are some of the most effective interventions VA currently utilizes? Have they been adopted nationwide? How are you tracking their successful implementation?

Regarding the Targeting of Interventions as Part of the Public Health Approach:

1. How is VA ensuring the modernization of the Electronic Health Records includes data collection necessary to the further development of effective interventions?

2. How is VA ensuring the new EHR incorporates systems that will allow frontline providers and support staff to target those effective interventions to veterans that need them most?

Regarding Limiting Access to Lethal Means:

1. 69% of Veterans completed suicide via firearm. However, it has come to my attention [by staff from APA] that VA staff have been directed to stop using the term "lethal means" even though it is a standard phrase used throughout the mental health industry. Is this true? If so, what is your reasoning?

2. During Committee Staff's recent trip to the Phoenix VA Medical Center, VA staff stated that approximately 800-gun locks are given away to veteran patient's each week. These locks are not issued by staff, but rather placed in areas such as primary care, mental health, and women's health clinics, as well as, in the Emergency Room so that veterans can take them without fear of being judged or tracked.

a. What are other ways VA is ensuring veterans are fully aware of the staggering amount of suicides completed via firearm? And what resources, besides gun locks and video training, does VA offer to veterans that may choose to limit their access to firearms?

Regarding Interventions for the Aging Veteran Population:

1. Male veterans age 55 and older had the highest count of suicide according to the 2016 National Suicide Data Report. Kaiser Health News and PBS NewsHour also found that an alarming number of seniors, not only veterans, are committing suicide in Long Term Care Facilities. The article suggests that depression, debility, access to deadly means, and disconnectedness are the main risk factors for senior suicide

a. How is VA working to track these risk factors in its Community Living Clinics? How are CLC staff being trained to deliver interventions in response to veterans that exhibit these risk factors?

2. How does VA track suicide attempts and death by suicide in its Community Living Clinics?

3. What is the readmission policy surrounding previously suicidal veterans once they have been treated for their mental health concerns?

4. Does VA intend to offer peer support in its Community Living Clinics?

5. Does VA intend to offer the Whole Health Program at its Community Living Clinics?

6. How is VA ensuring aging veterans enjoy a high quality of life at its Community Living Clinics?

7. More broadly, given that depression presents differently in older adults, how has VA adjusted its screenings for this cohort?

Gaps in Medical Training

1. Dr. Avenevoli or Dr. McKeon, could one or both of you elaborate on the existing gaps in formal medical training for suicide risk assessment and management and the impact that has, as America as a whole adopts this public health approach to suicide?

a. Dr. Stone, would you agree that VA plays a significant role in educating America's future medical workforce?

b. In that case, what is VA doing to ensure the 70 percent of medical professionals who spend time at VA receive adequate training and exposure to suicide risk assessment and management?

Staffing

1. A number of VA OIG reports on VA's efforts to reduce veteran suicide found issues, weaknesses, or mistakes by Suicide Prevention Coordinators. Our Suicide Prevention Coordinators are central to so many of VA's efforts to reduce veteran suicides.

a. In your opinions Dr. Stone and Franklin, do the workloads and responsibilities of these Coordinators align with the resources they are provided?

b. Currently, how many vacancies are there in these roles across VA?

c. Given the nature of the work, are these roles susceptible to high turnover rates?

i. If yes, what do the exit surveys tell us about why these critical staffers are leaving? And what is being done to address these findings?

Family & Provider Support

1. Following the tragic loss of a veteran from suicide, thoughts and prayers are sent to their loved ones. I suspect it is particularly distressing for the psychiatrists, psychologists, social workers and nurses in mental health who provided direct care. Naturally, the process of case review for completed suicides may pose a particular challenge for these team members. Many are interested in better understanding potential missteps or ways to better engage their patients in care.

a. Dr. Stone, could you outline how VA creates an environment of support, free of judgement, for frontline staff impacted by a patient's suicide?

2. I think we can all agree it is important to surround a vulnerable individual, such as a suicidal veteran, with support. Often, we find support amongst our family, friends, and colleagues.

a. How is VA ensuring that those closest to veterans are prepared to identify risk factors and empowered to connect that veteran with the resources he or she may need - such as a mental health professional or the veterans crisis line?

b. What barriers have you identified that would prohibit the distribution of information and access to training for these families, friends and colleagues?

