VETERAN SUICIDE PREVENTION: MAXIMIZING EFFECTIVENESS AND INCREASING AWARENESS

JOINT HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

AND THE

SUBCOMMITTEE ON HEALTH

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Thursday, September 27, 2018

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

The Committee met, pursuant to notice, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe presiding.

Present: Representatives Roe, Bilirakis, Coffman, Flores, Radewagen, Bost, Poliquin, Dunn, Arrington, Bergman, Mast, Walz, Takano, Brownley, Kuster, Rice, Correa, Lamb, Esty, and Peters.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order. Welcome and thank all of you all for joining us today for the Full Committee hearing on Veteran Suicide Prevention.

Most of us have heard VA's staggering and heartbreaking statistic that every day 20 veterans end their lives, 20. We also know that over the past several years VA has invested significant resources toward addressing that number, which stubbornly has not changed. We know from VA's testimony that 14 of those 20 veterans have not sought medical care at a VA, meaning that the 30 percent of the veterans who commit suicide have been to a VA campus for an appointment. Significant resources have been put forward as outreach as well.

These numbers leave me with a lot of questions, ones which I hope we can find the answers to today. What did these veterans, men and women who reached an appalling level of crisis find lacking when they sought VA health care or what prevented them from seeking mental health services from VA in the first place? Sadly, it is too late to ask these veterans themselves.

I hope to hear more about the various programs and initiatives VA mentions in its testimony, such as those for women and homeless veterans. I am also eager to hear about how these programs and initiatives partner with communities and organizations that also are working hard to be a part of the solution.

I also want to know how these initiatives are truly executed. It is nice to outline how a program should work, but for every veteran who is not properly referred for treatment, for every veteran who is not admitted due to a shortage of staff or bed, or for every veteran who feels that they have been ignored or dismissed, we run

the risk of not only adding another tragic number to the statistics, but the veteran is not a number, the veteran is someone who has fallen through the cracks regardless of the good intentions.

Today's conversation should primarily revolve around the root cause of veteran suicide, identifying those at risk for suicide, recognizing the unique barriers that certain veteran populations face, and tying all of that to advancing and innovative approaches at the promise of preventing suicide among veterans.

I am eager to hear about the efficiency of recent improvements to VA's eligibility rules for mental health care. Under Trump Administration, VA will now expand mental health services to all departing servicemembers for 12 months following separation from the military, which as we know is also the highest risk period for suicide among veterans.

And thanks to the works of this Committee, veterans with other than honorable discharges may now seek mental health services for conditions that possibly contributed to their unfavorable separation status.

Have these changes made a difference? I hope that today's hearing will shed light on this very challenging subject. We have the expertise, we have the support of the President, we can and must reduce suicide among veterans and there is no excuse not to.

The CHAIRMAN. I will now yield to Ranking Member Walz for any opening statement that he may have.

OPENING STATEMENT OF TIM WALZ, RANKING MEMBER

Mr. WALZ. Well, good morning, everyone, and thank you, Mr. Chairman, a special thank you for holding this important hearing.

And I know the folks who are here testifying, the members that are here, and those that are both in the room and listening, this is the most important hearing happening on Capitol Hill today, because the heartache that is here and the things that we need to do are ongoing. And so for that I am grateful.

The tragic epidemic of veteran suicide is one of the most serious challenges facing our country. The VA Report on Veteran Suicide detailed yesterday, the rate of suicide is increasing amongst the younger veterans, and this is that ever-ongoing process of reaching zero sum, that if we lose one veteran, it is far too many. The need to work together, identify root causes, and figure out a constructive, holistic way to turn the tide on the veteran suicide epidemic.

I want to take a few minutes, and thank you, Mr. Chairman, for indulging me on this, to tell the story of a young veteran we tragically lost and, in the audience, became familiar with in recent days because of the IG report that came out on this. I share this story with permission. I was on with his mom, Drinda, and his father, Greg, and his sister this morning, and like so many who have lost this, they are trying to turn this tragedy into something positive to tell the story.

On February 20th of this year, Justin Miller, a young, 33-year-old Marine Corps reached out to the VA Crisis Line dealing with thoughts of suicide. He explained that he had access to firearms nearby and he feared for his life. He expressed a sense of hopelessness, confusion, sorrow, regarding his personal and professional life.

Justin reached out to VA for mental health care through the Veterans Crisis Line. They recommended, correctly so, that Justin visit the VA emergency department, which he did immediately. Upon his visit to the emergency department, Justin explained that his significant other of 2 years had asked him to move out. Justin also explained that battling the symptoms of PTSD, watching the erosion of his personal relationships and the family, and financial stressors had been overwhelming to him.

Unfortunately, when Justin arrived at the Minneapolis VA Medical Center, the help he needed never materialized and VA clinicians failed to utilize cutting-edge interventions that the facility has at their disposal, one example being the three-step REACH VET process, in which a clinician can assess a veteran's risk of suicide. If a veteran is determined to be at a high risk of suicide, the medical record is then flagged for a suicide prevention coordinator, who will then ensure the veteran receives an appropriate level of care, and has knowledge of and access to other services throughout the VA that may assist the veteran.

Those are things that previous hearings and we have put in place that are best practices, and we will hear from I am sure all of you, this could happen. In Justin's case, REACH was never utilized, and so he was never given a high-risk designation.

In the written testimony of Dr. Brown, an expert on the development, implementation, and assessment of suicide interventions, he commends the VA on its use of Safety Planning Intervention, or SPI, the SPI six-step protocol in which a clinician can empower a veteran to cope with suicidal thoughts through the development of a post-discharge plan. When Justin was discharged after 3 days, he did not have a discharge plan.

Clinicians weren't sure whether Justin had access to guns or a surplus of medications that he could hurt himself with. Clinicians failed to ensure that Justin had identified friends and family who he could reach out to in the case he felt suicidal again. The suicide prevention coordinator never consulted with Justin, engaged with Justin's clinicians, of flagged him.

Though Justin steps out of that hospital on that cold winter day in February, away from the nurses, the doctors, and the medications that could have assisted in stabilizing him, he went to his car and tragically took his life. He was not found until the next day.

Our hearts ache for his family and the friends of Justin Miller. I cannot even begin to understand their pain. No loved one should ever go through this. We may not know if what they could have done at VA would have saved his life, but we certainly as a Nation mourn his loss.

It is infuriating to me to know that the possibility was there, though, that could have prevented this. It should outrage all of us. The entire health care system failed at some point on something so serious. We need to do better, and we will. We can only do better if we do our jobs, the agency must continue to serve veterans and we must continue to oversee the agency.

Secretary Wilkie implying in his testimony yesterday before the Senate that our constitutional right to oversight is a burden on his ability to implement the VA MISSION Act signals a very dan-

gerous misunderstanding of the role of Congress; that must be corrected immediately.

Our oversight is integral to ensuring that VA is accurately and effectively carrying out policies and procedures that are in place, including policies aimed to help prevent suicides. Our ability to conduct oversight could literally be the difference between life and death. This I cannot stress enough, and it is why we are here today, to determine how we can better prevent tragedies like the one that took place on that cold winter day in Minneapolis last February.

Given this is my last term in Congress and sitting across from Chairman Roe, I want to thank him and everyone on this Committee for showing the true bipartisanship, probably nonpartisanship, in serving our Nation's veterans. Veteran suicide has been elevated to the top priority of this Committee for years, both by Democrats and Republicans; there is no space between us in saving the lives of heroes.

I am going to be gone, some of us in here will be gone, eventually all of us will be gone from here, but this issue and our charge must remain the same. That is why congressional oversight is the absolute key, putting policies in place that extend beyond individuals and making sure the oversight to implement them is a priority.

I want to thank the Chairman and thank all of you for this hearing. I look forward to our questioning.

The CHAIRMAN. Thank you, Mr. Walz.

We are joined on our first panel and only panel today by Dr. Gregory Brown, Director of the Center for the Prevention of Suicide at the Perelman School of Medicine at the University of Pennsylvania. Welcome.

Mr. Michael Richardson, Vice President of Independent Services and Mental Health, the Wounded Warrior Project. Welcome.

Lieutenant Colonel James Lorraine, United States Air Force, Retired, President and Chief Executive Officer of America's Warrior Partnership.

Mr. Bill Mulcahy, Co-Founder of Guard Your Buddy. Welcome.

Dr. Keita Franklin, Ph.D., National Director of Suicide Prevention for the Office of Mental Health and Suicide Prevention for the United States Department of Veterans Affairs. Dr. Franklin is accompanied by Mr. Michael Fisher, the Chief Readjustment Counseling Officer for the Readjustment Counseling Service at the United States Department of Veterans Affairs.

Thank you all for being here today. I will now move to witness testimony.

With such a big panel today, I respectfully ask that all of our panelists keep their oral testimony at or under the 5-minute time limit, as indicated by the timer on the microphones in front of you. Your full written statements have been included as part of the official hearing today.

And, Dr. Brown, we will start with you, you are recognized for 5 minutes.

STATEMENT OF GREGORY K. BROWN

Dr. BROWN. Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee, thank you for giving me the

opportunity to appear before you on such a critically important issue, veteran suicide prevention. I am honored to provide testimony, as I have devoted my entire career to suicide prevention, with a strong interest in preventing suicide among veterans.

As I will discuss, there have been a number of psychotherapy, evidence-based and brief interventions developed and validated that are available for at-risk veterans to prevent suicide. However, there remains some major challenges in the dissemination and implementation of these strategies, both in VHA and in the community. Today I will share some thoughts on a couple of recommendations for improving suicide prevention for our veterans.

I and my colleagues at the University of Pennsylvania developed a 10-to-16-session psychotherapy intervention for patients who recently attempted suicide called Cognitive Therapy for Suicide Prevention. In a landmark study published in the Journal of the American Medical Association, we found that patients who received this intervention were 50 percent less likely to re-attempt suicide during follow-up than those that did not.

These findings were partially replicated by Dr. David Rudd at the University of Memphis using a similar intervention for Active duty Army soldiers called Brief Cognitive Behavioral Therapy.

The dissemination and implementation of these interventions in VHA have been limited; there are efforts underway, however, to address this issue. For example, the Office of Mental Health and Suicide Prevention launched a project to remotely deliver this intervention via clinical video telehealth. This program will increase access for high-risk veterans to evidence-based suicide prevention services.

There also exists a strong need for scalable or brief interventions that are used in acute care settings such as emergency departments that often function as the primary or sole point of contact for suicidal individuals in the health care system.

To address this concern, Dr. Barbara Stanley of Columbia University and I developed a 20-to-40-minute intervention called the Safety Planning Intervention. This intervention was designed to decrease the risk of suicide by providing at-risk veterans with a written, personalized safety plan of coping strategies and resources of support to be used in the event of a suicidal crisis. This intervention also includes lethal means counseling to reduce access to potential methods such as firearms and lethal medications.

Since 2008, safety planning has been widely used in VHA. In response to a recommendation from the Federal Blue Ribbon Panel of Veteran Suicide in 2008, the VHA Office of Mental Health Services called for the development and implementation of an ED-based intervention for suicidal veterans. In this project, safety planning was developed in the ED and follow-up telephone calls were made until the veteran was engaged in care.

Recently, Dr. Stanley, myself, and others published the results in JAMA Psychiatry. We found that safety planning, plus follow-up care, was associated with 45 percent fewer safety behaviors than usual care.

In another study, Dr. Craig Bryan of the University of Utah found that crisis response planning, a brief intervention that is

similar to safety planning, was more effective than contracting for safety for preventing suicide among high-risk Active duty soldiers.

Since 2008, one of the most important lessons we have learned about the implementation of safety planning is that fidelity to the intervention involves more than simply completing a piece of paper or completing a medical record template. Rather, it involves taking a collaborative and understanding approach for addressing painful experiences, coupled with feasible and helpful suggestions that veterans can do to manage a crisis.

Two published studies have explored the quality of safety planning in VHA medical records. One study found that the quality of safety plans was low and that higher safety plan quality scores actually predicted a decreased likelihood of future suicide behavior reports in VHA. The other study found that safety plans in VHA were mostly complete and of a moderate quality.

To improve the fidelity and quality of safety plans, the Office of Mental Health and Suicide Prevention recently developed a medical record template with detailed instructions for safety planning, offered didactic training to use the template, as well as a corresponding safety planning manual, which I co-authored.

In closing, we have made considerable progress in developing validated interventions to reduce suicide risk, but there is important work to be done. This includes: (1) increase the dissemination of proven interventions for individuals at risk for suicide, such as CBT–SP (cognitive behavior therapy for suicide prevention), with the goal of raising awareness among providers and VHA and in the community, as well as the veterans we serve; and, (2) systematically evaluate the fidelity of implementing these evidenced-based interventions and provide additional comprehensive training to improve the quality, if needed.

Thank you for the opportunity to offer this testimony. I welcome any questions from the Committee.

[THE PREPARED STATEMENT OF GREGORY K. BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Brown.

Mr. Richardson, you are recognized for 5 minutes.

STATEMENT OF MICHAEL C. RICHARDSON

Mr. RICHARDSON. Chairman Roe, Ranking Member Walz, and distinguished Members, thank you for the opportunity to testify on how we together can work to increase the effectiveness and the collective efforts to prevent veteran suicide.

I am Mike Richardson, I serve with the Wounded Warrior Project, responsible for the mental health and brain health programming. I am also a combat veteran and a military retiree, as is my wife, Beth. I also commanded a Warrior Transition Battalion in Europe. So I have seen firsthand the challenges of combat and transition that our veterans and their families face.

We just heard the data about the suicide rate among 18-to-34-year-olds continues to increase. They now have the highest rate of suicide across all generations at population. The average age of the more than 120,000 warriors registered with Wounded Warrior Project's free service and programs is 38. As such, Wounded War-

rior Project's largest program investment is in mental and brain health.

We are transforming the way we approach mental health for our veterans through our comprehensive and more holistic approach, focused on resilience and psychological well-being. We know mental health treatment works and it is our belief that suicide prevention must move beyond the health care crisis management model more towards an integrated, comprehensive, public health approach, focused again on resilience and prevention. We need a broader, multi-pronged approach to prevention and treatment, a combination of clinical, non-clinical, and peer-to-peer community-focused efforts.

Suicide prevention can't just be about saving someone's life when they are in crisis, it must be about creating a life that is worth living.

Wounded Warrior Project has a mental health continuum of support that is comprised of a number of mental health programs, both internal to Wounded Warrior Project and also with our external partners where we serve and treat upwards of 10,000 veterans and family members a year. Although our continuum is comprised of several programs, I would like to highlight two, but please know our continuum provides warriors and their families a path to increased resilience, thereby lessening the likelihood of suicide.

The first program I would like to mention is our Warrior Care Network, which is focused on warriors that present with severe to moderate post-traumatic stress, anxiety, and depression, as well as other mental health challenges. Wounded Warrior Project partnered with four academic medical centers from across the country, Massachusetts General Hospital, Emory University, Rush University, and UCLA Health, who each developed an innovative 2-or-3-week intensive outpatient program that integrates evidence-based treatments with wellness, nutrition, and family support and mindfulness as well.

Since the launch in January of 2016, we have treated over a thousand veterans in our intensive outpatient programs. On average, the warriors are receiving more than 70 hours of therapy in this 2-to-3-week period. We are seeing significant clinical results.

Simply stated, on average warriors are starting treatment at the severe level of post-traumatic stress and following treatment they are now at the minimal level. The same holds true for depression and we have over a 94-percent completion rate for the treatment. These changes translate into increased functioning and participation in life, again lessening the likelihood of suicide.

I would like to specifically thank the VA for being an integral part of our Warrior Care Network success in that we have an MOU at the VA that allows for a VA teammate to work at each one of our academic medical centers to help with medical records, referrals, as well as education.

The other program I would like to highlight very quickly is our Project Odyssey. Project Odyssey is a non-clinical, 90-day program consisting of a multi-day, adventure-based mental health workshop, with a lot of follow-up after that. Each workshop includes psycho-educational activities, evidence-based exercises focused on improving resilience. Each warrior cohort learns how to process

emotions in a productive way to build resiliency, as opposed to employing avoidance techniques.

Over the course of the past several years, we have had over 10,000 participants in our Project Odyssey programs across the country and, again, we are seeing statistically significant increased levels of resilience. Again, these are just two of our programs.

We strongly feel that peer-to-peer engagement in communities is critical and, in addition to our own connection programs, we partner with many other organizations, like America's Warrior Partnership, Team Red, White, and Blue, Mission Continues, Team Rubicon, and others, focusing on the efforts, and as well as the Bush Institute's Warrior Wellness Alliance, whose focus is on optimizing the efforts across the veteran space to help foster the resilience of our veterans and prevent suicide.

I would be remiss if I did not bring up the strong connection between stigma and mental health care. Sadly, there is still a deafening silence when it comes to suicide. We need to demystify this topic through open dialogue like we are having here today. We must loudly state that there is nothing wrong with seeking help. We must make sure these incredible men and women who serve our country know that seeking mental health care does not equal weakness. Just the opposite, it takes strength to step forward when you are having challenges with mental health and seek that care.

And again I would like to thank you for having the opportunity to testify.

The CHAIRMAN. Thank you, Mr. Richardson.

Colonel Lorraine, you are recognized.

STATEMENT OF LT. COL. JAMES R. LORRAINE

Lieutenant Colonel LORRAINE. Chairman Roe, Ranking Walz, and Members of the Committee, thank you for the opportunity to provide testimony today on the crisis of veteran suicide.

Thank you for your leadership in holding this hearing and I respectfully request my written statement be submitted for the record.

Additionally, I am fortunate to follow my colleague at Wounded Warrior Project, because without their vision and financial support, the veterans in eight of our affiliate communities and their families would not be served.

I am a veteran of nine combat deployments in conflicts and locations from Desert Shield, Storm, Mogadishu, Somalia, Haiti, Iraq, and Afghanistan. I have had brothers and sisters in arms who have taken their own lives, leaving all who love them to wonder why.

Last week, I talked to a close friend of mine and begged him to promise me that he would get more assistance, and that he would not take his life. For me in America's Warrior Partnership, the prevention of suicide is not only necessary, it is personal.

As the Veterans Affairs report indicates, the number of veteran's death in suicide is unacceptable, with far too many unknown and untreated by the Department. As a Nation, we can do better.

In America's Warrior Partnership, our mission is to empower communities to empower veterans. Our approach as accomplishing this mission takes many forms, but it starts with getting to know all veterans; not just those who are seeking assistance, but all vet-

erans, building a relationship ahead of a crisis, so that they can reach out and seek you and get connected to existing services.

Through this model, we have established a relationship with more than 42,000 veterans in eight communities since 2014.

This year, the Department of Veterans Affairs released the VA National Suicide Data Report. This study is impressive, this report is impressive in the volume of the records, the big data aggregation, and the national span that it analyzed, but it didn't provide the granularity of the community impact, it didn't provide the granularity of what the service experience of the veterans was that contributed to the untimely death of a servicemember, or how communities might be able to enact it. It looks great about how the Nation has to respond, but it doesn't talk to the community level.

As a Nation, we often speculate about the causal effects of veteran suicide. We have not been able to differentiate the attributes of veterans that might be in the life that might take their life in Buffalo, New York, or Johnstown, Tennessee, or Orange County, California. We believe that when it comes to preventing veteran suicide, I believe when it comes to preventing veteran suicide, we need to move from fishing for those who are going to take their lives to hunting to those who are going to take their lives, by a better understanding of the characteristics of veterans at the local level, at the community level.

In December 2017, we announced the launch of Operation Deep Dive. It is the first-of-its-kind, four-year research study that we are conducting in partnership with the University of Alabama and through the visionary funding from Bristol Myers Squibb Foundation. With our partners, we are examining the context of community factors contributing to the potential causes of suicide and early mortality.

This study is a community-based initiative with a national scope, designed to be led by and for communities to ensure that they gain direct and tangible benefits that are tailored to the unique veterans. I have been absolutely amazed at how engaged the local community, coroners, medical examiners, and community leaders have been in getting involved in this project.

We are compiling the local data and aligning it with the national databases. We are fortunate to have a great partner in Keita Franklin in the Department of Veterans Affairs who have really stepped forward and said we want to help. We are also working the U.S. Census Bureau, the CDC, and civilian partners using publicly available credit bureau data such as organizations like TransUnion. And then we are applying advanced analytics such as geo-spatial analysis to identify the characteristics and gain a better understanding of what is a veteran in a community who is going to take their life look like in a specific community.