Rep. Brownley

1. Drs. Stone and Franklin: As you know, a 2018 VA OIG report found that 49 percent of military sexual trauma-related claims were incorrectly denied, meaning that women and men were perhaps not receiving the benefits they were owed. Obviously, MST is linked to the topic of this hearing. Can you provide information on what the VA is doing to correct these mistakes? Are each of these denied claims being reviewed to ensure accuracy and that veterans receive the care they are owed?

2. Drs. Stone and Franklin: During your testimony, you discussed a national network of Women's Mental Health Champions. Can you provide more background on this program, the duties and responsibilities of these champions, and the practices they use to support women's mental health?

3. Studying suicide and developing medications to prevent it has been challenging. To prevent suicides, one successful approach so far has been treating related mental health conditions. Do you think that suicide prevention should focus on treating underlying conditions such as Schizophrenia, Bipolar, Depression and PTSD or is there another approach you favor?

4. PTSD is a major factor in many Veteran suicides, but a recent VA report found that "most [PTSD] patients are treated with medications or combinations for which there is little empirical guidance regarding benefits and risks," and there is "no visible horizon for advancements in medications that treat.PTSD." This is a big challenge. How is the VA positioning itself to reduce barriers to partnerships on clinical trials and big data research and work with companies of all sizes to encourage new therapies and diagnostics for PTSD?

Rep. Pappas

1. Dr. Franklin: I appreciate your response to my question on providing care for transgender veterans in light of the implementation of the ban on their serving openly in the Armed Forces. Could you please elaborate on what specifically VHA/VA is doing to ensure a "positive handoff" of these service members from DOD to VA, recognizing their increased risk for suicidal ideations?

Representative Lauren Underwood to Veterans Affairs

Question 1: Your written testimony mentions a national network of Women's Mental Health Champions created by VA. Please provide a brief written overview of the Women's Mental Health Champions Program, including any evidence-based practices that have influenced the development of that program, and a list of program participants located in Illinois.

VA Response: Established in 2016, the Women's Mental Health Champions program is a network of individuals throughout the VA health care that serve as points of contact for Women's Mental Health. The Women's Mental Health Champion role is a collateral position which means they perform these responsibilities outside of their clinical assignment. A minority of Champions receive some protected time for this position. None are full-time.

Champions disseminate information, facilitate consultations and support the development of women's mental health resources at their local facility. Specific duties vary by site, local priorities, and resources. All Women's Mental Health Champions undergo specialized training in women Veterans' mental health, including completion of a Women's Mental Health Mini-Residency. The Women's Mental Health Mini-Residency is an intensive 3-day clinical training during which nationally recognized experts lead sessions on a broad range of topics related to the treatment of women Veterans, including gender-tailored psychotherapies and pharmacotherapies; the influence of hormonal changes; and the reproductive cycle. As part of the mini-residency curriculum and requirements, all Champions are required to apply new learning by developing and implementing an action plan to improve women's mental health clinical resources at their local facilities.

Collaboration by Champions with local stakeholders is strongly encouraged and all plans are reviewed by facility mental health leadership prior to initiation. Action Plans commonly include the development of gender-sensitive mental health intake processes, screening strategies, and/or new treatment options. For example, Gender-sensitive intake and screening strategies include standardized processes to better identify disordered eating; sexual trauma-related sexual dysfunction; and exacerbations of mental health problems during perimenopause. Gender-sensitive treatment approaches include gender-tailored pharmacotherapy considerations (e.g., when working with women who are pregnant or planning to become pregnant) and psychotherapy approaches that target women's unique mental health treatment needs, such as Skills Training in Affective and Interpersonal Regulation (STAIR). STAIR addresses areas of functioning that are often disrupted in female survivors of severe interpersonal traumas, such as sexual assault. STAIR teaches skills for managing strong emotions and building healthy interpersonal relationships (including parenting relationships).

The development of the Women's Mental Champion program was not based on evidence-based practices but rather it aligns with policy and basic tenets of Veteran-centered care and as described above, the Women's Mental Health Mini-Residency includes training on evidence-based psychotherapies and pharmacotherapies. All Illinois VA medical facilities (e.g., Jesse Brown VA Medical Center (Chicago); VA Illiana Health Care System (Danville); Edward Hines Jr. VA Hospital (Hines); Marion VA Medical Center (Marion); Captain James A. Lovell Federal Health Care Center (North Chicago) have a Women's Mental Health Champion.