Through Operation Deep Drive, we will look at things such as the community environments that impact the veterans, the experience of all veterans across their service, and then into the veterans and what happens in the community; the impact of less-than-honorable discharges on the rate of suicide, and the analysis of cases of self-harm, not just declared as suicide, but self-harm that contribute to it.

We are currently in seven communities, many of them represented here, and we will add another seven in the next year.

When the four-year project is done, we hope to understand the context and work closely with all of our benefits. One of the issues that we are facing, and then I think all of us face and I know VA faces, is understanding is having DoD provide us with what does the data look like in terms of the service, specificity of service-related data of those who took their lives as veterans.

I want to thank the Committee for allowing me to testify and I look forward to your questions.

Thank you.

[THE PREPARED STATEMENT JAMES R. LORRAINE APPEARS IN THE APPENDIX]

The CHAIRMAN. Colonel Lorraine, thank you, sir.

Mr. Mulcahy, you are recognized.

STATEMENT OF BILL MULCAHY

Mr. MULCAHY. Chairman Roe, Ranking Member Walz, and distinguished Members of the Subcommittee, thank you for the opportunity to testify on the challenge of preventing suicide among our veterans.

My comments today are informed by the cohort who is most at risk. Behind me today is the Co-Founder of Guard Your Buddy, Cindy Sheriff. I would ask her to stand just for a moment. She is my buddy today in case I need her help.

In 2012, Guard Your Buddy was launched in the Tennessee National Guard in response to General Max Haston's mission to stop the suicides. A seasoned health care executive, Cindy accepted this assignment, and drew upon our backgrounds and professional colleagues to team with the Jason Foundation to create a clinically sound solution to the General's request. We are proud of Guard Your Buddy's impact in Tennessee, and we appreciate the opportunity to share with you what we have learned and hopefully expand Guard Your Buddy's capabilities to all veterans.

Guard Your Buddy is strategically focused on two priorities: suicide prevention and intervention. With Guard Your Buddy's smartphone application, Guard Service members and their families are directly connected to a master's level clinician who can provide immediate intervention and support. Professional help is literally a click away.

Guard Your Buddy is unlike other suicide prevention programs that are accessed through an 800 number. It is critical that individuals contemplating suicide have immediate access to professionals who provide in-the-moment support. Clinically, the window for successful interventions are during that initial outreach. Once the crisis is resolved, Guard Your Buddy clinicians will continue to assist with other resources within the National Guard and their local communities.

Our clinicians become the personal advocates for the servicemembers and/or their families by helping them get their lives back on track.

We are wholly supportive of national crisis lines to address a wide variety of concerns for millions of our veterans. However, a

suicide crisis requires a unique, dedicated solution. It is unrealistic to expect a suicidal person to have a crisis line number memorized or readily available at that moment in need.

As the name suggests, Guard Your Buddy supports the strategy of connecting someone, their buddy, or loved ones in need with resources immediately. Since implementing Guard Your Buddy with the Tennessee National Guard, suicides have been reduced an average of 68 percent annually since 2012. As we know, 2012 is recognized as the peak for active component military suicides and Guard Your Buddy's baseline year for program outcomes.

General Haston asked us to share with the Committee his thoughts as follows. Since 2012, the Tennessee National Guard believes that over 85 men and women of the Guard have been talked off a ledge or possible prevented from hurting themselves by using the Guard Your Buddy app technology. The Guard Your Buddy program provides real help in real time.

When that master's level clinician answers the telephone, you don't get forwarded to someone else and that makes a difference.

The last 5 years is referred to as the new normal because active component suicide rates remain stubbornly high and have not receded to expected levels. That is not the Tennessee National Guard experience. We reject this inevitably and hope Guard Your Buddy's model will be considered as another tool available to all of our veterans in time of need.

Imagine for a moment a Guard Your Veteran initiative with a foundational community approach similar to Guard Your Buddy and what we have heard today. The Guard Your Veteran strategy will involve community-based groups, religious organizations, Wounded Warriors, and existing veteran programs such as the Readjustment Counseling Service. Guard Your Veteran will save our veterans' lives using the proven Guard Your Buddy prevention and innovation strategies with tactics adjusted for demographic differences. Guard Your Veteran's goal will be to reduce veteran by 34 percent within the first 36 months of implementation.

Guard Your Veteran adjustments for veteran demographics include the following. Leadership, convenient access, educational outreach, and triage. Most importantly, branding. We have to create a consensus around the country to address this issue immediately.

Collaboration with veteran leadership organizations at all levels to achieve the mission stop the suicides. The Guard Your Veteran program design considerations would include the fact that suicide rates for veterans are highest during the first 3 years out of the military; 70 percent of veterans who commit suicide are not under VA care; suicide rates are 16 percent higher for veterans who never went to Afghanistan or Iraq; and approximately 65 percent of all veterans who committed suicide were 50 or older.

Guard Your Veteran solutions will be multidimensional with different sectors, young and old, working together every day. Suicide prevention is everyone's job.

We appreciate the invitation to address this Committee and the opportunity to share our experiences about Guard Your Buddy and the Tennessee National Guard. We look forward to your question and thank you for your time.

I would like to read to the Committee and everyone in the room just an example of a letter that we got. "This is not an urgent matter. I just wanted to say thank you for helping me in my time of need, as well as my brothers and sisters. You are all very important, you are all a very important part of the military community and I thank you for your service from the bottom of my heart. P.S. your hard work saved four of my buddies, including myself."

[THE PREPARED STATEMENT OF BILL MULCAHY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Dr. Franklin, you are recognized.

STATEMENT OF KEITA FRANKLIN

Ms. FRANKLIN. Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. I appreciate the opportunity to discuss preventing veteran suicide.

I think you know that I am accompanied today by Michael Fisher. He is our Chief Officer of the Readjustment Counseling Service. He is also an Army National Guard veteran from OIF.

Please know that I accepted this position back in April of this year. Like many in the room today, the military has always been a significant part of my life. My father is a 20-year Navy enlisted veteran and my husband is an Air Force veteran.

Prior to joining the VA, I did serve as the Director of the DoD's suicide prevention program. My Ph.D. course work focused on deployment in the heat of the war effort and trauma impact on families, particularly marital relationships and parenting of children. So, my background as a clinical social worker, I have focused on child welfare, I have focused on programs in the military sector around domestic violence, sexual assaults, substance abuse, combat operational stress, before narrowing in in the field of suicide prevention. I am also the proud mother of two, Lexie and Trevor.

And we know and it was mentioned here already this morning that suicide is a serious public health concern; it affects communities across the country. Like all Americans, I have seen firsthand the irreversible impacts on communities, on families, on workplaces, in our Federal buildings across the Nation. I can say without hesitation that suicide has had devastating and long-lasting impacts.

I myself have learned from survivors of suicide that the loss, the pain, the guilt, the emptiness, it never goes away. So, despite this comprehensive a loss, the survivors have tremendous courage. They share their stories with us, they recommend solutions, and while they know they can't change the past and bring their loved one back, they are here to help us to change the future; they want to help us prevent this from happening with anybody else.

They are the individual voices and stories that keep me committed to this mission of eliminating suicide among our Nation's veterans.

At VA, we ground our work in the truth that suicide is preventable. Zero suicides is and must remain our ultimate goal. So, with this in mind, I am prepared to talk to you today also about the recently released IG report. I heard this morning about Justin and,

if his parents are in the room, know that I am happy to talk to them and I would want nothing more than to learn from their son's story, and to have them inform our policies and the way forward.

You have likely heard the figure—and it was mentioned this morning—about 20 veterans a day. It is a number that has remained regrettably stable since 2008. And I want to break this down, because it is important for how we understand the way forward.

Within the 20 deaths per day, we know that six of the individuals have received VHA health care in the last two years leading up to their death, and we know that the other 14 have not. Within these 14, the VA has also consistently reported on servicemember deaths. So, it is about one a day when you run the math by 365 days. So, we have also reported on deaths of former servicemembers who don't meet the Federal definitions of "veteran." So, I want to talk to you more. I am happy to share more about that today.

So, when you hear this figure of 20 a day, I encourage you to think about it as 20 current and former servicemembers' deaths per day. And from our perspective, when it comes to preventing suicide, we are committed to saving lives among all those that have worn the uniform, so our approach must embrace the full 20.

We are working, as you see today, with like-minded partners across numerous sectors, a few here at this table this morning, and including other partners across the national Federal space, health care, the faith-based industries, community-based organizations.

If we are going to be successful in the VA, we must prevent suicide among all veterans, including those who do not and may never seek VHA health care. This is an immense task, but one that we fully accept and that we are fully equipped for. It will require an expansion of our existing approach.

VA has long been a leader in suicide prevention and has historically focused on providing crisis support for veterans at imminent risk and helping them access mental health care. We know that crisis support, and mental health care are vitally important parts of the solution, but alone they are not enough.

We know that to end veteran suicide we must think about how to support veterans well before there is a crisis. We need to find new and innovative ways to deliver the support and care to the entire 20 million-veteran population. This philosophy is at the heart of our new public health approach, which is outlined in detail in a recently published national strategy for preventing veteran suicide, which was created to help guide the Nation in preventing veteran suicide over the next decade. This strategy is consistent with the U.S. national strategy, as well as the Department of Defense strategies for suicide prevention, so that we can ensure that our efforts align and are in concert with the broader issue going on across the Nation.

VA recognizes the important role that we play in this work, but we also recognize that we can't do it alone. This strategy reflects VA's vision for a comprehensive approach that involves many different sectors working together to achieve 14 shared suicide prevention goals.

Our framework developed by the National Academy of Medicine considers three levels of prevention. It focuses on making sure we are providing services to all 20 million veterans, it calls for us to dig in deep on those groups that we know are at preexisting levels of risk, and then dig in even deeper for those individuals that are at risk.

I also want you to know, the national network of over 300 Vet Centers and 80 mobile Vet Centers in over 950 community access points under the leadership of my colleague here, Mike Fisher, works alongside our 400 Suicide Prevention Coordinators across the Nation, and I am just excited for you to hear more about that work and dialogue.

But at the same time, I know that we have much work ahead of us, Mr. Chairman. I have seen the public health approach in action, I am confident that it can be successful. I appreciate the Committee's continued support and encouragement as we identify challenges and find new ways to care for veterans, and my colleague and I are here, prepared to answer anything, questions you may have.

[THE PREPARED STATEMENT OF KEITA FRANKLIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Franklin. And I am going to before I turn my clock on, I am going to take a point of privilege as the Chairman of the Committee.

And this will be our last Committee hearing before some leave the Congress, and I want to just personally as the Chairman of this Committee thank every Member of this Committee. I look around, and I belong to other Committees, and I don't see the participation has occurred in this Committee. And I want to thank you here personally for passing 70 bills to help our veterans out of this Committee onto the floor, over into the Senate, 26 of which these bills are signed into law.

When we leave Congress, when all of us leave here, I think you can leave with some pride with knowing that your time here was well spent.

And I want to say one thing about my good friend Tim Walz here, who is leaving Congress after many years of service and he hopes to continue his public service in his state, and I want to personally thank you, Tim, for the work you have done. You have sat here at the end of the dais and you have sat at the head of the dais, and I can tell you personally it has been a privilege to serve with you.

And I just wanted to take that point of privilege and thank this entire Committee for the work, the tremendous work that you have done.

Mr. WALZ. Thank you, Mr. Chairman.

The CHAIRMAN. Now you can turn my clock on.

[Applause.]

The CHAIRMAN. You know, I think this hearing is an incredibly important hearing and what I look at, five experts in the field of suicide prevention.

And I look back from 2004—and I spent over almost four decades of seeing patients, and I look at the expertise that is sitting in front

of me and then I realize how fragmented our mental health system is in this country.

If you are in an ER, if you work in emergency room in Tennessee, Kentucky, I don't care, California, and you are sitting there and you get a patient in extremis, you are concerned about that patient committing suicide, you don't really have anywhere to send him most places. You don't have the resources and yet we have gone from spending $2.4 billion in 2003 to I think $8 billion this year on mental health in the VA, that is just in the public side. We just passed in this last budget $8 billion for opioids, and we know that opioids and addiction very much are mental health, that there is many times the same issue, just using a different mechanism, whether it is on the civilian side or the public side.

And what I want to do when we leave here today is, we want to continue a roundtable discussion, which I find probably more helpful than even the hearings that we have here, about how do we coordinate all of this. If we are spending all this money and effort, I mean, incredible programs that you all set up, why is the rate still 20? Why is it still—we have not moved the needle? That is so frustrating to me to realize that we are either not getting the information out—and I want to start out with Guard Your Buddy, with Mr. Mulcahy.

When General Haston came to me and he said, he mentioned that I think in the first month, 6 weeks of his command, he had four suicides the first 40 days. He said we have got to do something. So the Tennessee Guard put this in. It reduced, it looks like, the best they can calculate, based on data compared to other Guards, they have reduced almost 70 percent. Why aren't we doing that in every Guard, in every state, in every Reserve unit in the United States? Why hasn't that been done?

Mr. MULCAHY. Can we take a vote on that right now?

[Laughter.]

The CHAIRMAN. I am just simply asking. It is not an expensive program.

Mr. MULCAHY. No.

The CHAIRMAN. And that is the thing that impressed me was it is functioning. I have been to Canandaigua, New York, and been to the call center, and those folks are trying the best they can. I have been there. And I asked them when I was there, don't we need to study is what you are doing successful, because if it is not, then we need to change and do something different.

I am going to open it up to any of you. How can we better coordinate all of these amazing—I mean, you all are amazing people doing the work you are doing—how can we coordinate that?

Dr. Brown, we can start with you, or Colonel Richardson or whomever.

Dr. BROWN. As I mentioned in my testimony, I think one of the things that we can do is to assess the quality and whether the programs actually work. I am a scientist. I am a researcher, and we can use scientific methods to find out does the intervention reduce suicide risk.—

The CHAIRMAN. It works, I agree.

Dr. BROWN. We need to identify evidence-based interventions to reduce suicide risk or prevent suicide, and then implement it. And

if it is successfully implemented, that is great, but we need to monitor how well we implement these programs.

The quality of the implementation matters tremendously. Just like any other medical procedure that you would do, quality matters. And so I think, you know, we have to put in some resources into measuring quality and then providing additional training, you know, to improve quality.

Mr. RICHARDSON. Sir, and again as I mentioned in my remarks, it is going to take us all to do that, right? As you mentioned, the roundtable synchronization of efforts across the board. And there are some grassroots efforts of that happening already. As I mentioned, working with America's Warrior Partnership, working with the VA, working with the Travis Manion Foundation, Elizabeth Dole Foundation, to really focus on the mental health aspect of our warriors, as well as their family members, because we can't forget about the family members as well in this, because they are having their issues as well.

And so having hearings like this is really the opportunity to bring it to the forefront, to make sure it stays. It is not just Suicide Prevention Month in September, it is Suicide Prevention Month every day, every week, every month, all year long, and we can never stop talking about it in trying to find out which areas are working and leave the egos at the door and come together, so we can better the environment for our veterans and their families.

The CHAIRMAN. Well, I am going to cut myself off right now. And I have been instructed by the Sergeant Major to not start at the front, but to start with Mr. Peters at the end. So you all have to wait here at the front.

[Laughter.]

Mr. PETERS. Thanks very much, Mr. Chairman. I love these days. We are going to miss Tim Walz for calling on me first, but for a lot of reasons. You have been a tremendous Ranking Member. And it has been a pleasure, by the way, to work on this Committee, which is a model of bipartisanship.

And all of us here today are deeply concerned about the gravity of veteran suicide. We are all troubled by the idea that our servicemen and women might return home from battle, survive battle, only to take their own lives because they are tortured by something they experienced during their service.

Many of us have someone in mind as we tackle this tough subject. I wanted to mention the Somers family who are here right now. I know you have met them. Their son, Daniel, served valiantly in Iraq, including multiple combat missions, that caused severe post-traumatic stress and traumatic brain injury. Caught in the back load of veterans' cases at the VA in Phoenix, he didn't get the care that he deserved, that he had earned, and tragically he committed suicide at 30 years old. And as his mother said, if he not met so many obstacles, would my son be alive today?

Dr. Howard and Jean Somers, they are now tireless advocates for fixing and reforming the broken health care system at the Department of Veterans Affairs. I think they would rather be taking vacations and traveling places other than Washington, D.C., but they are always here on the Hill and we are honored to work with them,

but it is tragic that it took a parent's loss to draw this to our attention.

San Diego has the third largest population of veterans in the country, about 235,000 who call our region home. And we now know that veterans experiencing homelessness are at particular risk for suicide. So veterans who haven't experienced homelessness have a suicide rate of 35.8 per 100,000, but suicide rates are 81 per 100,000 for veterans who have been homeless in the last year, and that is more than twice as likely.

So I wanted to put in my plug for making sure that we understand that if we prevent homelessness, we can help prevent many veteran suicides. We have to preserve and expand resources to homeless vets, including HUD–VASH vouchers which provide crucial support of housing. And I am relieved we were able to stop the VA from thinking about taking that money away from homelessness funding from the HUD–VASH program, which we did last year.

I did also want to say, we want to make it not harder to access care, we want to be actively working to reduce the stigma, to increase the outreach.

So I had two questions, I think, Dr. Franklin, probably for you. And it is how the VA uses data to intervene early and what data comes through. In particular, what information are you receiving from the DoD, the Department of Defense, about exiting servicemembers in their transitioning screener? So how would red flags be conveyed to you and what are the obstacles for you getting that information?

Ms. FRANKLIN. It is a very good question and thank you so much for the opportunity to talk about this important topic in terms of the intersection between DoD and VA.

Primarily, what we are getting in terms of data is heavily reliance on medical data. So, the channels are cross-walked, and we are getting clinical records and medical data. Where I think there are areas for improvement are data points that might not be as medically focused.

And so, things that we talk about if we were able to do better in this space—it would be focused on more personnel data. So, did they not deploy? Did they not get promoted when they intended to? You can see how that can be a very quick risk factor when they have perhaps fallen from glory within the unit. Did they have an Article 15 while they were on Active duty? Did they go through a rough divorce?

These types of personnel factors that are sometimes known to the system because they are in a record and sometimes known to the small unit leader, we could do a lot more, I think, in the care for them while they are veterans if we had that good, rich information.

Mr. PETERS. I think it would be helpful going forward if you identified what you needed from the Department of Defense, and we could go check and see whether that information is coming out as part of the screening.

Ms. FRANKLIN. Yes, sir, very well.

Mr. PETERS. The other thing I want to ask you about, there was a recent report by KPBS in San Diego that said that only 115 vet-

erans nationwide are enrolled in a suicide prevention program targeted to vets with other-than-honorable discharges, and of those 115, 25 went to San Diego VA.

I would like to know what the outreach for this program looks like or how you would like to see it changed?

Ms. FRANKLIN. Yes, this is another very good question and top on our mind at the office as well—other-than-honorable. You know, we've made great strides since this first got passed and we started rolling out with this work, we made great strides to put the word out. So, we brought all of our VSOs in and we asked for their help to reach out to their millions of veteran constituent groups, and fact sheets and Q&As, and we did all of this good work. And some time has gone by, and now, with the new omnibus coming out, we need to refresh it.

And one of the things that we are working on is bringing in veterans themselves to really help us talk about how to market that, so that we are using the right words and that we are doing the outreach in the right way. So that family members in particular we think are part of the equation, like they may not recognize it, but a family member will help and help get them in. I don't know if you guys—

Mr. PETERS. My time is up, but if you could, you know, sort of brief me in particular, but the Committee on what—

Ms. FRANKLIN. Yes, sir—

Mr. PETERS [continued]. —you are doing about that, we would love to hear about it.

Ms. FRANKLIN. —I would be pleased to.

Mr. PETERS. Thank you. I yield back.

The CHAIRMAN. Chairman Bost, you are recognized.

Mr. BOST. Thank you, Mr. Chairman.

Dr. Franklin, first off, I want to say thank you for the work that you do over here, over here. So I want to thank you for the work you do and the work the others do.