Question 2: Given the recent incidences of veteran suicides at VA medical facilities, has VA enacted any new policies or procedures to reduce the number of on-site suicides?

VA Response: VA has not enacted any new national policies or procedures to reduce the number of on-site suicides because VA has policies that direct reporting, evaluation, and improving risk reduction for all suicide deaths, including those on VA campuses. These policies direct local efforts to review, evaluate, and update local guidance and practices to prevent Veterans Suicide on campus, while fitting the needs of our Veterans and their VA health care facility. VA is open to revisiting and refining policies and practices upon the findings of these recent tragic events and subsequent Root Cause Analysis.

For reference, Veteran suicide deaths that occur on VA property are evaluated by the local facility and reported through a process known as an Issue Brief (IB). Issue Briefs are intended for internal use and are reviewed by senior leaders within our organization, including the Secretary. VA has a Guide to Veterans Health Administration (VHA) Issue Briefs that provides the processes VA medical centers should follow when evaluating and reporting Veteran suicide deaths.

These reported events are monitored by the National Suicide Prevention Office (Office of Mental Health and Suicide Prevention) in near real-time with follow up back to the VA medical center, as appropriate. In addition, VA facilities complete Environment of Care Rounds, to include identification and recommendations for mediation of potential safety issues, including those specific to suicide and suicidal behavior.

When VA medical centers decide to further investigate a suicide or suicide attempt, they do so by completing an RCA to review a larger systems issue, or a Peer Review to focus on a particular aspect of a Veteran's care. An RCA is a multidisciplinary approach to study health care-related adverse events and close calls. This involves a systematic process for identifying root causes of problems or events and an approach for responding to them. The goal of the RCA process is to find out what happened, why it happened, and how to prevent it from happening again.

Question 2a: Have any internal reviews been conducted with regard to improving onsite security and threat screening?

VA Response: As a result of recent suicides and violent events involving weapons, VHA has initiated an enterprise wide collection of security deficiencies and vulnerabilities. Action plans are being developed that will be used to prioritize corrective actions to address detected deficiencies and vulnerabilities. Facility police chiefs are collaborating with the Veterans Integrated Service Networks (VISN) leadership to adjust resources that improve protective postures at all facilities. VA Police currently perform annual physical security assessments and biennial vulnerability assessments at VA facilities to identify risks at each medical center. VA Police also provide suicide prevention training to community police. Additionally, VA have implemented: panic buttons, badge restricted access to certain areas, limited guest hours, secure camera monitoring, emergency preparedness training, and other site-specific security measures.

Question 2b: If so, when will those review findings become available?

VA Response: After a recent suicide on campus and shooting at the West Palm Beach VA Medical Center, a VHA team visited the West Palm Beach VA Medical Center to review its security processes and procedures. An internal review was conducted and is complete. The release of the internal review report to Congress requires a written request from the Chairman of the U.S. House of Representatives Veterans' Affairs Committee.

Question 3: In your written testimony you highlighted VA as a national leader in providing "telemental" health services. Please provide data regarding the efficacy of "telemental" health programs as a useful means of reaching, retaining, and providing effective mental health care to patients.

VA Response: Numerous studies have shown Telemental Health (TMH) to be safe, as clinically efficacious as the same treatments delivered in person, cost effective, engaging, and satisfying to patients. Particularly for mental health care that often requires weekly visits, TMH removes a major barrier to receiving care. From Fiscal Year (FY) 2002 through FY 2018, VA has provided Veterans with more than 3,344,000 TMH visits. TMH is VA's largest video telehealth clinical specialty and accounts for 46 percent of all Veterans who received video telehealth services. In FY 2018, 180,600 Veterans received over 593,000 TMH visits - a 19 percent increase in Veterans served over FY 2017 totals. VA is using telehealth to increase Veteran access to quality VA care, especially for Veterans in rural and underserved areas. Also in FY 2018, more than 92,000 (over 50 percent) Veterans receiving TMH services were from rural areas - a 16 percent increase compared to FY 2017.