But whenever Mr. Mulcahy gave his testimony about Guard Your Buddy, in April he mentioned that the program emphasizes the use of Master level clinicians. What are the requirements for those that take those calls? What does the VA set as a standard that their background should be?

Ms. FRANKLIN. Thank you for the question. Are you talking about our Veteran Crisis Line?

Mr. BOST. Yes.

Ms. FRANKLIN. Okay. So traditionally the standards are—the field has grown in this respect, so this is relatively new in the last few years—the standards are a masters. So you go through a standard graduate program and then you become licensed. And so, that typically takes up to, depending on whether you are in the field of social worker psychology, between a year or two, where you work under somebody, and they guide, and they sign off on your work. And then you take a test and, upon completion of the test, then you are licensed and then you can operate at the independent level.

Mr. BOST. Just so I am—I know that there were some adjustments that needed to be made and recommendations that OIG and

GAO, how are you implementing the requests by them? Is there some implementation being done there as well?

Ms. FRANKLIN. Yes, sir. Yes, sir, the Veteran Crisis Line has undergone great strides in many respects as a result of working with this Committee and closed out all of their IG and GAO recommendations. And they are in a good, healthy place as an organization but continue to need to be oversighted and monitored so that that stays in place.

Mr. BOST. Okay. My next question, I am going to stay with you on this, in my district we have a number of organizations that work with veterans with symptoms from PTSD, mental health illnesses, and they work to reduce veteran suicide. One that I am especially involved with and understand is something that is called This Able Vet. Now, there has been like three college studies done on the success of This Able Vet. It is a program where they train them with a service dog, okay?

And it allows our veterans—because even in your testimony, you highlighted that the veterans are resilient and they are, and they have a strong sense of belonging to a unit, and what this does is this—what this group did is it discovered that and their research finds that when veterans leave service, you know, as veterans we are taught to take charge, be in command, boom, boom, boom, right? And this is in a case where, okay, they give them a companion dog and, if something happens to the dog, then they are upset or whatever. It gives them a purpose to take care of that and hold that mission of the dog. So it is different from that aspect.

So my question is, what groups like this are you working with that have success rates, or do you do that? And where are we reaching out, because, yes, the VA is trying desperately to help with this, but there are other groups and organizations that are trying to help to, and which ones are successful and how do you check that and everything?

Ms. FRANKLIN. It is such a good question. At the heart of our model is partnerships, and so then when you drill down within the partnership sort of framework, working with partners around the service dog issue is absolutely part of the solution.

You know, there will be people in the field, the researchers or people like that will debate the merits of service dog, caring, comfort dog, this, that, and the other. I don't myself engage in that kind of debate. I think that if a veteran tells us that something helps them, it helps them, particularly if we know that it does no harm. Certainly, there are studies underway, sort of testing that and that sort of thing. But partners are partners, and we cannot do it alone, and we need any and all type of partners. I particularly am also interested in pursuing nontraditional partners.

So, we have in some cases worked with who we have worked with for quite some time and we do have to turn our heads, I think, to the left and right and find new partners that perhaps we haven't worked with for quite some time. And they do undergo a certain vetting process, particularly if we are going into a formal agreement with them in the context of an MOA or an MOU; it has to go through legal review and there are a number of hoops, but that is all worth it when it comes to bringing them on board arm-in-arm with us to save lives.

So I am not familiar with the one that you mentioned, but I wrote it down, and my staff are here, and they are likely already pulling it up.

Mr. BOST. I think you will be surprised on what they do do. But thank you, thank you for being here today.

And with that, I yield back.

Ms. FRANKLIN. Thank you.

The CHAIRMAN. Thank you.

Ms. Esty, you are recognized for 5 minutes. And I hope I still get Christmas cards since I am going backwards here. It is his fault.

[Laughter.]

Ms. ESTY. Absolutely. And, again, I want to thank the Chairman and Ranking Member. It has really been a pleasure and an honor serving on this Committee, and in a very fractious time in the Nation's political life, it has really been gratifying to see the good work that we have been able to do together. So I want to thank both of you and wish the Ranking Member in particular safe travels as he returns to Minnesota, in the district I grew up in.

We are all very concerned about these issues, and I think frustrated and worried about the obstinance of those figures staying where they are despite great effort. Everyone in this room, those of you at this table, and allies around the country. So we clearly need to do better and there are things afoot that we don't understand yet.

So in that spirit, I think this is not about casting blame, but continuing that search for greater effectiveness to support each and every veteran and each and every family when people return.

In thinking about these issues, I think it is also helpful to look to other populations that could help us. The Israeli Defense Force recently did a study looking at suicide rates there and concluded the number one factor was access to firearms. And in full disclosure, I represent the town of Newtown. I have spent a great deal of time trying to figure out what to do on these issues, and I have a very large veterans' population in my district.

And looking at effective ways, recognizing in our country we have the Second Amendment, which I am supportive of, but we need to find—for men in particular it is a huge issue, 66 percent are using firearms and the access that veterans have to firearms is pretty great. I have personal friends who have had children, and this has been an issue in their families. We had calls into our office and had to talk people down and get folks there.

So this is for all of you. Mr. Mulcahy, I know on Guard Your Buddy, there have been programs, Phoenix has tried a program of, you know, give your gun to a buddy, trying things outside maybe a formal legal process. So that's one thing I would like you folks to address what your thoughts are, again recognizing legally there may be some barriers, but we do know that immediate access. I think having the app in a pocket has got to be the sort of thing that we look at, because people aren't going to remember the number. They may not actually be a veteran by technical terms, we need to empower them.

And the final one, which we have talked about a lot about on this Committee, is the importance of a warm handoff between DoD and the VA, and in particular looking at a check-in maybe 6 months

out. You know, we have the TAP program, we give people a lot of information, and we know a lot of it gets at best thrown into a drawer, because a veteran wants to go home and see their family. And when those resources are really needed is later and then they don't even know where that file is.

So if you could, anyone who would like to address the firearms issue, creative approaches around that, continuing to use things like apps, and what do you think the value would be of having some kind of mandatory check back in 6 months out maybe—or sometime within the first year, but maybe 6 months to check in and see how things really are going, and people may be open to and aware they need help at that point, or family members may see.

Thank you.

Mr. MULCAHY. I think the data is pretty conclusive that firearms are the primary vehicle, number one; number two, I think the most recent data would indicate that suicide amongst women has really become a big problem recently and firearms are kind of central to that. That is a much larger discussion than my pay grade for this discussion today, but I think it is really clear that that is a problem.

What we focus on is—and let's just say firearms is the, you know, vehicle of choice, if you will, the key is that we have learned—and my background is in population health health care, Cindy's background is in behavioral health care, so we see this as a puzzle. And the way we came at this, I mentioned that the cohort that is most at risk is the cohort that actually helped us develop this program. We talked to those 20-year-olds, 22-year-olds, 25-year-olds, General Haston brought them in. We said help us understand what you see, because they know people that have either committed suicide or who are in trouble.

So from our perspective, the singular moment that we had to focus on to make an impact on the numbers was in that moment when that person is moving from ideation to, I am actually going to do something about it. And what they do at that moment is they typically reach out to somebody. It could be a flippant comment, it is not necessarily a declaration of this is what I am going to do, it is a signal. The problem across the country is that we don't know what to do with that in that moment. And, Dr. Brown, I don't know if that is your research, but that is our experience, that if I were to tell you that, you know, you would know what to do with that, but most people don't know what to do with that at that moment in time. Over half of our referrals to our call, if you will, comes from the buddy, not from the person who is actually suicidal, it is a family member.

And when you look at population health risk at large, risk in population, the earliest sign of risk is psycho-social. So all the things that Dr. Franklin was talking about that creates that risk, that anxiety, that depression, that builds that puzzle into a picture where somebody is going to do something. What we focus on is that moment. There is a lot of good other ideas around the table, around the country, but if you were to say why do we think our program has worked well, and it has not been successful, because General Haston asked us to stop the suicide. You know, we had one quar-

ter, you know, we were able to do that. But the reason is recognizing that there is a brief window to intervene and then, as General Haston said, talk them off the ledge and then get them the help that they need.

Ms. ESTY. Thank you. And I'm so sorry, that is over. But thank you—

The CHAIRMAN. No, that's fine—

Ms. ESTY [continued].—that was very illuminating.

The CHAIRMAN [continued].—that was a good discussion.

Dr. Dunn, you are recognized.

Mr. DUNN. Thank you very much, Mr. Chairman. I thank the panel as well.

Please, I am going to start, if I may, with Dr. Brown. My staff and I had the opportunity to visit Florida State University recently and they are working, they are doing a lot of research in veterans suicide, and they are using, at least in one other experience, virtual reality and advanced monitoring technology to study individuals as they deal with stress, as they deal with situations, they put them in stress, and then they design a response tailored to that individual so that they develop resilience and a much more well-being sort of focus on that.

Their problem is that they see no translation of their research into clinical practice. How can we help these advances of whatever type they are, wherever they come from, into clinical practice in the evidence?

Dr. BROWN. Yeah, I am a big advocate for using technology to individualize suicide prevention strategies that may help. We are just at the beginning stages, from a research perspective, in understanding how, and if these interventions work.

Mr. DUNN. What can we do to help here in Congress?

Dr. BROWN. Excuse me?

Mr. DUNN. What can we do here to help here in Congress?

Mr. BROWN. Well, we need to fund more research to develop these programs. Once we develop the intervention, do they actually work, and then if they work, how do we best implement them.

Mr. DUNN. And my question is, how do we get it into the clinics, right? Okay, so we have some research, we think it works, we need to get that into the VA. Is there—I mean, who do I call?

Dr. BROWN. I will maybe defer to Dr. Franklin about that.

Ms. FRANKLIN. We have a dissemination process and a pipeline that goes that when studies and results come to bring to bear and have positive results, that we look to generalize them as quickly as possible across the VA. There are likely areas for improvements—

Mr. DUNN. I want to work on that with you.

Ms. FRANKLIN. Okay.

Mr. DUNN. We also have the VA Health Subcommittee. So we are going to work on that together going forward, because I think—

Ms. FRANKLIN. Dissemination to practice, yes, sir.

Mr. DUNN. Yeah, I think that is something we can do better with.

Now, Mr. Richardson, in recent years we have seen Active duty suicide rates normalize, but it remains high for VA. And I wondered, does this speak to how critical it is for our veterans to con-

tinue to feel a sense of mission and connection to a social network as they transition out of the service.

Mr. RICHARDSON. Yes, sir, great question, and that is absolutely critical. Again, doing 32 years myself, the sense of purpose that entire time, from the time I was 17 and 32 years later I retired, and I get that now with Wounded Warrior Project. And not all of our veterans have that opportunity to find that sense of purpose.

Where we find the real challenge is when they go back home, back in the communities. It is not immediately right after, it is as it manifests itself. And so that is where it takes us to be involved in the communities—

Mr. DUNN. So I think you mentioned in your testimony one of the groups that is helping veterans with that transition, the Mission Continues. Did you—I think I heard you say that.

Mr. RICHARDSON. Yes, sir, Mission Continues is one that we partner with as well and, again, when there is disasters or, you know, in communities helping build houses, et cetera—

Mr. DUNN. Team Rubicon, stuff like that?

Mr. RICHARDSON [continued].—Team Rubicon with disasters, exactly.

Mr. DUNN. So I think we do, I think we want to turn more proactively. The conversation changes from suicide to proactively communicating well-being and resiliency in our veterans.

I wanted to ask a question, Mr. Mulcahy, if I can. There is a concern among Active duty personnel that reporting mental health issues or seeking help jeopardizes their career. And it does, let's admit that. So, in effect, in the DoD end of the spectrum now, so they are still on Active duty, we respond to their call for help by bayoneting the wounded. What can we do to address this in our Active duty population?

Mr. MULCAHY. That is a great question. Early on with Guard Your Buddy, as we learned the protocols within the military, there was a big question about confidentiality, and it was clearly the largest obstacle that we were engaged with in talking with the servicemembers about the program. And we worked with General Haston and we, you know, created a way in Tennessee where there was a level of confidentiality when people reached out to Guard Your Buddy.

Mr. DUNN. You mean legally, you actually made—

Mr. MULCAHY. Yes.

Mr. DUNN [continued].—the medical records somehow so confidential it did not invade their career?

Mr. MULCAHY. Yeah, we kept it confidential, and that made a huge difference. We actually, another group, a group that we partner with in Tennessee is the Jason Foundation, they have a golf tournament every year, and at that golf tournament when Cindy and I were there, people will come up to us and they will say, you know, thank you for the program, we have to tell you, it is working because it is confidential. They are concerned about that type of information getting out, they are concerned that it could impact their ability to advance.

There are a lot of concerns around that, that is a huge stumbling block.

Mr. DUNN. I agree. Our time has run out, but thank you for underscoring that. I am not really ready to take up golf yet, but thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Dunn.

Mr. Lamb, you are recognized.

Mr. LAMB. Thank you, Mr. Chairman.

Dr. Brown, first of all, I am a proud graduate of your university. So thank you very much for your hard work on this. You have made us really proud.

You talked about trying to replicate and prove the findings of some of your research on cognitive therapy. It seems like your research has mostly been on DoD populations and could you explain a little bit about the limitations of that study or maybe some of the challenges we would face going forward to expand it to others?

Mr. BROWN. Yes, actually my research for cognitive therapy for suicide prevention was with non-veterans, non-DoD people, but David Rudd did do a study with Active duty military—

Mr. LAMB. Correct.

Mr. BROWN [continued].—soldiers at Fort Carson, and he found that using a similar intervention was very effective in reducing subsequent suicide behaviors, you know, in that population than those who didn't receive the program. Now there is a replication underway in the DoD just launching now to replicate the studies, which is really important, because if we have replicated studies, we can definitely say these programs work, so we have got to get them out there. So replication is crucial to raising awareness about interventions that we know works and how to disseminate them.

Mr. LAMB. Thank you. I guess what I am getting at is the challenge of replicating this within the veteran population, knowing some of the unique circumstances of veterans' lives as opposed to someone who is on Active duty within DoD right now. Can you speak to the importance of data tracking and electronic health records as they might relate to how we use the VA system to learn more about this?

Dr. BROWN. So I just got done—I haven't published the results yet, but I just got done doing a study with suicidal men in VA using the cognitive therapy intervention. It is currently we are in the process of doing analyses. The VA is a wonderful place to do this research, because they do standardized assessments, they do follow-ups, it is easy to engage providers in care and get referrals. So it is a really beautiful place to do this type of research.

Mr. LAMB. Thank you.

Now, Dr. Franklin, have you been involved at all or met with the EHR Modernization team within the VA?

Ms. FRANKLIN. No, sir.

Mr. LAMB. Okay. Are you aware of what I am talking about? There is an effort underway to basically modernize the electronic health records—

Ms. FRANKLIN. Oh, yes, I am absolutely aware. I have not met with them personally, but I am absolutely aware of the initiative, yes, sir.

Mr. LAMB. Okay. I would encourage you to do that and maybe if you would like to meet at some point to go over that. I see this

as an important tool in the fight against veteran suicide when it comes to data tracking.

Dr. Brown, you mentioned kind of the most successful model has to do with doing the safety planning first, then having follow-up phone calls, then having follow-up care, and it leads to fewer behaviors. I would imagine that a well-functioning electronic health records system is integral to that; would you agree?

Mr. BROWN. I totally agree. And the better that we can identify suicide behaviors and note them in the medical record reliably, that is going to help us evaluate whether these programs are effective or not. So, absolutely.

Ms. FRANKLIN. And this notion of, from an 18-year-old soldier all the way through end of life, to be able to track that in a consistent way, there is nothing but good going to come from that.

Mr. LAMB. Exactly. Well, and I guess that is what I am hoping is that, with your expertise, you can play a role in making sure that the needs you would have as a professional in this space are actually being baked into the EHRs that will be used in DoD and the VA. I mean, we don't want to get to the end of this product rollout and realize there are things that you needed in there that—

Ms. FRANKLIN. A piece or a part, yes, sir.

Mr. LAMB. Yeah. So I would encourage you to do that and let's stay in touch—

Ms. FRANKLIN. Will do.

Mr. LAMB [continued].—about that.

And with that, Mr. Chairman, I yield back. Thank you.

Mr. DUNN. [Presiding.] Thank you.

Next I recognize the gentleman from Florida, Mr. Brian Mast.

Mr. MAST. Thank you, Chairman Dunn. And I note Chairman Roe had to move on, but I think there were some pertinent comments made by people on both sides that really recognize the jurisdiction between both Veterans Affairs and Armed Services, and I would just love to recommend or ask that it be considered that we do have a joint hearing between Armed Services and Veterans Affairs, because there should be a seamlessness that exists between that Active duty, that Guard, that Reserve service, and somebody moving into the veteran status, and I think that that would be beneficial. I would love that that be considered. So that is a request that I would like to make to you.

I have got to pull up my phone a moment now, because it timed out and I took some screen shots of some comments that have been sent to me over time and I wanted to read some of them, I am not going to disclose who they are.

"The hardest adjustment from being a soldier to now being a civilian is realizing that you are all alone and you no longer have battle buddies to lean on." That is one.

"I am just struggling with feeling worthless. I know I am not, but when something does go wrong it is hard to fight those thoughts. But I have got to retrain my brain and not let those thoughts in my head just because something went wrong. I am not worthless. I am a good person with a good heart. I am a child of God and I trust He has a plan for me.

"I am a failure, I am a loser, and I am tired of kidding myself that I can ever be more than that, more than what I was and what I am now. I am tired of being a disappointment.

"I am not feeling down on myself at all, but honestly dealing with mental health issues makes me feel like a wimp.

"I am not interested in"—I was referencing some specific cares that exist out there, some very similar to what have been discussed here today, and the response was, "I am not interested in that. I will leave that to somebody that's actually worth something. Me, I'm a POS, and that's been proven over and over again."

And I have comments that continue more and more and more. And I find as I deal with this year in, year out, that those friends of mine that are struggling with suicide are constantly struggling with what is their value. What is their worth in this world? What is their worth to us as their friends, what is their value to their family members? What is their value to this world, to their employers?

I am not a medical doctor, and this isn't what I study as my livelihood, but that is what I see across every message and every phone call that I get from a family member or a veteran or a mother that is worried about, you know, her son or her daughter.

And so I have a question for all of you. Do you have anything profound or something that I haven't thought about, or the panel hasn't thought about to say how do we make sure that our veterans know their value? Because that is what I see them struggling with.

Lieutenant Colonel LORRAINE. Congressman Mast, if I can, I have listened to the comments and the questions and one common thread amongst them, including yours, is the community-based. You can't push purpose from Washington, D.C. down, it has got to come from the community up.

The community has an enormous amount, all of your constituents have an enormous amount of ability to reach out and connect to veterans to bring them up. The fact that 21 million veterans are out there and that the VA, we know 9.7 million. And when you look at the other Veterans Service Organizations that are great, you know, 140,000 veterans post-9/11, but there are 5 million that served post-9/11.

I think the focus is that it has got to be from the community up. How do you empower communities to reach out and give veterans a purpose, give them opportunities to move forward? I think it has got to start there through other resources.

Mr. FISHER. Thank you for the question. I actually want to talk a little bit about what vet centers do in that space and that is first it starts with outreach. It is going out and finding these kind of individuals. I look at my own experience. I am here today because a vet center counselor wouldn't let me shut my barracks room door on him until I came and talked to him. All I wanted to do was say no and he helped me say yes.

And that is what our outreach workers are doing and in partnership with communities, going out and creating those connections. It is not about evidence-based modalities at that time, it is about let's make a connection, a therapeutic relationship. And then from there, once we are connected, how can then we go on and provide whatever your goals are.

Now, one of the other things that we are doing within vet centers is that ability to meet an individual while they are on Active duty, be that force and start providing services to them before they meet our eligibility to help them transition through the veteran status into the next part of their life.

Mr. MAST. My time has expired, but thank you for your comments.

Mr. DUNN. Thank you, Representative Mast.

The gentleman from California, Mr. Correa.

Mr. CORREA. First of all, I wanted to say to Ranking Member or Governor Walz, thank you very much for your friendship and your guidance in this Committee. We are going to miss you. I know you are going to do great things as governor, so I am not going to say goodbye, but I look forward to continue working with you.

I know Chairman Roe is not here right now, but I just really thought his idea of a roundtable was excellent.