Established in FY 2010, the National Telemental Health Center (NTMHC) provides Veterans access to clinical experts throughout the country for a variety of disorders including but not limited to affective, psychotic, and substance use disorders. In FY 2018, NTMHC provided more than 2,600 consultation visits for approximately 600 Veterans. The VA National Bipolar Telehealth Program, which is part of NTMHC, utilizes Bipolar specialists to deliver the evidence-based Collaborative Care Model from an expert hub to the patient's local VA clinic. Patients receive a comprehensive diagnostic assessment, psychopharmacologic consultation, and self-management skills sessions. Since FY 2011, the program has served over 50 patient sites and over 1,600 Veterans, and Veterans who complete the program show improved mental health quality of life. In FY 2018, the program began a specific focus to identify at-risk Veterans with Bipolar Disorder.

In FY 2016, VA established four regional TMH Hubs to increase VA mental health care for Veterans living in rural or other access-challenged areas. Since then, VA has expanded to 11 TMH Hubs around the country. Through these Hubs, VA

leverages providers to deliver timely care to underserved areas and reduce the impact of clinical staffing and/or service gaps. In FY 2018, TMH Hubs provided over 135,000 telehealth visits to more than 36,000 Veterans at over 240 VA sites of care. In FY 2019, VA has begun development of Clinical Resource Hubs (i.e., integrated Primary Care and Mental Health Hubs) in all 18 VISNs. This collaborative effort enhances VA's provider capacity, broadens the mission and scope of the Hubs, and ensures they will serve as clinical care safety nets for a variety of high priority areas (e.g., staffing gap coverage, emergency management, etc.).

VA has also developed the secure and private VA Video Connect (VVC) mobile application. Veterans around the country have the option of receiving evidence-based psychotherapy and pharmacotherapy via telehealth through their mobile devices, tablets, or computers at home or other preferred location. VVC makes VA health care more convenient and addresses barriers to mental health treatment engagement (e.g., lack of transportation, work/school schedules, stigma, distance to VA, and child care responsibilities). With no travel time required, VVC increases access for Veterans, especially in rural areas without nearby VA health care facilities. In FY 2018, over 16,400 Veterans connected with their VA mental health providers via VVC for 75,500 visits, an 88 percent growth in Veterans served compared to FY 2017. Approximately 46 percent of these Veterans live in rural areas. VA's vision is that all outpatient VA mental health providers will be VVC-capable (i.e., trained and equipped to provide a telehealth visit to a Veteran's home or other preferred location within the United States) by the end of FY 2020.

Because not all Veterans have access to the Internet or a mobile device for VVC, VA is collaborating with community, private, and alternate agency partners to establish telehealth access points in communities for use by Veterans. These pilots are part of VA's Advancing Telehealth through Local Access Stations project, which aims to help remove barriers to VA mental health care.

To further increase access for Veterans who do not have their own mobile devices, VA provides mobile devices (e.g., VA telehealth iPads with built-in 4G data plans) through its Tablet to Home Initiative. This initiative started in FY 2016. VA has distributed over 18,000 tablets to Veterans, including Veterans with mental health issues.

Question 4: In Dr. Shelli Avenevoli's written testimony for this hearing, she outlined the effectiveness of the REACH–VET suicide risk identification system.

Question 4a: Please provide information on the specific patient characteristics that REACH–VET analyzes.

VA Response: The specific patient characteristics that REACH–VET analyzes are as follows:

- Demographics
  Age / 80
  Male
  Currently married
  Region (West)
  Race/ethnicity (White)/ (Non-white)
  Service Connected (SC) Disability Status
  SC / 30%
  SC / 70%
- Prior Suicide Attempts
  Any suicide attempt in prior 1 month, 6 months, or 18 months
  Diagnoses
  Arthritis (prior 12 or 24 months)
  Bipolar I (prior 24 months)
  Head and neck cancer (prior 12 or 24 months)
  Chronic pain (prior 24 months)
  Depression (prior 12 or 24 months)
  Diabetes mellitus (prior 12 months)
  Systemic lupus erythematosus (prior 24 months)
  Substance Use Disorder (prior 24 months)
  Homelessness services (prior 24 months)
- VHA Utilization
  Emergency Department visit (prior month or 2 months)
  Psychiatric Discharge (prior month, 6, 12, or 24 months)
  Any mental health (MH) treatment (prior 12 or 24 months)
  Days of Use (0–30) in the 13th month prior or in the 7th month prior
  Emergency Department visits (prior month or 24 months)

First Use in Prior 5 Years was in the Prior Year
Days of Inpatient MH (0–30) in 7th month prior, squared
Days of Outpatient (0–30) in 7th month prior, 8th month prior, 15th month prior, 23rd month prior
Days with outpatient MH use in prior month, squared