Personally, I served on the Veterans Affairs Committee in California for almost a decade and right now I am feeling a lot of frustration, because in terms of suicide, homelessness, unemployment, opioids, cannabis, VA wait times, Choice Act, education, mental health, stigma, we have been talking about this forever. And as Chairman Roe said, we are all throwing resources at these issues, but they are really uncoordinated.

The State of California, we are the home to the biggest number of veterans in the country, we are doing a lot of these things, yet I am not quite sure we are really coordinated with the Feds. Of course, private sector, I do believe one of the biggest issues when it comes to suicide is unemployment. A veteran comes stateside, can't find a job, things start going in a bad way. Maybe I am right, maybe I am wrong, but the point is a lot of this research that has been going on and we still have research that is going on, I would like that roundtable to bring in the private sector, how can we give these veterans jobs immediately.

And as I am thinking to myself, listening to all the great research you are doing, thank you very much for what you do, let's keep plugging at it.

We are talking about who is it that is prone to suicide and I think—I close my eyes, I think about all the veterans in my district, we have a lot of veterans in our district. It is like we have time triggers, not quite sure if it is going to hit you a year out or 10 years out or 15 years out. So we come back to the assumption has to be made that you come back with some serious invisible wounds and how are we preemptive in terms of assuring that we find those factors that may lead you in that direction.

Guard Your Buddy, I love the topic, I love the term, because all of us as human beings need to have somebody to turn to at all times in our lives, but especially I think veterans.

So my comment is, I will turn it into a question, what else can we do to bring Chairman Roe's vision of a roundtable to make sure we are addressing all these issues and not leaving any of these factors out?

Ms. FRANKLIN. I can go ahead and start on this. I think this is a wonderful suggestion and I am going to share it with Mr. Wilkie and Dr. Stone, our leadership, to talk about the VA serving as the

convening authority for something alongside and with support from this Committee. So, it is a great idea.

And suicide is very complex, and I particularly appreciate your idea around bringing private industry and public partners and nonprofit partners to the table, and just leave no rock unturned.

Mr. CORREA. And of course let's not forget the states.

Ms. FRANKLIN. Yes—

Mr. CORREA. And I will say—

Ms. FRANKLIN [continued].—yes, sir.

Mr. CORREA. —I am glad you wanted to convene it around the VA. I would like to convene it around this Committee, because our job is oversight and making sure everybody is doing their job.

Ms. FRANKLIN. Please, and we will be in a support role. Thank you. Yes, absolutely.

Mr. CORREA. Thank you. Any other thoughts from the rest of the panel?

Lieutenant Colonel LORRAINE. I think, you know, when you convene the roundtable, I think it is a great idea that communities are represented, that there is a local perspective of how to implement. I think suicide prevention amongst veterans occurs at the—as I said, I think it occurs at the community level. We have to understand more about it and then aggregate it up, not aggregate it down.

Mr. MULCAHY. I think it needs a branding, frankly. What I mean by that is, I think there are 1100 suicide prevention programs that are funded by the government, all well-intentioned, you know, but I think in this country people that are not part of those 1100 programs and a lot of other people think that their duty to address this issue is on a Sunday afternoon—I happen to be a Giants fan, that is probably sympathies from a lot of people, but—

Mr. CORREA. You are excused.

Mr. MULCAHY. Yeah, you know, you go to a professional football game or a college football game and they bring out somebody, you know, usually at some point in time, some individual that has lost a limb, you know, that has suffered horrific experiences in war, and 80,000 people stand up, they cheer that person, they say nice things about them or their family, they go walking back into the tunnel and 80,000 people cheer like crazy, and that is their duty for suicide. That is how we look at it in this country.

And when I say a branding, I think we need to bring everybody around the table and the roundtable is a great idea, but it has to be a consciousness in this country that when somebody hears something, like we say in airports, they say something, we have to create those bridges so that when those messages are sent by people out there that people know what to do with it.

And we have a lot of ideas around that, but I think we have to raise and elevate the issue that it is not just the 1100 programs or not just this Committee, it is everybody's issue out there.

Mr. CORREA. Thank you very much.

Mr. Chairman, I am out of time.

Mr. DUNN. Thank you.

Next, I would like to recognize the gentleman from Colorado, Mr. Mike Coffman, for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

In 2015, in Colorado Springs, the State of Colorado, a former Marine, combat veteran, Noah Harter, was suffering from depression and had suicidal ideation, was diagnosed with that from going and visiting a CBOC veterans' clinic in Colorado Springs. He was given a fairly powerful antidepressant that I think on the directions said that it required fairly close monitoring. He was not scheduled for another visit. He subsequently took his own life. And in looking into that situation, it was very hard to get answers from the VA, because they didn't want to admit that they had made a mistake. In fact, it was a physician's assistant, not even a physician that prescribed that particular, very powerful drug, psychotropic drug, antidepressant drug.

And in looking to that situation and having other veterans complain to me, it seems that VA is in a way part of the problem by having a drug-centric modality of treatment where it is a drug to sort of stabilize them, but then it is another drug to help them go to bed at night, then it is another drug to help them get up in the morning and, not too far along, they are given a cocktail of drugs. That is very dangerous.

We even had a situation that came to the attention of this Committee where a veteran moved, couldn't quite get his prescriptions redone, was then going through fairly dramatic withdrawal and took his own life there.

And so I have a concern to that. And, Dr. Franklin and Mr. Fisher, maybe you could address my concern.

Ms. FRANKLIN. Absolutely. We will start with Mr. Fisher?

Mr. FISHER. No, go ahead.

Ms. FRANKLIN. Okay, I can go ahead and start.

When you review inside the VA, whether it is in the literature or just inside our system, people who are on psychotropic medication are absolutely at increased risk, particularly as those medications, as they increase. And so, for example, when they are on two and three of them at the same time. And so, it is a great concern to us inside the VA.

And I would offer that we get to a place where we are looking at—noting the data on that. So how much are we prescribing, over what period of time, and do we have goals around that in such a way that it is not used as our main effort when there could be other methods used, like talk therapy, like community-based interventions, support structure? So that it is used when it needs to be used, but it is not necessarily the first and the go-to and/or only treatment method. And when it is used, it absolutely needs to be used in a safe and protected way where strong protocols are in place, after-care models where they are monitored closely.

And so, it is tragic to me to hear about this Noah and others that you mentioned in the State of Colorado, and we will work on this and make sure that we are pulling the thread in a better way, so that we have data to support medication rates coming down over time, just as they have in other fields.

Mr. COFFMAN. Mr. Fisher?

Ms. FRANKLIN. I don't know if you have something to add to that, Mr. Fisher, or—

Mr. FISHER. The only thing I would add to that is exactly what you said about talk therapy or what we do at vet centers, and that

is that ability to go out, create that individual relationship, individualized treatment plan, and really set—for us, readjustment is about setting a goal, helping that individual create a support structure around that goal to accomplish it, accomplish that goal and then identify another one, and then just do it over and over and over again in concert or collaboration with our medical center counterparts.

Mr. COFFMAN. Okay. Well, the Harter family has lost a son, and so I would suggest that the VA take a look at that, and instead of trying not to hold anybody accountable for failures, to get down to the bottom of it and try to make best effort away from a drug-centric treatment model.

Ms. FRANKLIN. I agree with you, urgency and accountability, yes, sir.

Mr. COFFMAN. Okay. Just a final point that one thing, these other-than-honorable discharges was a terrible mistake for the United States Army when we were drawing down from Iraq and Afghanistan to take combat veterans that had trouble adjusting from a combat environment to a peacetime environment and for minor infractions discharging them with no access to VA care, to include mental health care. And I was able to pass legislation out of this Committee to mandate that the VA provide mental health care to those with other-than-honorable discharges.

And I can tell you as the Subcommittee Chairman for Military Personnel in the House Armed Services Committee, I am working not only to review those discharges, but to make sure that our military never, ever, ever does that again in a draw-down.

I yield back.

Mr. DUNN. Thank you.

Next, I would like to recognize the gentlewoman from New Hampshire, Ms. Kuster, for 5 minutes.

Ms. KUSTER. Thank you very much, Mr. Chairman. And I also want to thank Mr. Coffman for that line of questioning and for his bill that I have signed onto with Mr. O'Rourke on VA over-prescribing practices as they are related to suicide.

I also want to thank Ranking Member Walz for his service and leadership, and you have been a great mentor to us, and to Representative Esty for serving on our Committee as well.

I just want to follow up on that over-medication and contraindication. In particular, Dr. Franklin, The American Legion has a statement for the record referring to the well-known contraindication for opioids and that is benzodiazepines, most often used to treat anxiety disorders that can be related to military sexual trauma, PTSD. Could you just speak briefly on the danger in combining benzodiazepines with opioids and what steps are being taken to alert VA practitioners to caution against that contraindication?

Ms. FRANKLIN. Yes, absolutely, I will tell you what I know. I am not a medical doctor, so I should start there, but I know that when we look at our opioid, when we look at our prescription rates, and we look just specifically at the dangerousness of them, and since there has been an opioid safety initiative put in place, we have reduced the prescription of opioids by 45 percent. And so, I know also that they are monitoring that very, very closely and training all the

providers in such a way that there is an increased level of accountability and structure around all of that.

Specific questions that you asked that I felt are a little bit more medically focused I would want to take back for the record, if that is okay?

Ms. KUSTER. That's fine. And actually what I was going to ask for is some type of follow-up to this Committee on any data. I am hoping that the improvements to the electronic health record will help with tracking this, but that is an area for concern that I wanted to be sure to have on the record in this hearing.

The second area of concern that I have relates to military sexual trauma and the under-accounting that has been going on, the inappropriate denial of claims to the Veterans Benefit Administration, and how this might relate to suicide both for male and female veterans.

On August 21st, 2018, we had an OIG report detailing a series of serious errors with VBA's adjudication of MST-related PTSD claims, errors that led almost half of all MST claims to be denied. And I think given that the entire country is riveted on this issue of trauma from sexual assault and harassment today, I would like to ask for your response.

This is a bipartisan letter, August 27, 2018, that I led with my Republican colleague Jackie Walorski. If you could please ask for a response from Secretary Robert Wilkie.

This is a very, very serious issue throughout our military, and I cannot imagine a more dispiriting experience than to be denied a claim, to be dishonorably discharged, to be dealing with PTSD, anxiety, trauma related to an incident that happened during their service to our country. And I just have to believe that there are men and women taking their own lives every single day because they have not been cared for by our country. And if you could respond, I would be grateful.

Ms. FRANKLIN. Yes, ma'am, I will absolutely take that back to our VBA leadership for the benefits part of the question in terms of running that to ground truth on what gives and why, and if they need some education on the impact of trauma and sexual assault and how that intersects with suicide.

Ms. KUSTER. Well, and it is even worse, I don't mean to interrupt you, but what is troubling about this is it apparently has to do with retention of records and despite the Secretary's best efforts to acknowledge these claims, when there is not a record—that is what we are learning about, there is not a record, there is not in the interest of a survivor to bring this claim forward and create a record, and yet the DoD destroys records one year following the date of the victim's report of sexual assault. That is a very difficult thing to do in the military, bring a claim of sexual assault, and yet apparently those records are being destroyed.

And so my time is up, but if I could just ask you to take back to Secretary Wilkie the bipartisan desire by Members of Congress. And if I could just close by asking the chair for an oversight hearing on this issue, because I think it is related to the number of people taking their life in this country and it is a tragedy.

Thank you.

Mr. DUNN. Thank you.

Next, I would like to recognize the gentleman from Texas, Mr. Arrington.

Mr. ARRINGTON. Thank you, Chairman Dunn.

And let me offer my well wishes to the Ranking Member. I have enjoyed and have been honored to serve with you, and it is abundantly clear to me and I think everybody who is on the Committee or has participated in a hearing that you love our veterans and you are passionate about service, and I am glad you are seeking to continue that service for your state. So, good luck, and thanks for letting me serve alongside of you on this Committee.

I am obviously no expert and I know it is a very complex issue, and I recognize that you all have thought about it a lot more than I have and I appreciate all attempts to get at solving the problem.

Three things come to mind as critical success factors—you can dispute them and please do, I welcome that—early identification and engagement of high-risk individuals, coordination and continuity of care, and monitoring and measuring outcomes.

Now, Dr. Franklin, I invite you to address the first two. Where can we improve at early identification and engagement of high-risk individuals. How early do we know people in the military? Do we know from the front end? Do they screen people coming into the military and know who is more susceptible, who has a higher risk at the outset, at what point do we know that? Do you have that information? Do you need it? Can we help you get it?

Ms. FRANKLIN. Thank you so much. It is a very good question. And I have dialogued with military leaders about this exact issue for years, all through the entire war effort, from pre-9/11, all the way up where we have gotten into lots of debate and discussion, on—are we pulling the thread right at the recruit level? When they are in basic, are we asking the right questions? Is there a different way to screen? Can we give the A screener, which is like this adverse childhood reaction screener, whether you have been through trauma when you were seven and nine, and does that impact you in your teen years? And there's a host of factors in that.

And at the end of the day, it seems, you know, they are not screening for suicide risk per se, but they are screening for mental health history. I should use caution speaking on behalf of the DoD as well; it is not my area anymore. I know they do extensive screening when they bring folks in, but that type of information is necessary as we track veterans along their journey.

Mr. ARRINGTON. Do you have that information?

Ms. FRANKLIN. Not before me today, no, sir.

Mr. ARRINGTON. Okay. Do you know the correlation between the DoD data on mental health, high-risk individuals, and those who have committed suicide as veterans, and do we know that there is any connection there?

Ms. FRANKLIN. We are only in the early processes of sharing that data, it has only just begun literally in my last 6 to 12 months.

Mr. ARRINGTON. It seems like—

Ms. FRANKLIN. It seems critically important—

Mr. ARRINGTON [continued].—an imperative to me.

Ms. FRANKLIN. —in part because one attempt is a predictor of a future attempt, and what we see over time is, as somebody who

has had an attempt in their history, they are more likely to end their life. And so, yes, absolutely.

Mr. ARRINGTON. Dr. Brown, do we have good data? Are we monitoring and measuring the various programs? I heard Mr. Mulcahy mention 1100 government suicide programs throughout the country. Do we know which ones are working, which ones work well and why they work well, so we can—

Mr. BROWN. I'm sorry, I didn't understand your question.

Mr. ARRINGTON. Do we have good data on the strategies being deployed today, the programs that are being implemented, which ones are working, which ones aren't working, and then why are they working, so we can double down. Do we have good data?

Mr. BROWN. Yes.

Mr. ARRINGTON. At least with the VA programs.

Mr. BROWN. We have studies that have come out that have supported the various programs that are being enacted in VA, but I can tell you that the amount of resource we put into research for suicide prevention programs is really small compared to other problems. We need research to demonstrate which interventions work and which ones don't.

Mr. ARRINGTON. Well, the needle is not moving. We are spending a lot of money, we have got a lot of programs, 1100, and it is frustrating. And I don't know that we have good data, that seems to be a theme in my tenure here. And I don't like wasting money, I like solving problems, and I think the taxpayer would say that and I think my colleagues would say that.

So I feel like we have got to do something about information, so we know what we are—again, what is working, where we are getting traction and not.

To the community partners, what do you need from the VA that they are not giving you, and to the VA, what do you need from us legally where there are impediments to empower you to get everything you need to solve this problem? I want the partners to address what they need from you all and what you need from us, and I am done.

I yield back, Mr. Chairman.

Mr. DUNN. Thank you.

I would now like to recognize the gentlewoman from California, Representative Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I too want to add my voice to others on the Committee to thank you, Ranking Member Walz, for being truly a dedicated Member to this Committee, an extraordinary leader on the Committee, and we are certainly going to miss your expertise and your input on virtually every issue that veterans experience. But we wish you very, very well.

And I also wanted to thank all of the nonprofits that are at the table today, because I think that I believe wholeheartedly that there would be even more suicides if it wasn't for your efforts and your partnership with the VA. So I am very, very grateful to you all.

And, Dr. Franklin, I wanted to ask you, in your opening comments you talked about, you know, out of the 20 a day of veterans who commit suicide, you said six received VA treatment, 14 did

not. Do you have similar data on the men and women in that universe of data? In other words, you know, do you know—I know you know how many women commit suicide, but do you know in terms of women who have reached out to the VA for help and women who have not, who have committed suicide.

Ms. FRANKLIN. Now, that is a very good question. I am not sure we have sliced the data on help-seeking and non-help-seeking.

I will tell you that we have improved our VHA as a whole; we have increased our women accessing our health care three times, by threefold. And so, from there, we can look at the data. We know of the 20 a day, 19 of them are men and one is female, one is a woman, and we can look at it from those that are help-seeking and those that are not, certainly. It is a very good question.

Ms. BROWNLEY. Well, I do believe that the numbers of women veterans committing suicide is becoming a much more significant factor. And we certainly had a bill come out of this Committee, my bill to look at that data, so that we can bifurcate hopefully the data and come up with better practices in terms of specifically treating women veterans.

But I do believe that it is an issue for women veterans just to seek the help. And I think somebody made a comment about we can't be fishing, but we have to be hunting, and I think we have to be hunting in this case.

Dr. Roe in his opening comments asked the question, why are we still having 20 veteran suicides a day and why haven't we moved the needle. And I think part of that answer, quite frankly, is this, and that is, in August the VA reported more than 45,000 vacancies at the Department, more than 40,000 vacancies at VHA.

The Office of Inspector General determined that in fiscal year 2018 the Veterans Health Administration's number one shortage was psychiatrists, with psychologists as the fourth largest shortage. And during our budget hearing last year, we heard that the VA had 35,000 vacant mental health care positions, including 300 psychiatrists, 700 psychologists, 250 nurses, and nearly 2,000 social workers. That is just, in my opinion, unacceptable, and I think indeed it has to be part of the problem.

And, Mr. Fisher, I wanted to ask you as well. In my district in the Ventura County Vet Center—and I understand you lead that effort within the VA—my vet center in my district is suffering from ongoing staffing shortages. They just recently lost an assistant office manager, they are scheduled to lose a temporary readjustment counseling assistant in December, this is combined with increasing veteran demand for local services. And on top of that, the West L.A. VA is ending their long-term PTSD support groups and transferring those veterans back to Ventura County, a vet center that is having increasing demand, is having shortages, professional shortages, and now saying we are shutting this down in Los Angeles and now you need to go back to your vet center for services.

I think this is a crucial issue and needs to be addressed, and I guess I'm looking to you to see if you are committed to trying to look at our situation in Ventura County and trying to resolve it.

Mr. FISHER. Thank you, ma'am, and, yes, we are committed to looking at that and resolving that situation.

Ms. BROWNLEY. You are aware of it?

Mr. FISHER. I am. One of the projects that actually we started on a national level is we moved all of readjustment counseling service or vet centers to one HR office to increase or speed up our time to hire. That transition was completed in the beginning of the summer of this year.

So I would actually like to take this one back and I will report back to you on the status of this particular vet center, and when we can expect to have that staff on board to replace the individuals that we lost.

Ms. BROWNLEY. And as soon as you know that, will you reach out to my office?

Mr. FISHER. Yes, ma'am.

Ms. BROWNLEY. Thank you very much.

Mr. FISHER. Yes, ma'am.

Ms. BROWNLEY. I yield back.

Mr. DUNN. Thank you.

I would like to make note, I cut short the answers to Mr. Arrington's question before. If you would submit, if the panel would submit those questions—rather those answers in writing in the next 5 days, we would be grateful for that.

Now I would like to recognize the gentleman from Michigan, General Jack Bergman.

Mr. BERGMAN. Thank you, Mr. Chairman.

And we have heard a lot of stories today, folks. Seventeen years ago today, the 27th of September 2001, a Marine Corporal who had served honorably for four years took his life. He was my nephew. So it is real personal.

Now, having said that, those of us who have had the honor to wear the cloth of our Nation know, number one, first and foremost, it is our mission to win the fight, and, number two, is to take care of everyone else after that. That is how it works. And this is about taking care of others after they have served, whether they deployed to combat or not, it doesn't make any difference.

When we think about—and I am going to repeat a couple of the data numbers that have been thrown out here—we have 1100 programs funded by the government. In 2005, we had $2.4 billion committed to suicide prevention; in 2015, we had $6.9 billion committed. So that is a big chunk of money and we are all in kind of agreement here that we haven't been able to move the needle, and that I know is frustrating for all of us.

So if we continue down the road, we are on without seeing significant results, we need to really question is the road we are on the right way. So that is why we have these hearings. This group here on the Veterans' Affairs Committee is absolutely the most bipartisan and singularly focused for the outcomes of the veteran.

Now, Dr. Franklin, you have been in my office with your colleagues, and we have had some very detailed and direct discussions over a period of time about where we are and some thoughts on where we need to go. What are we missing? Is there anything that glaring, any point that we are missing here right now that we need to refocus on?

Ms. FRANKLIN. Thank you so much for the question.

When I think about this, because, as well, I am beyond frustrated about the numbers and the data and the fact that we are

not seeing a difference, and having worked in this field as long as I have, it does, it is frustrating, is not even the right word for it. And I think—when I try to think about what we are missing, I think about issues around dosage. And so, bear with me, but this is what I mean by this.

We tend to do a lot of one thing at one time. So we will invest in mental health and we will invest in crisis line work, and we will just do it very well, full-throttle, if you will. And preventing suicide, as you heard from the panel today, takes broad public health approaches, probably a bundled package of about 10 or 12 things at full throttle all the time. So, it takes community efforts that you heard about today, it takes crisis line work, it takes peer support that you heard. And it takes them in a scientific way under the leadership of the best, you know, scientists in the Nation, and the way that they are evaluated, but in a way that it is not over reliance on one and the absence of the other. So that is one thing.

And then the other is just when I think about it specific to veterans, we need a whole-of-Nation approach to veteran suicide. So, somebody brought up employment, I need all of the employers—

Mr. BERGMAN. I have got a couple more questions here. So we know we are not—because you and I talked. But the point is, what I wanted to hear was your passion and I just heard your passion for this, and that is one of the challenges we have in a bureaucratic state where the energy behind and the sense of urgency behind any task that is in front of us.

Dr. Franklin or Mr. Fisher, do you utilize the VA's Chaplain Corps as part of your suicide prevention effort?

Mr. FISHER. Vet centers actually do collaborate with chaplains, both in our outreach events and then also in our referrals back and forth.

Mr. BERGMAN. Okay. Now also, Mr. Fisher, you know, to what to attribute, you know, the vet center success. You have got a 28-percent increase, you know, in positive results. What has happened and what do we need to do going forward to continue for you to be an example?

By the way, I have traveled to many, you know, vet centers, especially in my district, we have one in Escanaba, and they are doing outstanding work because they are boots on the ground.

Mr. FISHER. So I think the success is exactly what you just said, sir, and that is we have amazing staff who—actually, over 70 percent of our staff are veterans, so it is that continuation of mission. Those that are not veterans, it is the heart for the veteran. And that boots on the ground, meeting the veteran/servicemember and family where they are, and then creating that relationship and then begin to create that individual plan to have them move forward.

Mr. BERGMAN. Thank you, Mr. Chairman, and I yield back.

Mr. DUNN. Thank you.

Mr. BERGMAN. Oh, Mr. Chairman, can I get just 30 seconds to congratulate the Sergeant Major?

Mr. DUNN. You absolutely can.

Mr. BERGMAN. Because that was—but, you know, thank you, Sergeant Major, for your service, because I know if there is one thing you are passionate about, it is leading troops. So thank you for

your contribution to the community. And in a Naval Officer format, I will say fair winds and following seas.

Mr. WALZ. Thank you, General.

Mr. DUNN. So let me just before I recognize Mr. Takano from California, I want to call everybody's attention to the irony of this exchange. Sergeant Major Walz is the highest-ranking noncommissioned officer ever to serve in Congress. Lieutenant General Jack Bergman is the highest-ranking officer ever to serve in the history of the country in Congress. So the exchange between you two is wonderful and warms my heart.

Mr. Takano of California, you are recognized for 5 minutes.

Mr. TAKANO. If I might risk to punctuate it all with a saying, a quaint saying that I have learned from the Sergeant Major, which is to run it up the flagpole hard, and he has often said that in our meetings. And I have come to admire his leadership and I believe we have become very good friends.

And let me just also say on a personal basis, the Sergeant Major brought the credibility of his military service and was an important voice in the debate to overturn the "Don't Ask, Don't Tell" policy. And that happened during his tenure here and he was one of the salient voices on that, as well as on the respect for marriage—you know, I thank you for your service, sir.

Let us move on to the issue at hand. The VA–OIG report, you know, we all know by now that the number that jumps out at us is the increase in the suicide rate among younger veterans during the year in 2015 and 2016. It was the highest rate of any group, the other groups tended to remain stable.

For anyone on the panel, how does that number, what does it imply for how we model our prevention and intervention programs? Do we deliver information differently? The basket of—Dr. Franklin, you mentioned a number of programs in response to General Bergman, you know, your frustration that we kind of emphasize one or the other, but what is it that we need to—what does it imply we have to do now that we have seen this data?

Lieutenant Colonel LORRAINE. You know, I am going to go back to—sir, I am going to go back to the community, and I think what Representative Mast brought up, some of the things that you see is that you have to build a trusting relationship and it is about trust.

And so even with younger veterans, when I left the military the biggest obstacle, I had in civilian life was trust, because in the military you know who to trust. I think it is about building peer networks, building friends that will use the system to notify when there is—that you can turn to and say I have got a problem, and you trust them to do that.

Mr. RICHARDSON. Sir, if I could, just to add, going back to being an old soldier, I think it starts, as Dr. Keita said, right when you enter the service, having that discussion about suicide prevention and mental health, and the importance of that.

When we transition out of the military, there is a lot of talk about resume writing and job-seeking, things along that, but we don't do a lot within the mental health part of it during the transition. But it really should start from basic training all the way

through their career, with a real emphasis as they are getting ready to transition into the civilian force.

Ms. FRANKLIN. I think it is a very good question as well, when we think about apps and the use of apps. The VA has made a couple of apps to help deal with depression, and we have an app called the Hope Box. I won't get into the specifics here, but know that I think that does have relevance for your question for this group, this cohort of 18-to-34-year-olds, as well the role of social media. We are seeing servicemembers and veterans put their risks online in a social media space and for providers like myself, you begin to think, are we ready and prepared to engage with people online when they are writing their risks online, and do we have the right resources at the ready for them in those environments?

Also, the last thing I would share is just thinking through 18-to-34-year-olds and the recency with which they leave the DoD, and the potential need for gray space between the two when it comes to this work. So, you know, it is not a hard and fast line in the sand when they leave Active duty one day and they are a veteran the next. And we have made great strides under the Executive Order, recent Executive Order that was pushed out in January to do something called Early and Consistent Contact.

And so, we are in the early stages of rolling this out, but it basically has us reaching out to servicemembers when they are still on the DoD rolls, perhaps 12 months before they transition out, in an early and consistent way over time, and then 12 months beyond. More recent looks at the data, we might need to do that even further than the first 12 months beyond, but this consistent engagement I think will help with that population, but we are going to have to engage with them in ways that they would like to be engaged. It might be text, it might be a chat model, it might—so bringing them into the solution I think will help. We don't know what we don't know about these 18-year-olds and how they like to receive information and that sort of thing.

Mr. TAKANO. So what you are telling me, we need to do a little more work and find out what is the best way to engage them.

All right. I yield back, sir.

Mr. DUNN. Thank you.

And at this point I would like to add my compliments to the Ranking Member, Sergeant Major Tim Walz, you know, and to say thank you to you not only for your service, but for your leadership in this Committee and in our country. And I want to recognize you now and yield the floor to you for any comments that you may have, Sergeant Major.

Mr. WALZ. Well, thank you all. I would like to know publicly, should I die, I want all these people to give my eulogy coming up and going, but I am grateful.

I am humbled and appreciative of the work this Committee has done, but I am also very cognizant we have failed in areas. There is much work to be done. But this Committee has been, I think, a reflection of the best that Congress can offer.

These are not easy. Everybody says, well, it is easy in the VA Committee, everybody agrees on that. This is the second-largest agency with employees and costs, and ideological differences on the care, but those things have not stopped us, they have brought us

closer together to find these. We have been able to get out of the simplistic arguments of privatization versus non-privatization and get to the delivery of services for veterans in the most efficient, cost-effective way, and that is what I am most proud of. There are heated debates in here, but all towards that common goal.

And I think what comes out of this, there have been great questions answered. The one thing we all know, especially as it deals with mental health, we can't see veterans as a whole, certainly veterans' mental health or health care in a vacuum. These are broader societal issues that go at this.

And I think about this, when I came here in 2007, the debate at that time was whether we should bury with honors a veteran who died by suicide. We were still debating whether that was an appropriate thing. Mental health parity had not yet passed the Congress on how we paid for it. There was no Veterans Crisis Line to even call, all of those things that have happened.

So I say that not as an excuse for not having a fierce sense of urgency, but to understand that a lot of this and on this frontier of brain-based research, as Dr. Brown said, we are on the beginning of this journey. There is a lot to be done, but there is so much we can learn.

I also want to point out, when I told the story of Justin Miller, it is not to point out a failing system at the Minneapolis VA or the VA in general. I also have the privilege of representing the Mayo Clinic in Rochester, Minnesota. And the folks at the Mayo Clinic will tell you one of the most outstanding medical, research, and delivery institutions in the entire world is the Minneapolis VA. The practitioners that are there, the employees that are there give everything. So when we have a failure, it is a failure of the system and it reminds us, trying to build in these redundancies, to make sure that if we have those best practices, we are not missing them, or we are having other eyes on that.

And I would say the thing that I have learned in this journey, especially on the mental health piece, is of using the science and using the best practices, bringing that down.

It comes back to what Mr. Peters says. My friends Howard and Jean are sitting out there today, and they are my friends because they lost their baby, they lost their son. And we would have never crossed paths had not happened. I now add Drinda and Greg Miller to that list of people that I have become acquainted with, they are in my lives.

But what they taught me, and especially Howard and Jean and Clay Hunt's family, is listen to the family, listen to the people who are out there, include them. And I understand the deep implications of HIPAA laws and privacy and all of that, but these are the folks closest know, want to help and integrate them, and that is what we were trying to do. And I heard Mr. Mulcahy said it, I heard Colonel Lorraine say it, use the institutions and use the support of the buddies and the families that are closest to home. We have to figure out how to get you to do that.

So there is much more to be done, the great questioning here. I think, Mr. Lamb, I can't stress enough of this, when I came here my mission was to align DoD and VA on electronic health records, and I am not naive, that is going to be a massive undertaking, but

it possesses the great potential to use technology and science to fix some of the things that are there. But that human compassion piece of this, the willingness to make functioning government be part of the solution rather than holding us down.

This is the one place when we say, "My dear friend from Michigan," unlike the House floor where they are mostly lying when they say that, it is true here, my dear friend, who I know is committed. But that sense of mission, that sense of purpose, that sense of listening to the experts, that sense of counting on the broad array of the American public that wants to get this right, is really hopeful. But, again, it just keeps coming back to me, the absolute zero-sum nature of this is Daniel is not here today because we didn't do or weren't able to fix that. Justin is not here because of that; the General's nephew is not here.

And so our commitment has to withstand folks will come and go from these seats. What we need to know as a country and for each of you, and I want to thank the panelists who are here today of what you are adding to this, we can get this, we can do this. It is what we know we need to do as a Nation.

So, thank you all. I want to thank my colleagues for the privilege of a lifetime of serving on this Committee and certainly, as a veteran myself, sleep very easily knowing that you are in charge of this and making improvement.

So, thank you all.

Mr. DUNN. Thank you very much for that, Ranking Member. That is a far more wonderful closing than I could manage, so I am going to merely say we have 5 days to revise and extend remarks, and add extraneous material.

And with that, this Committee is adjourned.

[Whereupon, at 12:53 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Gregory K. Brown

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Chairman Roe, Ranking Member Walz, and Members of the Committee, thank you for the opportunity to offer testimony on Veteran suicide prevention—maximizing effectiveness and increasing awareness. This is an incredibly important issue, and I commend the Committee for its leadership and convening this hearing. Over the past several years there have been a number of efforts to develop evidence-based treatments to mitigate suicide risk for Veterans at high risk for suicide and we have made significant progress. However, there remains some serious challenges in the dissemination and implementation of these effective strategies.

A Public Health Approach for Reducing the Rate of Suicide Among Veterans

The U.S. Department of Veterans Affairs (VA) has emphatically acknowledged that suicide prevention is the VA's highest priority. The National Strategy for Preventing Veteran Suicide for 2018–2028 provides guidance in how the VA plans to address suicide prevention efforts for Veterans.[1] Suicide is a complex problem that reflects an interaction among many different risk and protective factors at individual, family, community, regional and national levels. Given that there is no single cause for suicide, the VA has adopted a prevention framework that involves using a combination of prevention strategies to lower rates of suicide. Developed by the National Academy of Medicine,[2] this framework includes using universal strategies to reach all Veterans in the U.S., selective strategies that are intended to reach subgroups of Veterans who may be at some increased risk and indicated strategies that are for a relatively few number of Veterans who are at high risk for suicidal behavior, such as those Veterans who have attempted suicide or who have experienced suicidal thoughts. The focus of my testimony involves an update of a few of the indicated strategies for Veterans at high risk for suicide.

A critical approach for reducing Veteran suicides, among high risk Veterans, is to develop and test suicide prevention strategies, using rigorous scientific methods, to see if they actually prevent suicide or suicidal behavior. Once empirically validated prevention strategies have been identified, then the next step is to disseminate and implement these strategies to assure widespread adoption in the Veterans Health Administration (VHA) as well as in community health care settings who provide treatment to Veterans. These dissemination and implementation strategies also need to be developed and tested, again using rigorous scientific methods, to increase the likelihood that these evidence-based prevention strategies are acceptable, feasible, and most importantly, actually used by VA and community health care providers in a way that maintains fidelity to the interventions as designed, even if some adaptation is required.

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[1] Office of Mental Health and Suicide Prevention. National Strategy for Preventing Veteran Suicide: 2018–2028. Washington, DC: U.S. Department of Veterans Affairs; 2018. Accessed September 24, 2018, at www.mentalhealth.va.gov/suicide—prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[2] Substance Abuse and Mental Health Services Administration (SAMHSA), Center for the Application of Prevention Technologies, Risk and Protective Factors (2015). Accessed September 24, 2018, at www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors#universal-prevention-interventions.

Suicide as a Low Base Rate Event

The problem for the scientific community is that evaluating whether newly developed prevention strategies are actually effective for preventing suicide among high risk individuals often requires very large sample sizes and multiple recruitment sites. Large samples are necessary for ensuring that studies are adequately powered to detect clinically meaningful treatment effects, including changes in suicide rates.[3] This low base rate is problematic for researchers because obtaining adequate funding to support studies with enough statistical power for determining whether interventions prevent death by suicide is quite challenging due to the limited funding available. To address this problem, researchers have adopted proxy measures of suicide for evaluating the effectiveness of suicide prevention strategies, such as the occurrence of nonfatal suicide attempts rather than actual suicides, given that suicide attempts and other nonfatal suicide-related behaviors are major risk factors for death by suicide.

To improve the likelihood of accurately identifying and evaluating Veterans who may be at high risk for suicide, the VHA Office of Mental Health and Suicide Prevention has launched an initiative to develop and implement a national, standardized process for suicide risk screening and assessment, using high-quality, evidence-based measures and practices. This protocol involves three stages: (1) conducting primary screening for suicide risk using the suicide item from the Patient Health Questionnaire[4] —9,[5] (2) conducting a secondary screen using a screening version of the Columbia Suicide Severity Rating [6]Scale[7], and (3) conducting a VA comprehensive suicide risk evaluation using a standardized medical record template. Using standardized, evidence-based practices to screen for suicide risk will not only help to link at risk patients to appropriate health care services but will help with suicide prevention research. Support for the implementation of this program is provided by Dr. Lisa Brenner and colleagues of the VA Rocky Mountain MIRECC for Veteran Suicide Prevention.

Evidence-based Treatments to Prevent Suicidal Behavior

Our group at the University of Pennsylvania, developed a brief 10–16 session psychotherapy intervention for patients who recently attempted suicide, called Cognitive Therapy for Suicide Prevention (CT–SP). In a landmark study, funded by the National Institute of Mental Health and published in the Journal of the American Medical Association (JAMA), we found that participants who were randomly assigned to the cognitive therapy(CT–SP) group had a significantly lower suicide attempt rate and were 50% less likely to reattempt suicide than participants who were assigned to a usual care group.[8] These findings were partially replicated using a similar intervention, called Brief Cognitive Behavior Therapy, that was developed by Drs. David Rudd and Craig Bryan. In a randomized controlled trial, funded by the Department of Defense, researchers found that active-duty Army Soldiers who either had attempted suicide or experienced suicidal ideation and who were assigned to a Brief Cognitive Behavior Therapy (BCBT) condition were 60% less likely to make a suicide attempt during follow-up than Soldiers who were assigned to a usual care condition.[9] Efforts are underway to further replicate the findings of these studies for supporting effectiveness of Cognitive Therapy for Suicide Prevention and Brief Cognitive Behavior Therapy among Veterans and Military Service Members,

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[3] Institute of Medicine (US) Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide; Goldsmith SK, Pellmar TC, Kleinman AM, et al., editors. Washington, DC: National Academies Press (US); 2002.

[4] Spitzer, RL, Williams, JBW, Kroenke, K et al. Patient Health Questionnaire—9. Accessed September 24, 2018, at https://www.phqscreeners.com/sites/g/files/g10049256/f/201412/PHQ–9—English.pdf.

[5] Simon GE, Rutter CM, Peterson D, et al. Do PHQ Depression Questionnaires Completed During Outpatient Visits Predict Subsequent Suicide Attempt or Suicide Death? Psychiatric Services (Washington, DC). 2013;64(12):1195–1202. doi:10.1176/appi.ps.201200587.

[6] Posner K, Brown GK, Stanely B, et al. The Columbia-Suicide Severity Rating Scale, Screening Version. Accessed September 24, 2018, at www.cssrs.columbia.edu.

[7] Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From Three Multisite Studies With Adolescents and Adults. The American Journal of Psychiatry. 2011;168(12):1266–1277. doi:10.1176/appi.ajp.2011.10111704.

[8] Brown, GK, Ten Have, T, Henriques, GR, Xie, SX, Hollander, JE, & Beck, AT. Cognitive therapy for the prevention of suicide attempts. Journal of the American Medical Association. 2005; 294(5):563–570. doi: 10.1001/jama.294.5.563.

[9] Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., ... & Wilkinson, E. Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. American Journal of Psychiatry. 2015; 172, 441–449. doi: 10.1176/appi.ajp.2014.14070843.

respectively. Replication of clinical interventions helps to promote the adoption and implementation of these treatments.

Although CT–SP has been recognized by the National Registry of Evidence-based Programs and Practices, the dissemination and implementation of cognitive behavior therapies for suicide prevention (CBT–SP) in VA have been limited. However, a recent clinical demonstration project, led by Dr. Mark Ilgen of the VA Ann Arbor Healthcare System and supported by the Office of Mental Health and Suicide Prevention, will train a group of therapists in CBT–SP at two hub facilities, and remotely deliver this intervention via Clinical Video Telehealth (CVT) to Veterans within two VISNs. This program will increase access for high-risk Veterans to specialized, evidence-based, suicide prevention services. Simultaneous evaluation of the feasibility, acceptability, reach, and impact of this program will provide key data to inform the potential implementation of a telehealth delivery of CBT–SP across VHA. Additional dissemination and implementation initiatives are sorely needed to ensure that Veterans at risk for suicide have access to these evidence-based treatments.

The Need for Scalable Interventions to Prevent Suicide

Although psychotherapy approaches, such as CT–SP, are effective for lowering risk, a limitation of these interventions is that they require multiple sessions and cannot be easily used in acute care settings where patients may be briefly evaluated and then referred for additional care. Emergency departments (EDs), for example, frequently function as the primary or sole point of contact with the health care system for suicidal individuals. This contact often occurs either immediately following a suicide attempt or when suicidal thoughts escalate and the individual feels in danger of acting on these thoughts. Moreover, the risk of suicide is very high following contact with acute psychiatric services, and persistent challenges exist for providing continuity of care after discharge. To address this concern, Dr. Barbara Stanley of Columbia University and I, co-developed a 20 to 40 minute intervention, called the Safety Planning Intervention (SPI).[10] Although safety planning was a commonly-used strategy in cognitive behavioral therapies, we thought it would a useful strategy if it could be found to be effective as a stand-alone intervention.