- Medications

Alprazolam (prior 24 months)
Antidepressant (prior 24 months)
Antipsychotic (prior 12 months)
Clonazepam (prior 12 or 24 months)
Lorazepam (prior 12 months)
Mirtazapine (prior 12 or 24 months)
Mood stabilizers (prior 12 months)
Opioids (prior 12 months)
Sedatives or anxiolytics (prior 12 or 24 months)
Statins (prior 12 months)
Zolpidem (prior 24 months)

- Interactions

Between Other anxiety disorder (prior 24 months) and Personality disorder (prior 24 months)
Interaction between Divorced and Male
Interaction between Widowed and Male

Question 4b: Please provide more detailed information on how REACH–VET's effectiveness is evaluated.

VA Response: REACH VET is being evaluated from both an effectiveness and an implementation standpoint. An initial evaluation of effectiveness looked at 6-month outcomes for an initial cohort of identified Veterans and found the following:

- In comparison to the control groups, patients exhibited:
  - More health care appointments;
  - More mental health appointments;
  - Decreases in the percent of missed appointments;
  - Greater completion of suicide prevention safety plans; and
  - Less all-cause mortality.

Overall, findings on implementation and outcomes are positive. We are now finalizing a more extensive effectiveness evaluation and will be submitting that for peer-review for publication in June.

Question 4c: Has there been any effort to export the predictive system used by the REACH–VET model for use by other health care providers?

VA Response: Predictive risk models are built specifically on available data to model an outcome. Because the REACH VET model is built on the VHA electronic health record data, it is not directly exportable to other settings. Service connection, as an example, is a risk factor in the model but that data would not be available in another health care setting. It is possible to take the same approach and develop a model validated on available electronic health record data, but that would require a significant investment by the health care system to accomplish.

Question 5: The written statement provided by Disabled American Veterans for this hearing praised the utility of a personal workbook distributed by VA, "Your Personal Safety Plan," to identify stressors and to create a strategy for veterans for staying safe in times of emotional crisis. Given the elevated risk factors among the veteran population, has VA considered proactively providing the "Your Personal Safety Plan" workbook to all veterans as a presumptive positive intervention method?

VA Response: The Safety Planning Intervention Manual: Veteran Version, 2018 is a guide for VHA clinicians that defines best practices for developing suicide prevention safety plans (safety plans) with Veteran patients. Safety planning should be used with Veterans who meet one or more of the following criteria: attempted suicide or engaged in suicidal behavior, reported suicidal ideation, psychiatric disorder that increases suicide risk, and are otherwise determined to be at risk for suicide. VA has a new universal screening mechanism to assist clinicians with identifying those Veterans who may need more targeted intervention such as safety planning. Safety Planning is only recommended when clinically indicated, therefore, VA is not considering offering a safety plan to all Veterans at this time.

Question 6: Dr. Avenevoli's written testimony includes a section addressing several research studies supported by the VA that have uncovered benefits from an intervention called "caring communications." Please provide a summary of the current status of implementation of caring communications intervention methods, including the number of facilities using the methods; any research analyzing their effectiveness; and any plans or proposals for expanding use of the methods.

VA Response: Caring Communications (sometimes called "Caring Letters" or "Caring Contacts") has been studied in a number of clinical trials since the 1970s. A recent meta-analysis that statistically summarized the different studies found that Caring Communications reduced self-harm repetitions.[1] Caring Communications are included in the Department of Defense (DoD)-VA Clinical Practice Guideline on the Assessment and Management of Patients at Risk for Suicide (currently under revision).[2] In addition, the Joint Commission recently recommended that health care organizations consider Caring Communications, noting that it "has a growing body of evidence as a post-discharge suicide prevention strategy."[3]

There has only been one clinical trial published to date that has examined Caring Communications in a military population.[4] In that study, a text message version of the intervention reported mixed results. There was no significant effect on likelihood or severity of current suicidal ideation or likelihood of a suicide risk incident; there was also no effect on emergency department visits. However, participants who received Caring Communications had lower odds than those receiving standard care alone of experiencing any suicidal ideation between baseline and follow-up and they had fewer suicide attempts. This study also used Caring Communications as an adjunct to psychotherapy; it has generally been used as outreach for individuals not in care. A second study is underway; VA partnered with DoD to study the effects of an email version of Caring Communications with military personnel and Veterans;[5] the results of that study are not yet available.