What is the Safety Planning Intervention (SPI) and how does it work to prevent suicidal behavior?

The SPI is a brief clinical intervention that we designed to decrease future risk of suicide by providing suicidal individuals with a written, personalized safety plan to be used in the event of a suicidal crisis. The SPI uses evidence-based strategies to reduce suicidal behavior by providing prioritized coping strategies to successfully cope with a suicidal crisis. The SPI also includes lethal means counseling to reduce access to potential suicide methods such as firearms and lethal medications.

The Safety Planning Intervention consists of six key steps:

1. Identify personalized warning signs for an impending suicide crisis;

2. Determine internal coping strategies that distract from suicidal thoughts and urges such as listening to uplifting music or watching a comedy show;

3. Identify individuals who are able help patients to distract from suicidal thoughts, without necessarily disclosing suicidal thinking, as well as social settings that provide the opportunity for interaction;

4. Identify individuals, typically close friends or family members, who can provide help during a suicidal crisis;

5. List mental health professionals and urgent care services to contact during as suicidal crisis including the National Suicide Prevention Lifeline;

6. Lethal means counseling for making the environment safer.

In 2008, the SPI was adapted for Veterans and has been widely used in VHA for patients deemed to be at high risk for suicide.[11] Safety planning was identified as

[10] Stanley, B & Brown, GK. Safety Planning Intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice. 2012; 19: 256–264.

[11] Stanley, B & Brown, GK. (with Karlin, B, Kemp, JE, VonBergen, HA). Safety plan treatment manual to reduce suicide risk. Washington, DC: U.S. Department of Veterans Affairs. Accessed on September 24, 2018, at https://www.mentalhealth.va.gov/docs/va—safety—planning—manual.pdf.

a recommended practice by the VA/DoD clinical practice guidelines for suicide prevention. [12]

In response to a priority recommendation from a federal Blue Ribbon Panel on Veteran Suicide in 2008, the Office of Mental Health and Suicide Prevention (formally, the Office of Mental Health Services) called for the development and implementation of an ED-based intervention for suicidal Veterans. [13] The rationale for such an approach was based on the recognition that ED providers may prefer to hospitalize Veterans because of limited availability and feasibility of interventions that can be provided in the ED. Hospitalizing patients at risk for suicide may be problematic for a variety of reasons such as disrupting the person's life. The overall vision of this VA initiative was to augment emergency mental health service delivery to (1) enhance identification of Veterans at risk for suicide in VA hospital EDs, (2) provide a brief intervention to reduce risk, and (3) ensure that Veterans receive appropriate and timely follow-up care. This clinical intervention included the SPI and it was paired with follow-up contact for suicidal Veterans, resulting in an intervention we called SPI+. Follow-up contact consisted of telephone contacts after patients were discharged from an emergency department (ED). Calls were made by our trained project staff, social workers and psychologists, and were initiated within 72 hours of discharge from the ED. Calls were continued on a weekly basis until Veterans had attended at least one outpatient behavioral health appointment or until they no longer wished to be contacted.

The follow-up telephone contacts generally included three components:

1. Brief risk assessment and mood check;

2. Review and revision of the safety plan from the SPI, if needed;

3. Facilitation of treatment engagement.

The results from this clinical demonstration project were recently published in a high-impact journal, JAMA Psychiatry. [14] The study used a cohort comparison design with 6 months follow-up at 9 VHA hospital EDs (5 intervention sites and 4 control sites). SPI+ was administered to a total of 1,186 Veterans who presented to the intervention EDs for a suicide-related concern, but for whom inpatient hospitalization was not clinically indicated. Veterans in the SPI+ condition were less likely to engage in suicidal behavior than those receiving usual care during the 6-month follow-up period. The SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behavior over a 6-month period. Intervention patients had more than double the odds of attending at least 1 outpatient mental health visit following ED discharge than control patients.

In a randomized controlled trial, funded by the Department of Defense, Dr. Craig Bryan and his colleagues found that Crisis Response Planning, a brief intervention that is similar to SPI, was more effective than contracting for safety for preventing suicide attempts, resolving suicidal ideation, and reducing inpatient hospitalization among high risk active-duty Soldiers. [15] Contracting for safety typically involves asking patients to promise the clinician that they will not kill themselves.

Additional clinical trials, funded by the National Institute of Mental Health, are currently underway to examine the effectiveness of SPI+ in the year following jail release and to examine the implementation of the SPI in community outpatient settings in New York State, as well as in community ED settings across the county. We are also evaluating the efficacy of SPI in acute care hospital settings, funded by the American Foundation for Suicide Prevention, and we are evaluating the effectiveness of an adapted version of SPI for Veterans using an outpatient group format, funded by the VA. Finally, a randomized controlled trial of SPI, funded by the Department of Defense, is being conducted with Military servicemembers who were hospitalized for a suicide related event.

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[12] VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide. Washington, DC: U.S. Department of Veterans Affairs and Department of Defense. Accessed on September 24, 2018, at www.healthquality.va.gov/guidelines/MH/srb/VADoDCP—suiciderisk—full.pdf.

[13] Knox KL, Stanley B, Currier GW, Brenner L, Ghahramanlou-Holloway M, Brown G. An Emergency Department-Based Brief Intervention for Veterans at Risk for Suicide (SAFE VET). American Journal of Public Health. 2012;102(Suppl 1):S33–S37. doi:10.2105/AJPH.2011.300501.

[14] Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. JAMA Psychiatry. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776.

[15] Bryan, CJ, Mintz, J, Clemans, TA, Leeson, B, Burch, TS, Williams, SR, ... & Rudd, MD. Effect of crisis response planning vs. contracts for safety on suicide risk in US Army soldiers: a randomized clinical trial. Journal of Affective Disorders. 2017;212, 64–72. doi: 10.1016/j.jad.2017.01.028.

Quality Matters!

One of the most important lessons we have learned about implementation of the SPI in the VA since 2008 is that fidelity to the intervention involves more than simply completing a piece of paper, the safety plan form, but involves taking a collaborative and understanding approach to addressing painful experiences reported by Veterans. A 2015 study explored the implementation fidelity of safety planning in a regional VHA hospital.[16] A comprehensive chart review was conducted for patients who were flagged as high risk. Safety plans were mostly complete and of moderate quality, although variability existed. Despite the general mention of safety plans in the medical record, a significant proportion of the patient charts had no explicit evidence of ongoing review or utilization of the safety plan in treatment. An additional study of safety plans in VA medical records found that the quality of safety plans was low.[17] Higher safety plan quality scores predicted a decreased likelihood of future suicide behavior reports. Higher scores on Step 3 of the safety plan form (people and places that serve as distractions) predicted a decreased likelihood of future suicide behavior reports.

The discovery of low quality safety plans highlights the need for additional training in the administration of the SPI. To improve fidelity and quality of safety plans, the VHA Office of Mental Health and Suicide Prevention recently developed a comprehensive medical record template with detailed instructions for SPI as well as a corresponding, comprehensive SPI manual. Additional training efforts to assess and improve the quality of safety plans are planned for VHA mental health providers. Simply providing additional, noninteractive training materials for SPI is not likely to be sufficient for improving the quality of the intervention, however. Additional professional training for clinical staff of SPI may be implemented, using a blended learning model, that involves (1) interactive, web-based didactic training that includes demonstration videos, (2) experiential exercises that include individualized feedback from expert trainers, and (3) an evaluation of safety planning administration using standardized rating measures.

Recommendations for Improving Suicide Prevention Efforts for Veterans

1. Adopt and fully support the VA National Strategy for Preventing Veteran Suicide;

2. Increase funding of research to develop and evaluate suicide prevention practices in VHA and community settings;

3. Develop novel suicide prevention strategies, such as apps or web-based formats, that are feasible and acceptable to patients and staff;

4. Disseminate and implement evidence-based interventions to reduce suicide risk in VHA, including cognitive behavior therapies for suicide prevention;

5. Evaluate the quality of evidence-based, suicide prevention practices that have been implemented for Veterans at risk for suicide;

6. Provide training programs for clinical staff to improve the administration of evidence-based practices to reduce suicide risk; incentivize and support staff in using these practices;

7. Evaluate the effectiveness of dissemination efforts of evidence-based suicide prevention practices for Veterans at risk for suicide.

Thank you for the opportunity to offer this testimony. I welcome any questions from the Committee.

Prepared Statement of Lt Col James Lorraine, USAF (retired)

Testimony on Preventing Suicide Among Veterans:

Chairman Roe, Ranking Member Walz, and Members of the Committee:

[16] Gamarra JM, Luciano MT, Gradus JL, Stirman SW. Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA Healthcare System. Crisis. 2015;36(6):433–439. doi:10.1027/0227–5910/a000345.

[17] Green, J. D., Kearns, J. C., Rosen, R. C., Keane, T. M., & Marx, B. P. Evaluating the effectiveness of safety plans in military veterans: Do safety plans tailored to veteran characteristics decrease risk?. Behavior Therapy. 2017. doi: 10.1016/j.beth.2017.11.005.

Thank you for the opportunity to provide testimony today on the critical issue of preventing suicide among our nation's military veterans. The Department Of Veterans Affairs reported earlier this year that, on average, 20 veterans die by suicide every day, 6 of whom are nominally under Veteran Health Administration care and 14 who are not. This is a major public health concern that affects every community in the country, and it is one that my team at America's Warrior Partnership is actively combatting on a daily basis.

My name is Jim Lorraine, and I served as an Air Force Officer and Flight Nurse for 22 years. I was the founding director of the United States Special Operations Command Care Coalition; a Department of Defense wounded warrior advocacy organization that has been recognized as the gold standard in supporting wounded, ill or injured warriors along with their families. I also served as Special Assistant for Warrior and Family Support to the Chairman, Joint Chiefs of Staff, where I helped to transform the Chairman's "Sea of Goodwill" concept into a strategy.

I currently serve as the president and CEO of America's Warrior Partnership, a national nonprofit organization where our mission is to empower communities to empower veterans and their families. Our approach to accomplishing this mission takes many forms, but it starts with connecting community organizations with local veterans to understand their unique needs and situations. After gaining this knowledge, we connect local veteran-serving organizations with the appropriate resources, services, and partners to support each veteran. Our ultimate goal is to create a better quality of life for all veterans.

The foundation of our work is our Community Integration model, a framework for organizations to conduct proactive outreach to veterans and holistically serve all of their needs. Through this model, we have established relationships with more than 42,000 veterans since February 2014 in eight affiliate communities located across the country.

We are here today to discuss suicide among veterans, and I would like to share the work our team is doing to study this issue. I hope these insights will help guide this Committee's decisions towards developing and supporting the most effective community based outreach and prevention programs possible.

I am a veteran of nine combat deployments dating back to 1991 in conflicts and locations such as Desert Storm, Somalia, Haiti, Iraq, and Afghanistan. I've had brothers and sisters-in-arms who've taken their own lives, leaving all who loved them to speculate why. Just last week, I talked to a close friend and begged him to promise me he would get more assistance and not take his life. I've had a hero of mine leave me a note explaining that he could not take the constant head pain caused by his numerous blast injuries and asked that I forgive him for quitting. For me and America's Warrior Partnership, the prevention of suicide is not only necessary, it is personal.

The Department of Veterans Affairs released the "VA National Suicide Data Report 2005–2015" this past July. It was a comprehensive work that reported a vast improvement from previous studies in 2012, which estimated there were 22 veteran suicides per day, and 2014, which estimated there were 20 veteran suicides per day. The 2018 study is impressive in the volume of records, big data aggregation, and national span that it analyzed, but there was little granularity for communities to use in their efforts to prevent veteran suicide-in terms of veteran's service experience, their lives following service separation, their communities' attributes, or how communities might have engaged them during the years, months, or days before their death.

As a nation, we often speculate about the causal factors of veteran suicide. We speculate about the lack of access to treatment, the impact of head injury, the influence of pre-existing medical and behavioral conditions, the role of hereditary traits, access to lethal means, loss of purpose contributing to post-service transitional stress, and how financial or relationship strain could lead to a veteran taking their own life. A veteran who takes their life could be impacted by all, some or none of these factors. To further complicate matters, we have not been able to differentiate the characteristics of a veteran who might take their life in Buffalo, New York, as compared to Johnson City, Tennessee, or Orange County, California. We may never know exactly why a person finally dies from suicide, or how to interrupt them during the final moments just before death. However, energized communities can develop partnerships dedicated to engaging distressed veterans and their families at a time when, together, we can help to change the trajectory of their lives, such that they never become suicidal and accept help at times of increasing distress.

In December 2017, America's Warrior Partnership announced the launch of Operation Deep Dive, a four-year research study that we are conducting in partnership with University of Alabama researchers through visionary funding from the Bristol-Myers Squibb Foundation. The study is examining the factors and potential causes

involved in suicides and early mortality due to self-harm among veterans. Our ultimate goal is to identify the risk factors that lead to suicide in veteran communities as well as guide the development of programs to reduce self-harm among veterans. Or as I like to say, to move from fishing for veterans who are going to take their life, to using predictive factors to hunt for veterans who are going to take their life.

Operation Deep Dive is the first study of its kind in many ways. It is a community-based initiative with a national scope, designed to be led by and for local communities to ensure they gain direct and tangible benefits that are tailored to the unique veterans in their area. Representatives from America's Warrior Partnership and University of Alabama researchers are leading the study nationally, while local teams are coordinating the study at the community level. Currently, organizations from the following areas are participating in the study:

- Orange County, California
- The Panhandle Region of Florida
- Atlanta, Georgia
- Minneapolis/St. Paul, Minnesota
- Buffalo, New York
- Greenville, South Carolina
- Charleston, South Carolina

We are expanding the study to seven more communities within the next few months.

Operation Deep Dive is researching factors that have never before been evaluated. These include:

- The impact of community environments on veterans, which is an area that has typically been generalized in previous studies;
- The experience of all veterans across the spectrum of service, gender, and lifespan, which is an unprecedented level of detail for a study of this magnitude;
- The impact of dishonorable or less-than-honorable discharges on veterans who died by suicide, which has not before been quantified to this level;
- The use of geospatial analysis to provide greater granularity of the characteristics of a veteran who may take their life; and finally,
- An analysis of cases of self-harm in addition to suicide, which will provide a comprehensive understanding of behavior that can potentially prove fatal within veteran communities.

The project will be completed in four years. Phase 1 of the study, which is currently in progress, will take a year to complete. Our community-based teams have recruited enthusiastic local medical examiners, coroners, veteran-serving organizations, civic leaders and veterans, and military families to participate in Community Advisory Boards. These boards are shaping, reviewing and helping to direct the research within their respective areas. Researchers have also begun to conduct a five-year retrospective analysis of suicides and suspected suicides among veterans within each community. These cases will be geo-mapped to determine different geo-cultural contexts and locations that may affect the likelihood of suicide.

Once these actions are complete at the end of the first year, Phase 2 will begin. Researchers from The University of Alabama will compile all data collected at the community level and conduct a "sociocultural autopsy" to identify the specific individual, organizational and community factors that lead to suicide or self-harm among veterans. Researchers will also conduct in-depth, qualitative matched interviews with veterans at higher risk for suicide. The objective is to determine the role of community organizations in engaging those who have served and preventing negative outcomes that lead to suicide and self-harm.

To complement these qualitative interviews, we will conduct a quantitative, multi-database statistical analysis that links Operation Deep Dive data with records from a wide range of national sources. These include the Department of Defense, the Department of Veterans Affairs Suicide Data Repository, the U.S. Census Bureau, the Centers for Disease Control and Prevention, and civilian partners using publically available credit bureau information from companies such as TransUnion and geospatial analysis from Radiant Solutions. All of this will ensure the research team is positioned to access as much data as possible on the potential community and social factors that were identified during the first phase of the project.

When this four-year project is complete, we expect to have actionable insights into what risk factors, both individual and community are important markers in characterizing risk, as well as understand how to systemically and systematically engage veterans. However, Operation Deep Dive is only the beginning. The project's findings will help guide the development of more effective outreach programs, and we hope it will spur additional studies to identify those critical elements that will em-

power communities to help veterans live and thrive long after their service is complete.

Thankfully, there is already movement in the right direction. The administration is preparing a strategic multi-department Executive Order to synchronize prevention efforts from communities up to the national level. Additionally, as you know, efforts have been underway in both chambers through hearings such as today's session that are contributing to impactful legislation enabling the Department of Veterans Affairs, the Department of Defense, and the Department of Labor to establish a program to award grants for the provision of community integration solutions and suicide prevention services.

We enjoy a collaborative relationship with the Department of Veterans Affairs and are finalizing a data-sharing agreement critical to the success of Operation Deep Dive. Additionally, we have engaged with the Department of Defense for a similar data-sharing agreement that would bring understanding of service waivers, service experience and the impact of characterization of discharge to our research. We believe it is virtually impossible to study the suicide of former service-members without the active participation of the Department of Defense. Collectively, we need to create a data set that follows the veteran from Department of Defense recruitment through the Department of Veterans Affairs service. Lastly, the financial support from the federal level to all studies of veteran suicide, combined with the insights provided by community-based projects to holistically understand the needs of all veterans and suicide studies such as Operation Deep Dive, would signal a hopeful future for veterans in need.

In the end, our team at America's Warrior Partnership remains dedicated to empowering communities to help veterans achieve a higher quality of life. Much of the work we have accomplished to date would not have been possible without the cooperation of the Department Of Veterans Affairs and other veteran-serving organizations across the country. Continued collaboration and sharing of insights will be essential as we strive to understand the context that individual, community, and societal factors play in veteran suicide. Thank you again for the opportunity to testify on this critical issue.

Prepared Statement of Cindy Sheriff and Bill Mulcahy

Chairman Roe, Ranking Member Waltz and distinguished Members of the House Committee on Veterans Affairs , thank you for the opportunity to testify on the challenge of preventing suicide among our veterans. Before I begin, I would ask Cindy Sheriff, co-founder of GYB LLC (Guard Your Buddy) to stand and be recognized. She will be my "buddy" today and called upon if needed to back me up.

In 2012 Guard Your Buddy (GYB) was launched in the TNNG in response to AG Max Haston's mission to "stop the suicides." As seasoned health care executives, Cindy and I accepted this assignment and drew upon our backgrounds and professional colleagues to team with The Jason Foundation to create a clinically sound solution to the General's request. We are proud of GYB's impact in Tennessee, and we appreciate the opportunity to share with you what we've learned and, hopefully, expand GYB's capabilities to all Veterans.

We know twenty suicides a day between active servicemembers and our Veterans is twenty too much. GYB is a cost-effective, proven solution that we can scale nationally for active components and the Veteran population. Opportunities exist for GYB to partner with VA health care system Vet centers (Readjustment Counseling Service), Wounded Warriors, like-minded organizations, community resources and many other organizations to disseminate GYB's best-practices model to save lives and help those who have put their lives on the line for us.

We believe GYB can reduce Veteran suicide by 34% over the next three years and is strategically focused on two priorities: suicide prevention and intervention. With GYB's smartphone application, Guard servicemembers and their families are directly connected to a Master's-level clinician who can provide immediate intervention and support. Professional help is a click away.

GYB is unlike other suicide-prevention programs that are accessed through an 800 number. It's critical that individuals contemplating suicide have immediate access to professionals who provide "in the moment support". Clinically, the "window" for successful interventions are during the initial outreach. Once the crisis is resolved, GYB clinicians will continue to assist with other resources within the NG or their local community.

Our clinicians become the personal advocate for the servicemember or their families by helping them get their lives back on track.

We are wholly supportive of national crisis lines to address a wide variety of concerns for millions of our Veterans. However, a suicide crisis requires a unique dedicated solution. It is unrealistic to expect a suicidal person to have a crisis line number memorized or readily available. Long call queues, call backs, or having a phone answered in a moment of crisis by anyone other than a Master's Level Clinician is not the GYB model. To fight suicide, we need to bring our best educated and trained staff to serve our esteemed servicemembers and their families.