VA has several ongoing projects working to expand or improve the use of Caring Communications. In the REACH VET program, existing data from Veterans' health records are analyzed to identify those at a statistically elevated risk for suicide, hospitalization, illness, or other adverse outcomes. This allows VA to provide preemptive care and support for Veterans, in some cases before a Veteran even has suicidal thoughts. Caring Communications are one of many options considered when a Veteran is identified by the REACH VET program. To facilitate the implementation of Caring Communications, a provider template for 8 Caring Cards was developed (based on messages used in prior successful studies) and tested with 154 high-risk Veterans.[6] Eighty-five percent of the Veterans Agreed or Strongly Agreed that they would like to receive Caring Communications. The messages were overwhelmingly rated as caring and helpful; 84 percent believed that Caring Communications could help suicidal individuals.

Since repeated outreach is thought to be key to the Caring Communications intervention, streamlined business processes are important to ensure the administrative burden on busy providers is minimized. VA is currently testing a program to centralize the administrative work of sending Caring Communications across two facilities (VA Puget Sound and Central Arkansas Veterans Healthcare System). This program has been in operation for about 2 months. Future analyses will examine whether it increased the use of Caring Communications in the REACH VET population.

VA is currently piloting another streamlined process for implementing Caring Communications in the VA emergency department setting in one facility (Central Arkansas Veterans Healthcare System). This pilot is focused on reaching Veterans who may not receive mental health care.

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[1] Milner, A. J., Carter G., Pirkis, J., Robinson, J., Spittal, M.J. Br J. (2015). Letters, Green Cards, telephone calls and postcards: Systematic and Meta-Analytic Review of Brief Contact Interventions for Reducing Self-Harm, Suicide Attempts and Suicide. Psychiatry. 206(3):184–90. doi: 10.1192/bjp.bp.114.147819.

[2] https://www.healthquality.va.gov/guidelines/MH/srb/VADODCP—SuicideRisk—Full.pdf.

[3] Joint Commission (February 24, 2016). Sentinel Event Alert: Detecting and treating suicide ideation in all setting, Issue 56.

[4] Effect of Augmenting Standard Care for Military Personnel with Brief Caring Text Messages for Suicide Prevention: A Randomized Clinical Trial. Comtois KA, Kerbrat AH, DeCou CR, Atkins DC, Majeres JJ, Baker JC, Ries RK. JAMA Psychiatry. 2019 Feb 13. doi: 10.1001/jamapsychiatry.2018.4530. [Epub ahead of print].

[5] https://clinicaltrials.gov/ct2/show/NCT01473771-term=luxton+caring&rank=1.

[6] Veteran Preferences for the Caring Contacts Suicide Prevention Intervention. Reger MA, Gebhardt HM, Lee JM, Ammerman BA, Tucker RP, Matarazzo BB, Wood AE, Ruskin DA. Suicide Life Threat Behav. 2018 Nov 19. doi: 10.1111/sltb.12528. [Epub ahead of print].

This pilot will inform whether this initiative will spread to other facilities. VA is also piloting a potential improvement to the traditional Caring Communications model in which a provider signs the letter. Given the importance of peer support in the Veteran population, investigators at VA Puget Sound are testing a model in which the letters are written by a peer Veteran. In a small pilot (30 participants), investigators recruited volunteers from a local Veterans Service Organization (the American Legion) to write six Caring letters (one mailed per month) to high-risk Veterans recently discharged from the psychiatric inpatient unit. This study should be completed by Winter 2019. The investigators are currently planning a larger clinical trial of peer Veteran Caring Letters.

In addition, for Veterans identified as surviving a suicide attempt or identified as being at high-risk for suicide and placed on the facility's high-risk list, the VA Suicide Prevention Coordinator will make personal contact with the Veteran and establish a United States mail contact with him or her to ensure communication is maintained with the Veteran. Mailings are simple and personal messages. This process is codified in the Suicide Prevention Coordinator Guide, sections 2008.04 and 2018.01 for Patients at High Risk for Suicide.

Question 7: In your written testimony you highlighted several times the need to better understand and target prevention efforts towards the 14 veterans who die by suicide each day who were not recent users of VA health services. Please provide an overview of any current methods to identify the demographics of 14 veterans.

VA Response: Suicide is a national public health issue that impacts all Americans, Veterans and non-Veterans. Currently, only about 30 percent of Veterans receive their health care through VA, and fewer than 50 percent use any VA benefits or services at all. To reach Veterans where they work, live, and thrive, VA is advancing a public health strategy to reduce deaths by suicide among the greatest number of Veterans possible. The public health approach cuts across all sectors in which Veterans may interact and includes collaborating with Veterans Service Organizations (VSO), State and local leaders, medical professionals, criminal justice officials, private employers, and other key stakeholders. Using the public health approach, the Suicide Prevention Program (SPP) can deliver resources and support to Veterans before they reach a crisis point.

The March 5, 2019 Executive Order 13861, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), will empower Veterans to pursue an improved quality of life, prioritizes related research activities to improve interventions and the translation of knowledge, and facilitates collaboration across the public and private sectors. Influenced by the National Strategy for Preventing Veteran Suicide and progress from the private and nonprofit sectors, the Roadmap outlines the specific strategies needed to effectively lower the rate of veteran suicide among our nation's veterans, developing opportunities for collaboration within federal, state, local, tribal, and non-government entities. The Roadmap will utilize a public health approach and focus on changing the culture of mental health broadly and specifically how suicide is addressed nationally and focus on the continuum of the veteran's experience and will target interventions across multiple opportunities - including prevention and early intervention. The Roadmap focuses on three areas: community integration, research strategies, and implementation strategies.

Understanding suicide risks among all Veterans is a VA priority. Through a collaborative effort between VA, DoD, and the Centers for Disease Control National Center for Health Statistics National Death Index, we identify suicide decedents among all military Servicemembers and Veterans. Available data sources from this collaborative effort, including military service personnel records, and benefit and service administrative records, are used to identify age, gender, and State of death for all Servicemembers and Veterans. Through additional sources and collaborations, we are able to identify other select demographics of Veterans such as race, ethnicity, and marital status, including among the 14 who are not recent users of VHA care.In addition, VA suicide data surveillance analyses have examined suicide risk among Veteran patients who received care from VA that are 65 and older, by receipt of mental health diagnoses from Medicare providers. Preliminary findings indicate Medicare diagnoses of mental health conditions are associated with increased suicide risks, adjusting for patient characteristics and receipt of mental health diagnoses from VHA providers.

Question 8: Please provide information on what data is being collected on these individuals, including their character of service; medical history; and access to VA, military, or private sector care, etc.

VA Response: VA obtains information on the cause, date, and State of death from the National Death Index for all Veterans and Servicemember suicide decedents, including the average of the 14 per day who are not recent users of VHA care. VA works closely with DoD's Defense Manpower Data Center (DMDC) to identify these individuals and some limited data on their military service histories. However, DoD electronic personnel data originated in the 1970s and for a significant proportion of decedents whose military service predated the 1970s, DMDC data are not available. Further, some decedents not accessing VHA care at the time of their death may have accessed VHA care in the non-recent past, or care from a non-VA provider that was paid for by VA. In these cases, some, possibly dated, medical information may be available. For persons with no history of VHA engagement, we do not have access to comprehensive private sector health care information to examine their health status at the time of death. Such limitations underscore the importance of a public health approach that seeks to reach all Veterans and their communities.

Question 9: The written statement provided by Veterans of Foreign Wars referenced an August 2018 report from the Department of Veterans Affairs Office of Inspector General (Report #17–05248–241) detailing the VA's staffing shortages in the area of mental health care. Please provide a roadmap with specific and measurable goals toward reducing the shortage of mental health staff in VA facilities, along with an outline of the resources you need to successfully implement the plan.

VA Response: VHA has made hiring mental health providers a priority. The current Mental Health Hiring Initiative has resulted in a net gain of over 1,000 additional providers in VHA. Ongoing efforts to continue to build the mental health workforce include:

1) Ongoing enhanced coordination of VHA offices including Workforce Management and Consulting and the Office of Academic Affairs. Currently, we are coordinating the hiring efforts and recruitment strategies for VHA trained students, interns, and residents, providing local hiring support and national recruitment efforts.

2) Actively tracking mental health staffing for efficiency and for population coverage. Tools have been built to monitor local changes in staffing to promote optimization for efficiency (eliminate waste or excess) and reach (coverage available for the population). Recently, the tools have been expanded to identify population gaps at the Community Based Outpatient Clinic level, allowing Medical Center leadership to make hiring decisions to enhance access. VHA has identified the most critical staffing gap sites based upon available staff and known Veteran population. Ongoing focused efforts are outlined to address staffing needs at these most critical sites.