As the name suggests, GYB supports the strategy of connecting someone, their buddy, or loved ones in need with resources immediately. Since implementing GYB the TNNG suicides have been reduced an average of 68% annually since 2012. 2012 is recognized as "peak" for active component military suicides and GYB's base-line year for program outcomes. AG Haston asked us to share with the Committee his thoughts as follows:

- "Since 2012, the TNNG believes, that over 85 men and women of the TNNG have been talked off a ledge or possibly prevented from hurting themselves by using the GYB app."
- "The GYB program provides real help in real time."
- "When that Masters level clinician answers the telephone, you don't get forwarded to someone else.and that makes a difference. Getting put on hold or getting transferred to a number that's not answered is not the answer."

The last five years is referred to as the "new normal" because active component suicide rates remain "stubbornly" high and have not receded to expected levels. That is not the TNNG experience, we reject this premise and hope GYB's model will be considered as another "tool" available to all of our Veterans in time of need.

Imagine a "Guard Your Veterans" (GYV) initiative with a foundational communal approach similar to GYB. The GYV strategy will involve community-based groups, religious organizations, Wounded Warriors and existing Veteran programs such as the Readjustment Counseling Service.

GYV will save our Veterans lives using the proven GYB prevention and intervention strategies with tactics adjusted for demographic differences. GYV's goal will be to reduce Veteran suicides by 34% within the first 36 months of implementation. "Guard Your Veteran" adjustments for Veteran demographics, include:

- Leadership: collaboration with trusted Veterans leaders and organizations
- Convenient Access: All calls must receive "in-the-moment" support. Eliminate the clutter. Technology must facilitate connectivity, not frustrate callers seeking help.
- Education Outreach: Most of our calls come from concerned "buddies" or loved ones. Suicidal individuals will often tell someone about their distress. The problem is people don't know what to do with that information at that critical moment. GYV will change that.
- Triage: beyond immediate assessment/support, refer to appropriate VA resource professionals, programs, and facilities to ensure optimal engagement and follow-up.

A national Branding strategy to support collaboration with Veteran leadership organizations at all levels to achieve the mission—stop the suicides—is important. "Guard Your Veteran" Program design considerations:

- Suicide rates for Veterans are highest during the first three years out of the military
- 70% of Veterans who commit suicide are not under VA care
- Suicide rates are 16% higher for Veterans who never went to Afghanistan or Iraq
- Approximately 65% of all Veterans who committed suicide were 50 or older

GYV's solution will be multi-sectoral including, young and old, working together. Servicemember and Veteran suicide prevention is everyone's job and a national imperative. GYB hopes to be part of that strategy and an integral part of the solution.

We appreciate the invitation to address this Committee and the opportunity to share our experiences with GYB in the TNNG. We look forward to your questions and thank you for your time.

Respectfully,

Cindy Sheriff and Bill Mulcahy, GYB Co-founders.

If time allows, I would like to share the following letter received from a servicemember that will give the Committee a feel for GYB's effectiveness in the TNNG.

An email we recently received (redacted).

From: XXXXXXXXXX
Date: December 12, 2017 at 7:23:06 PM CST
To: <gyb@jasonfoundation.com>
Subject: Thank you

This is not an urgent matter. I just wanted to say thank you for helping me in my time of need as well as my brothers and sisters. You all are a very important part of the military community and I thank you for you service from the bottom of my heart.

Sincerely, XXXXXXXXXXXXX

P.S.—Your hard worked saved four of my buddies including myself.

What is Guard Your Buddy?

In 2012 "Guard Your Buddy (GYB) was launched in Tennessee as a program designed and developed from TNNG General Max Haston's mission to "stop the suicides". The GYB initiative has two goals:

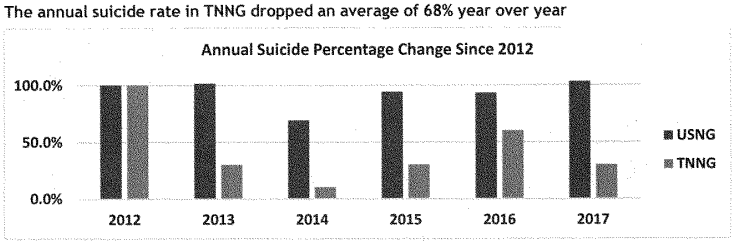
- Prevent suicide among members of the Tennessee National Guard
- Promote psychological fitness and resiliency by providing members of the Guard-and their loved ones-the confidential support, education, advocacy and resources needed to eliminate this "silent" epidemic before it can continue to do harm

What makes Guard Your Buddy unique?

- Singular focus on stopping suicide, focus both on prevention and intervention
- Leverage technology: Smart Phone App to help a Guard-member, "buddy" and family
- Masters level clinicians are two clicks away
- Clinical intervention and resources for both Guard-members contemplating suicide and their battle buddy/family

What are the Guard Your Buddy outcomes in Tennessee 2012 through 2017?

The annual suicide rate in TNNG dropped an average of 68% year over year



Suicide is a public health issue and population health challenge. Similar to GYB, GYV's foundation will be a communal approach. We anticipate that GYV's strategy will involve public-private partnerships, religious organizations, Wounded Warriors, community-based groups and existing Veteran programs such as the Readjustment Counseling Service.

GYV will save Veterans lives using the same GYB strategy of prevention and intervention, with tactics adjusted for demographic differences. GYV's goal will be to reduce Veteran suicides by 34% within the first 36 months of implementation. Preliminary considerations for GYV program design include:

- Suicide rates for Veterans are highest during the first three years out of the military
- 70% of Veterans who commit suicide are not under VA care
- Suicide rates are 16% higher for Veterans who never went to Afghanistan or Iraq
- Approximately 65% of all Veterans who committed suicide were 50 or older

Suicide prevention is everyone's job.
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Prepared Statement of Keita Franklin

Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. I appreciate the opportunity to discuss preventing suicide among Veterans. I am accompanied today by Mike Fisher, Chief Officer, Readjustment Counseling Service (RCS).

Introduction

Suicide is a serious public health concern that affects communities nationwide. Nationally, suicide rates are rising for Veterans and non-Veterans alike, and after adjusting for differences in age, both male and female Veterans have an elevated rate for suicide across nearly all ages groups compared to their civilian counterparts. Veterans as a group tend to possess unique characteristics and experiences related to their military service (such as transition-related challenges or posttraumatic stress disorder (PTSD)) that may increase their suicide risk; however, they also tend to possess protective factors, such as resilience or a strong sense of belonging to a unit, that may minimize this risk. Our nation's Veterans are strong, capable, valuable members of society, and it is imperative that we eliminate Veteran suicide.

Suicide prevention is a top priority for the Department of Veterans Affairs (VA). According to recent data published by the VA Suicide Prevention Program, an average of twenty (20) Veterans, active-duty Service members and non-activated Guard or Reserve members die by suicide each day. Of those twenty (20), fourteen (14) have not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support. In June, VA published a comprehensive national Veteran suicide prevention strategy that encompasses a broad range of bundled prevention activities to support the Veterans who receive care in the VA health care system as well as those who do not come to us for care.

Since 2010, the Veterans Health Administration (VHA) has worked to reach all Veterans through a national suicide prevention media outreach campaign, which raises awareness about suicide prevention, the Veterans Crisis Line, and services available through VA. Established by VHA in 2007, the Veterans Crisis Line provides confidential support to Veterans in crisis. Veterans, as well as their family and friends, can call, send a text message, or chat online to speak with a caring, qualified responder, regardless of VHA eligibility or enrollment. VA is committed to providing free and confidential crisis support to Veterans 24 hours a day, 7 days a week, 365 days a year. In addition, we as a nation must do more to support Veterans before they reach a crisis point in the first place.

VA Is Advancing a National Public Health Approach to Suicide Prevention

In order to be effective, suicide prevention efforts must be comprehensive and encompass a wide variety of initiatives. To cite one successful effort, the U.S. Air Force significantly lowered suicide rates among its Service members over a 16-year period by taking a broad, bundled approach that relied on community-based outreach. As VA advances a public health approach to preventing Veteran suicide, we are using data and the best evidence available to design and promote prevention strategies across many sectors.

As not all Veterans have the same risk for suicide, VA has relied on a framework developed by the National Academy of Medicine (formerly the Institute of Medicine) in designing our prevention strategies. This framework, which is also employed by the Defense Suicide Prevention Office, considers three levels of prevention strategies:

- Universal strategies aim to reach all Veterans in the U.S. An example of a universal strategy is VHA's ongoing suicide prevention media outreach campaign.
- Selective strategies are intended for some Veterans who fall into subgroups that may be at increased risk. An example of a selective strategy is our collaborative work with the Department of Defense and the Department of Homeland Security to support Service members transitioning out of the service with suicide prevention and mental health services.
- Indicated strategies are designed for the comparatively few individual Veterans identified as being at high risk for suicidal behaviors. An example of an indicated strategy is referring Veterans in crisis to the Veterans Crisis Line or providing a Veteran survivor of a suicide attempt or loss with enhanced support and expedited access to care.

This framework and other guiding principles are outlined in the recently published National Strategy for Preventing Veteran Suicide. The strategy is intended to serve as a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention and is organized around four strategic directions:

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

Further, the Suicide Prevention Program has developed an evaluation framework for tracking and measuring both short- and long-term outcomes of suicide prevention activities related to the goals described in the National Strategy for Preventing Veteran Suicide.

VA recognizes that our experience, expertise, and leadership make us well-positioned to lead the charge on suicide prevention. However, VA alone cannot end Veteran suicide. We are working with like-minded partners across numerous sectors—including health care, faith-based, and community organizations—to advance our public health approach. To date, the Suicide Prevention Program has established 21 formal partnership agreements with organizations in health care, research, government, and beyond to expand the network of support and care for Veterans. In addition, we have dozens of informal partnerships with Veterans Service Organizations, nonprofits, employers, and technology companies, among others.

One resource that many of our external partners and internal teams have found valuable is our S.A.V.E. (Signs of suicidal thinking, Asking the question, Validating the Veteran's experience, Encouraging treatment and expediting help) suicide prevention course, which was developed through a partnership with the education nonprofit PsychArmor Institute and educates people on how to support a Veteran in crisis. Since May 1, 2018, the S.A.V.E. course has been viewed 9,140 times on PsychArmor.org and social media and is one of PsychArmor's five most-viewed courses. This is just one example of our efforts to equip partners and networks across the country with the skills they need to support Veterans.

VA has also partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement the public health approach at the local level. The Mayor's Challenge is a program that empowers city leaders to work together in preventing suicide among local Veterans.

As of today, seven cities nationwide have established coalitions to prevent Veteran suicide, and we are planning to expand the program to 20 more.

Suicide Prevention Is VA's Top Priority

As the largest integrated health care system in the United States, VHA's role in preventing Veteran suicide is imperative, and we are continuing to develop and implement innovative suicide prevention approaches and resources. While continuing to expand our crisis intervention services, we are also expanding our treatment and prevention efforts to address issues that arise well before a suicidal crisis:

- VA has expanded the Veterans Crisis Line to three call centers. Since its launch in 2007, the Veterans Crisis Line has answered more than 3.5 million calls and initiated the dispatch of emergency services to callers in crisis nearly 100,000 times. The anonymous online chat service, added in 2009, has engaged in more than 413,000 chat conversations. In November 2011, the Veterans Crisis Line introduced a text messaging service to provide another way for Veterans to connect with confidential, round-the-clock support and since then has responded to nearly 98,000 texts.
- Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.
- VA works continuously to expand suicide prevention initiatives by:
- Bolstering mental health services for women
- Broadening telehealth services
- Providing free mobile apps to help Veterans and their families
- Improving access to care by providing mental health screening and treatment services through Vet Centers and readjustment counselors
- Using telephone coaching to assist families of Veterans

VA's Community Outreach and Mental Health Access

Every day, more than 400 Suicide Prevention Coordinators (SPC) and their teams—located at every VA medical center—connect Veterans with care and educate the community about suicide prevention programs and resources:

- In fiscal 2017, 100 percent of VA's facilities conducted monthly outreach events, for a total of over 14,000 events that reached more than 400,000 people.
- VA facilities have reported 14,511 outreach events in fiscal year (FY) 2018 to date.
- The estimated total attendees for year-to-date outreach events is more than 1.46 million.

VA has undertaken efforts to improve Veterans' access to VHA's high-quality mental health care; these efforts are proving effective:

- From 2005 to 2015, the number of male and female Veterans who had recently used VHA services increased by nearly 20 percent and 55 percent, respectively.
- From 2012 to 2017, the number of unique Veterans receiving mental health care from VHA has risen 20 percent and the number of outpatient mental health visits delivered by VHA has risen 24 percent.
- According to the National Academies of Science, Engineering, and Medicine's 2018 "Evaluation of the Department of Veterans Affairs Mental Health Services," VA provides mental health care of comparable or superior quality to care in the private sector and elsewhere in the public sector. This report—the result of a Congressionally mandated assessment of access to and quality of VA health care services for Veterans of the wars in Afghanistan and Iraq—indicated that Veterans who use VA services reported positive aspects of and experiences with VA mental health services. These aspects of care include the availability of needed services, the privacy and confidentiality of medical records, the ease of using VA mental health care, the mental health care staff's skill and expertise, and the staff's courtesy and respect toward patients.
- The quality of VA mental health care is generally as good or better than care delivered by private plans, and VHA outperformed private plans on seven of nine quality measures, according to a RAND study from 2011.

VA Readjustment Counseling Service (RCS)

RCS provides services through the 300 Vet Centers, 80 Mobile Vet Centers (MVC), 18 Vet Center Out-Stations, over 990 Community Access Points and the Vet Center Call Center (877–WAR–VETS). The Vet Center model of service is designed to decrease barriers associated with receiving care including providing services during non-traditional hours or in communities distant from existing "brick and mortar" Vet Center facilities. Over 70 percent of Vet Center staff are Veterans, and the majority have served in combat zones.

RCS is aggressively focused on preventing Veteran suicide through partnership with other VHA programs, expanded access to Vet Center services, and innovation. In FY 2017, RCS increased the number of successful suicide interventions by 28 percent over the previous two FYs.

In 2017 RCS and the VHA Office of Mental Health and Suicide Prevention began collaborating to increase coordination between the Program Offices to address Veteran suicide. Since beginning this collaboration quality improvements include:

- Increased collaboration through regularly scheduled interaction with local Vet Center staff and SPCs to provide consultation, support, and joint care coordination to high-risk Veterans.
- Increased bi-lateral connection to services for high-risk Veterans.
- Increased training to local Vet Centers by SPCs. In addition, RCS held 29 mandatory face-to-face trainings for clinicians, outreach specialists, and office managers between May and September 2018. Each training had a focus on Suicide Prevention Strategies and Best Practices. Participants discussed warning factors, various suicide risk assessments, safety planning, VA's REACH VET Program, and other available resources and trainings.

RCS has consistently increased access and delivered services to more Veterans, Service members, and families each year. In expanding access over the last two FYs:

- The number of unique Veterans, Service members, and families provided these services increased by 31 percent. Vet Center visits for Veterans, Service members, and families increased by 18 percent.
- Visits during non-traditional hours (before 8:00 AM, or after 4:30 PM), and on weekends and holidays increased by 41 percent.

- Community Access Points where services are available on a regularly scheduled basis, depending on the demand in communities located away from the brick and mortar Vet Centers increased by 76 percent.
- Visits provided specifically to Service members increased by 12 percent.

In addition to providing quality readjustment counseling, RCS staff focus on early intervention through targeted outreach designed to create face-to-face connections with the sole purpose of providing access to services.

- Over the last two FYs, the number of distinct outreach events Vet Centers hosted or participated in increased by 28 percent.
- RCS is coordinating with the National Guard Bureau and State Adjutant Generals to leverage Vet Center clinical and outreach staff and 80 MVCs to provide outreach, direct counseling, and referral to National Guard and Reserve Units during drill weekends to combat the rising suicide rate. This includes connection to other available services when National Guard and Reserve members are not eligible for other VA services.

VA is always looking for new and innovative suicide prevention strategies. Some examples of these strategies taking place at Vet Centers across the nation include:

- Provision of suicide prevention training to community stakeholders such as police, fire departments, and schools. First responders typically encounter more Veteran suicidal ideation and Veterans in crisis than other community stakeholders.
- Vet Centers have been working directly with the Suicide Prevention Resource Center in obtaining Suicide Alertness for Everyone (SafeTALK) training. SafeTALK is a training program that teaches participants (Veterans and nonclinical staff) to recognize and engage persons who might be having thoughts of suicide and to connect them with their local Vet Center. As a result of the training, several Veterans have entered into care due to interventions implemented by this first set of participants.

Conclusion

VA's goal is to prevent suicide among all Veterans, including those who do not—and may never—seek care from our health system. To do that, we are using a public health approach to suicide prevention, finding new and innovative ways to deliver support and care to all Veterans where they live and thrive. We are committed to advancing our outreach, prevention, and treatment efforts to further restore the trust of our Veterans and continue to improve access to care and support inside and outside VA. Our objective is to give our nation's Veterans the top-quality care they have earned and deserve. Mr. Chairman, 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.

Prepared Statement of American Veterans (AMVETS)

Statement for the Record of Sherman Gillums Jr.
Chief Advocacy Officer
American Veterans

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

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

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

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

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

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

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

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

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

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

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

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

There is currently a bill in the Senate, which passed the House, that seeks to honor his memory,

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

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

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

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

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

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

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

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

access to mental health care and suicide prevention resources for veterans who have recently separated from military service.

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

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

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

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

Prepared Statement of Disabled American Veterans (DAV)

STATEMENT OF
SHURHONDA Y. LOVE
DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR

On behalf of DAV (Disabled American Veterans) and our more than one million members, all of whom are wartime injured or ill veterans, thank you for inviting DAV to submit testimony for the record for today's hearing to discuss the findings of the Department of Veterans Affairs (VA) most recent suicide data. We appreciate the Committee's attention to this critical topic.

Suicide prevention is not "just" a VA and Department of Defense (DoD) problem because it affects everyone and every community. According to VA's most recent report on suicide, its numbers within the military and veteran community have remained relatively static in spite of all of the new programs, services and community partnerships put together to reduce it or stop it altogether. For this reason, we must take a look beyond the data, to examine what VA is doing to prevent suicide, the efficacy of its suicide prevention programs, what it is doing to reduce or eliminate suicide, and its suicide prevention efforts in its partnerships within the community and other Federal agencies.

One way VA is attempting to lower the rates of suicide is its social media campaigns to increase awareness and the provision of tools for veterans, their families, and those working with veterans. One of these campaigns between VA and DoD is the "Be There" campaign. "Be There," in summary, means feeling comfortable to address someone you think may be in distress, knowing what to do and who to call, and being there to hear the needs of that person. We know that suicidal behavior is often related to the consequences of problems like failed relationships, combat exposure, illegal substance use, terminal disease, poor physical health, low or no income, job stress, physical or sexual trauma, and legal or housing stress. "Be There" and other awareness and prevention campaigns could be the first steps in lowering the rates of suicide, by arming more individuals with the knowledge and confidence to speak up and recognize when they, a loved one or someone they know is struggling.

A simple way we can all make a difference within our communities is by asking the question, "Are you ok; are you thinking of harming yourself?" "Be there" to listen for the response, and if necessary, to keep them safe. In acknowledgment of sui-

cide prevention month, DAV recently provided S.A.V.E. training at our Service and Legislative Headquarters in Washington, D.C. Personnel having received the training have been provided with resources to aid them in feeling comfortable enough to address a fellow staff member, veteran, friend or neighbor who they perceive may be experiencing distress. Through the support of the VA's Office of Suicide Prevention, staff members who participated in the training received items with the VA Crisis Line number, 1–800–273–8255, along with other relevant information to aid a person in crisis. This line connects persons in need to first responders trained to deploy lifesaving conversation skills or actions, who know what to do, and have access to life saving interventions such as activating EMS or the police, and stabilization methods to follow up with additional screening and/or treatment as needed.

VA's Suicide Report

VA's study found that the general trends in veteran suicide have remained relatively consistent at about 20.6 veteran suicides per day, and about 6 of the 20 were recent users of VHA services. DAV recently released a new report, Women Veterans: The Journey Ahead. This report highlights research data to indicate the importance of looking more closely at subpopulations of veterans such as women. While women veterans are at lower risk of suicide than their male peers, VA's recent study indicated that women veterans are two times more likely to commit suicide than women who have never served. In contrast, male veterans have 1.3 times increased risk of suicide. Women veterans' rate of suicide is also increasing much faster than their male peers.