3) Continuing to be a leader in the implementation of telehealth services, expanding the pool of available providers through tele-video conferencing services. The current VHA initiative focuses on expansion of VA Video Connect (VVC) capacity and utilization to enhance Veteran care. Current metrics monitored include the percentage of mental health providers utilizing VVC.

4) Locally, funding is the most commonly cited barrier to hiring additional mental health staff. VHA is coordinating ongoing discussions that evaluate current funding/utilization methodologies to update projections on the known mental health population. This will enhance the ability of local leadership to maintain ongoing hiring based upon population need rather than established workload.

5) With growing Veteran demand and ongoing VHA hiring, a lack of available space for care is similarly an often-cited barrier to hiring. Current VHA space guides have been updated and population-based tools have been developed which will provide space planners the ability to plan future space needs based upon population-based modeling.

6) Investigating and creating action plans to address barriers. Needs include:

a. Dedicated Special Purpose funding for hiring mental health providers using population-based models.

b. Dedicated funding for enhanced space to meet the rapidly growing clinical need.

Question 10: In her testimony during the hearing, Dr. Keita Franklin stated, "If it were up to me, we'd train the entire VA on how to talk about lethal means." Are there any existing barriers that would hinder VA from expanding lethal means training for its staff?

VA Response: The goal of universal training for all of VA related to lethal means safety is obtainable. It requires, though, a further expansion of our previous efforts. We have national-level initiatives for VHA clinical staff that involve safe firearm storage and medication safety (lethal means) in our facilities, including the following:

- A universal Safety Plan document that clinicians engage with, when appropriate. This document includes specific interventions around lethal means, to be agreed upon by the Veteran and their clinician, and there is a mandated requirement for all VHA mental health clinicians to take the training that discusses the administration of the Safety Plan.
- Although not mandated, we also offer an adjunctive training on lethal means for clinicians. According to the most recent progress report, this training has been completed 16,128 times since it rolled out in 2018.

Recently, the VA took a cursory step in expanding the dialogue across the system, not just in the clinical realm. Suicide Prevention staff was given the opportunity to provide information on lethal means for all VA staff who were able to attend a Summer Safety Stand-Down. The presentation was approximately 5 minutes and included a question and answer session where other resources were shared. This was not a full training, nor a comprehensive one, but a good start to introducing the topic across the system. The Stand-Down will also be placed on VA's training system, for staff to review in the future.

With those points in mind, one major barrier to expansion of knowledge across the VA is that a general training needs to be created As a means to meet this lift head on, a lethal means working group has been added to the PREVENTS Taskforce, pulling together the team of subject matter experts needed to make this process a reality, not just in VA, but across the government enterprise.

Question 11: Dr. Franklin also highlighted official partnerships between the VA and outside organizations to promote firearm safety. Please provide an overview of VA's current partnerships with organizations (such as firearm dealers and firearm ownership groups) aimed at reducing veteran suicide rates. Please include data on any funding provided, the number of involved organizations, and the number of veterans reached by these efforts.

VA Response: VA's SSP currently has more than 60 non-monetary partners working in prevention, intervention, and/or postvention. Traditional partners cut across 14 partnership sectors, as defined in the National Strategy for Preventing Veteran Suicide, and include Federal, State, and local leaders, as well as community organizations such as VSOs, medical professionals and other community service providers, criminal justice officials, private employers, and many others.

The VA has entered into a Memorandum of Agreement with the National Shooting Sports Foundation (NSSF) to provide firearm safety toolkits, to create coalitions to promote firearm safety, to suggest and explain safe firearm storage options, and to identify state laws for firearm storage and safety. VA and NSSF will share NSSF and VA public domain resources including NSSF"s Project Child Safe public firearm safety materials, websites, and related materials with emphases on Service Members, Veterans, and their families. This is a Public-Private Partnership whereby NSSF is donating its time, energy, and resources at no cost to the public or to the Department of Veterans Affairs. The Department is accepting NSSF"s philanthropy under its statutory authority to accept gifts and donations under 38 United States Code § 8301.

All partnerships are non-monetary agreements. Our goal is to reach all Veterans across the Nation.