As we examine the findings of VA's most recent report on veterans' suicide, the efficacy of its current suicide prevention programs, community involvement, and the identification of veterans shown to be at highest risk, we must also evaluate how these programs and services meet the needs of women veterans. Women veterans represent a small portion of veterans; however, they continue to be the fastest growing cohort, not only in the Veterans Health Administration (VHA), but also in the Active duty and Reserve components of the military.

Women veterans continue to die from suicide each year at twice the rate of women that have not served. However, there is a difference in the method these two cohorts choose when committing suicide. Women who have not served tend to use less lethal means of self-directed violence, such as suffocation or poisoning. Women veterans have a higher tendency to use firearms, resulting in higher rates of fatality. In addition, while male veterans' use of firearms was relatively stable, women veterans' use increased from 34.3 to 39.9 between 2005 and 2015.

VA Approach a Public Health Model

VA has adopted a public health model for addressing veterans' suicide, which is impressively outlined in its recently released National Strategy for Preventing Veteran Suicide 2018–2028. This model relies upon using a population-focused approach; focusing on primary prevention; using science to inform policy; and multidisciplinary collaborations that develop solutions for diverse populations. VA's plans include bolstering health and empowerment in veterans and their families; taking steps to prevent veterans from committing suicide, including reducing access to firearms for those veterans at the greatest risk; treating those at risk of suicide; and creating systems of surveillance, research and evaluation to support preventive efforts.

With this understanding, VA has partnered with the American Foundation for Suicide Prevention (AFSP). AFSP is a community effort led through state chapters to reach the approximately 10.2 million (only 6 million use VA health care) out of 19.9 million veterans that do not use VA benefits or services. The AFSP places an emphasis on teaching providers about identifying those at risk, determining their level of risk, and appropriate actions to take for individuals at risk of suicide, gun safety, and post-vention (interventions for survivors following a death by suicide), and is one of the five initiatives identified by VA to combat veteran suicide from within the community.

VA continues to fine tune its REACH–VET (Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment) program, which uses predictive analytics to assist its providers in identifying and intervening in patients identified as being at high risk of suicide. DAV believes this is a state of the art program rivaling or even besting programs in large-scale private sector health maintenance organizations. DAV endorses the recommendation within our new report on Women Veterans that in updating its Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide with DoD, the guidelines work group should assess the scientific basis and publish recommendations on gender-based differences in risk, protective factors and treatment efficacy for suicide prevention. Gender-fo-

cused risk factors such as lack of social support or a history of sexual abuse may factor into VA's predictive analytics. In addition, the growing use of firearms in self-directed violence seen in women signals the need to provide firearm safety training to all at-risk veterans.

Initiatives to combat veteran suicide from within the community include the Mayor's Challenge, which features partnerships between VA, Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), and the Mayors of eight cities in its initial phase. The goal of the Mayor's Challenge is to reduce suicides among servicemembers, veterans and their families using a public health approach to suicide prevention including building awareness of problems and knowing where to get help.

Suicide prevention effort has also been extended to some college campuses where veterans are taking classes. The Veterans Integration to Academic Leadership (VITAL) program provides mental health services to student veterans on college campuses. In 2017, VITAL programs served 124 college and university campuses, and assisted 2,012 new student veterans on those campuses. Although suicide rates are generally higher for veterans using VHA, veterans not using VHA have higher risks of suicide relative to non-veteran peers. Unfortunately, these veterans are also harder to reach. For this reason, DAV is pleased to see emphasis on partnerships within the community to combat suicide.

Military Sexual Trauma

High rates of military sexual trauma (MST) among women may also factor into reasons some women veterans are at high risk for suicide. Among VHA users, 20 percent of women compared to 1 percent of men report military sexual trauma. In fiscal year (FY) 2017, DoD reports having received a 9.7 percent increase in the reporting of sexual assaults. DAV's Women Veterans report recommends that DoD work with other federal agencies and outside experts to evaluate and disseminate effective approaches to creating gender equity within a male-dominated workplace. Additionally, DoD should take an aggressive stand against sexual harassment and assault in the military by holding commanders accountable for creating a positive culture of inclusion and respect and sponsoring women's empowerment.

The effects of MST are often felt many years after service women and men have left the military. Once servicemembers transition into their communities, DoD, VA and community providers must work together to be sure all veterans receive the care they deserve.

Exceptional care must continue in the veteran's pursuit of benefits related to MST. In August 2018, the Office of Inspector General (OIG) issued a report (17–05248–241) that found that nearly half of denied MST-related claims from reviewed cases were not properly processed in accordance with Veterans Benefits Administration (VBA) policy, possibly resulting in the denial of benefits to these survivors of military sexual trauma. MST-related claims can be complicated, difficult to develop and often appear to lack the necessary evidence to warrant a grant of service connection. DAV supports recommendations made by the OIG for VA to revert back to ensuring its Veterans Service Representatives and Rating Veterans Service Representatives that are processing MST-related claims, have up to date, issue-specific training on MST. Furthermore, all denied MST claims during the period of the OIG report are reviewed and assessed for accuracy.

VA provides MST-related care to survivors free of charge, and regardless if service connection has been established through VA's disability compensation process. Veterans having experienced MST should be referred to VA to receive treatment and related services.

Need for Gender Specific and Sensitive Care

Women veterans also need patient care environments that they perceive as safe, private and inviting. They need knowledgeable gender-specific care providers who understand their issues and the health and mental health conditions in addition to their gender-specific needs. Women providers should be available to women veterans who request them, along with peer specialists who have similar experiences who can help them navigate services. DAV believes that VA provides comprehensive services and a whole health model approach that is best for women veterans. VA's wrap-around services, military competencies, integrated system and holistic approach to care make it superior to care in the private sector.

Assessing the Effectiveness of VA Mental Health Programs and Ability to Identify At-risk Veterans.

A critical step in ensuring VA's ability to deliver the high quality mental health care that veterans have not only earned through their service, but also deserve, is

highly dependent on having appropriate resources including personnel and capital assets to meet the demand for this specialized care. OIG released a report (17–00936–385) in September of 2017, that ranks the shortage of psychologists as third out of the top five occupations with the largest staffing shortages over the last four years. In the OIG's more comprehensive report (18–01693–196), released in June of 2018, the most frequently cited shortages were in the Medical Officer and Nurse occupations; a lack of qualified applicants, non-competitive salaries, and high staff turnover were cited as the most common reasons for the shortage. VA must have adequate resources to allow it to not only compete with salaries within the private sector, but also attract qualified candidates. With mental health conditions being cited as the third most frequently diagnosed category of conditions at VA for male and female patients, it is imperative that mental health providers be adequately staffed at VA facilities.

In response to these OIG reports, VA has implemented the Mental Health Hiring Initiative, and committed to hiring more than 1,000 more psychiatrists, psychologists and other mental health professionals. DAV Resolution 129 adopted at our most recent National Convention calls for a simple-to-administer alternative VHA personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector. We acknowledge VA's efforts and responses to the shortage of critical personnel in mental health, and we encourage the Department to continue its efforts in establishing innovative ways to not only attract, but retain qualified mental health professionals.

One way VA has leveraged its mental health capabilities, and increased veteran access to mental health care is through its "Anywhere to Anywhere Telehealth" initiative. As part of a federal health care system, VA providers are able to treat patients across the country unrestrained by state-specific telehealth laws and licensing. Leveraging telecommunication technology to provide mental health care to remote veterans greatly enhances veterans' access to care. Telehealth has been implemented in over 900 sites of care with high rates of satisfaction from providers and patients electing its usage. More than 450,000 veterans receiving care at VA have used home and clinical video telehealth. According to VA, mental health services that have been provided to veterans via clinical video telehealth (TeleMental Health) have reduced acute psychiatric VA bed days of care by 39 percent. VA also reported a 32 percent decrease in hospital admissions while boasting a 92 percent approval rate by veterans.

DAV Resolution No. 293, adopted at our most recent National Convention calls for program improvements, data collection and reporting on suicide rates among servicemembers 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.

VA's REACH–VET program was piloted in October of 2016, and was fully implemented in April of 2017. This program was designed to identify veterans in need of care, and provide care as early as possible by using predictive analytics to flag charts of veterans who may be at risk for suicide. Once a veteran has been identified, his or her VA mental health or primary care provider reaches out to check on the veteran's well-being, and reviews their condition(s) and treatment plans to determine if enhanced care is needed. By identifying at-risk veterans early, it allows VA to provide treatment before a crisis can occur, and decreases the likelihood of more serious conditions developing later. In May of 2017, VA reported that all VHA medical centers are working with those veterans at the highest risk; 0.1 percent of the veteran population, which includes about 6,400 veterans, roughly 46 per facility. Over time, the focus will expand to include those at a more moderate risk for suicide.

DAV views the REACH–VET program as a valuable tool for VA mental health providers in identifying veterans who are most at risk for suicide and connecting with them. It is important to ensure that once the connection is established, and the needs have been assessed, that there is a clear path for the veteran to receive the care that they need in a timely, efficient way. It is important that every opportunity is taken to eliminate barriers to this care and that these veterans receive the care that they have earned, and need. These veterans should continue to have their needs assessed until they no longer meet the criteria placing them in the highest risk for suicide.

Expanding Access to Veterans with Discharges Characterized as Other Than Honorable

According to the Government Accounting Office (GAO) report 17–260, more than 57,000 veterans that had been separated from service due to misconduct during fiscal years 2011 through 2015, had been diagnosed within two years prior to separation with post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), or certain other conditions that could be associated with misconduct. Because their service had been characterized as other than honorable, these veterans lacked access to VA health care for many years. In January of 2018, the VA Secretary concurred that this problem should be remedied and authorized emergency mental health care for veterans with other-than honorable discharges. This should allow VA to intervene with a new sub-group of veterans who may be at high risk of suicide.

Inter-agency Initiatives

In January 2018, the President signed Executive Order 13822, "Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life," directing the DoD, VA, and Homeland Security to develop a plan to ensure that all new veterans receive mental health care for at least one year following their separation from service. In implementation, the first goal of these three organizations is to facilitate seamless access to mental health treatment for transitioning servicemembers. Goal two is to provide access to suicide prevention resources to transitioning servicemembers and veterans through collaborative communication, and outreach efforts to veterans service organizations (VSO), and other stakeholders. The final goal is to leverage interagency partnerships to educate those who have recently transitioned about eligibility for VA mental health care services.

Several key initiatives have resulted from this interagency partnership. The Concierge for Care is a health care enrollment initiative that connects with former servicemembers shortly after they separate from the service. The Military Once Source, provides tools to help plan for deployments, educational and employment resources, and resilience tools to include medical counseling and other consultations in military life. The "Be There" peer support call and outreach center, helps provide access to a number of tools including help with relationships, family and financial counseling. Whole Health groups is an initiative that focuses the overall health of the veteran, desired health goals, and collaboration between the provider and veteran in making a plan around the veteran's desired goals. This may also include a connection to the community in the fulfillment of those goals. Whole Health groups have been established at all VA medical centers, which will help identify areas of life that are affecting veterans' lives, through communication between the veteran and his or her health care team to set goals, build a plan around those goals, and connect with the community. These interventions may be an important way of addressing newly separating veterans within a year of discharge, who are known to be at high risk of suicide.

Readjustment Counseling Service-VA Vet Centers

VA Readjustment Counseling Service (RCS) is home to VA Vet Centers. Vet Centers are one of VA's most popular and widely used programs. Qualifications to utilize these centers include veterans having served in any combat theater of hostility, those having experienced MST, those having served as a member of an unmanned aerial vehicle crew that provided direct support to operations in a combat zone or area of hostility, and for family members of veterans and servicemembers who require counseling for military-related issues such as bereavement counseling for families having experienced an Active duty death. According to RCS, Vet Center staff participated in over 40,000 outreach events during FY 2016.

Currently, there are a total of 300 "brick and mortar" Vet Centers located in every state, the District of Columbia, American Samoa, Guam and Puerto Rico. RCS staff members also deliver readjustment counseling services in other areas away from these traditional facilities through the use of its Vet Center Community Access Points (CAPS) and Mobile Vet Centers. CAPS are places where clinicians are able to provide readjustment counseling from other locations in accordance with the needs of that community. In FY 2016, RCS operated more than 740 CAPS which was reported to be a 25 percent increase from the previous fiscal year. Mobile Vet Centers allow RCS staff to deploy within the community to different locations to offer readjustment counseling where veterans are. Events such as gatherings hosted by VSOs or other stakeholders allow additional opportunities to reach veterans that may not receive care from VA for one reason or another, and provide them with the counseling services they need. RCS maintains a fleet of 80 Mobile Vet Centers that are designed to extend RCS staff ability to provide readjustment counseling to more locations within the community to qualifying veterans.

One of the least well-known services that RCS provides within the community is emergency response. In the aftermath of shootings, floods and other disasters, the

Vet Center staff frequently partners with Red Cross to provide clinical support in the affected communities. Most recently, Vet Center staff participated in responses to the West Virginia flooding, and the Dallas and Orlando shootings. According to RCS, more than 500 veterans and 60 family members were provided services at these sites, and through a leveraged partnership with Red Cross, provided referral and services to over 3,500 citizens of affected areas.

Peer Support

Peer Specialists in VA are generally veterans in recovery from a mental health or co-occurring condition(s) who have been trained and certified to help others with similar conditions. These veterans may be actively engaged in their own recovery and may volunteer or be hired to provide peer support to other veterans who are engaged in mental health treatment.

Peer specialists draw upon their own recovery experience to inform their support of veterans. The shared experience of military service tends to foster trust between the Peer Specialist and the veteran with whom they are working. Roles of the peer specialist are varied and include facilitating groups, role modeling, providing outreach and support, teaching coping skills, case management and acting as liaison between the veteran and mental health team.

VA peer support groups have also been seen as invaluable tools in helping veterans cope with symptoms of PTSD, depression, and other mental health related issues. Veteran peer support groups are an opportunity for interaction with people who share similar life experiences. This is especially important for women veterans, whose small numbers within each care facility may make it harder to find other women with whom to relate. While trained volunteers are a valuable resource, employing Peer Specialists often requires higher levels of commitment and engagement with veterans, care teams, in addition to accountability for the roles and responsibilities of the position that may exceed what can be expected of a volunteer. DAV supports Peer Specialists; however, we recommend that VA define specific outcome measures for the Women Veterans Peer Specialist program, including if they successfully connect veterans to mental health services, whether those services include evidence-based therapies, and whether participants had greater adherence to treatment and were more satisfied with their care. VA should continue to evaluate a variety of models to meet needs expressed by women veterans, including the integration of peer counselors in women veterans' comprehensive primary care teams.

In closing, DAV believes that VA and DoD have made important strides in understanding and addressing the issue of suicide among America's veterans. Unfortunately, the unchanged rates of suicide among veterans-and even increases in certain subpopulations such as women and younger veterans-make clear there is more work to be done. Within VHA programs, sufficient resources-staff, space and funding-are essential to ensure all veterans have access and are evaluated and treated within a reasonable timeframe. Veterans in crisis must be assessed immediately. VHA must continue to address staffing issues and other barriers to care such as transportation and child care that affect some veterans' ability to access care. VA and DoD must also ensure that programs are appropriately tailored for women veterans whose needs may be somewhat different than their male peers. VA and DoD must ensure its community partners are trained and effectively assisting in suicide prevention efforts and understand the special risk factors for veterans and when they should be referred to VA for help. Finally, VA must also continue its efforts to increase Americans' awareness of this crisis among veterans so we can all help to end it.

We appreciate the opportunity to provide this statement for the record. We ask the Committee to consider our views and statements as it addresses the issue of suicide prevention in the veteran population. I am pleased to address any questions from the Chairman of other Members of the Committee.

Prepared Statement of Dr. Barbara Stanley Ph.D.

PROFESSOR OF MEDICAL PSYCHIATRY AT COLUMBIA UNIVERSITY
AND
DIRECTOR OF THE SUICIDE PREVENTION TRAINING, IMPLEMENTATION AND EVALUATION PROGRAM ATNEW YORK STATE PSYCHIATRIC INSTITUTE

WITH RESPECT TO

″Veteran Suicide Prevention: Maximizing Effectiveness and Increasing Awareness″

Chairman Roe, Ranking Member Walz and members of the Committee, thank you for the opportunity to provide remarks on the critical issue of how to address the suicide epidemic among our veterans, including effective treatments and increasing awareness.

The hearing's aim, to examine the findings of the Department of Veterans Affairs' (VA's) most recent suicide data reports as well as the efficacy of ongoing efforts to prevent suicide among veterans receiving care in the VA health care system, is of critical importance. An additional goal, identifying actions needed to lower the rates of suicide among at-risk veterans, is within reach.

Suicide is one of the ten leading causes of death in the United States and, unfortunately, has increased by nearly 30% in the past 15 years. This increase stands in stark contrast to most other western countries where the suicide rate has either declined or remained the same. Furthermore, while suicide deaths have risen, other leading causes of death in the United States have mostly declined in this same time frame.

Among suicide victims, Veteran suicide remains a persistent problem. Veterans die by suicide at a significantly higher rate than the non-Veteran population with Veteran suicide 2.1 times higher than non-Veteran adults with about 2/3 of suicide deaths in Veterans by firearms.) This is dramatically higher than the overall firearm suicide rate in this country that stands at about 50%.

Despite the seriousness and complexity of the problem, simple actions can be taken that can help reduce suicide in the Veteran population that already have established effectiveness. While there are many strategies can and should be employed to address suicide in Veterans, this statement focuses on low burden intervention strategies with established effectiveness. Much has been done to identify those Veterans within the VA at greatest risk of dying by suicide. However, outreach to Veterans in the community who are not within the VA system can be increased by identifying those at risk using simple assessment tools like the Columbia Suicide Severity Rating Scale (C-SSRS), an assessment tool that is widely used within the VA.

Furthermore, once identified, Veterans need help to deal with their suicidal feelings to avoid acting of them. But the transition from identification of risk to asking for help is a challenge for Veterans. The majority of Veterans are male with females comprising only about 10% of the Veteran population. In general, males are much less likely to seek help than females particularly for emotional problems. Efforts made to encourage them to seek help should include care models that are consistent with a military approach that includes systematic problem solving, implementation of predetermined action plans and teamwork. These models are more likely to be acceptable and employed.

One such approach is the use of the Safety Planning Intervention. This intervention coupled with follow-up phone calls, called SAFE VET, has been found to reduce suicidal behavior almost in half in Veterans at risk for suicide. My colleague, Dr. Gregory Brown from the University of Pennsylvania, and I developed this simple, easy to use intervention that is consistent with a military approach to problem solving and includes identification of simple strategies to use in a crisis, people who can provide support and acceptable ways to reduce access to lethal means that the Veterans would use to kill themselves.

As one Veteran who used this intervention reported when asked about the usefulness of safety planning reported, ″How has the safety plan helped me? It has saved my life more than once.″ This Veteran's reaction has been echoed by many others who have used safety planning. While this intervention is used in the VA, the quality of its delivery is variable and needs to be improved. Furthermore, while we have established effectiveness of the safety planning intervention with phone follow-up for at risk Veterans discharged from the emergency room, large scale implementation in the VA with adequate resources for training to ensure high quality health care delivery has not been done.

Additionally, outreach efforts to implement safety planning with at risk Veterans who not in VA care are negligible. Finally, simple interventions can be readily translated into electronic modes of delivery in the form of apps with or without assistance of health care professionals. For example, a safety planning app could easily be developed, tested and disseminated to all Veterans whether or not they received health care within the VA. This app could be paired with additional suicide prevention apps such as insomnia apps, problem solving apps and depression apps.

Recommendations:

1.Systematic implementation of the SAFE VET intervention which includes the Safety Planning and telephone follow up in Emergency Departments, Behavioral Health and Substance Use Disorder Programs throughout the VA.

2.Couple training and dissemination of safety planning with efforts to screen for at risk Veterans who are not being treated in VA settings.

3.Develop and disseminate suicide prevention apps that include safety planning that are available to all Veterans whether or not they are receiving VA health care.

Prepared Statement of Iraq and Afghanistan Veterans of America (IAVA)

Statement of Stephanie Mullen
Research Director

Chairman Roe, Ranking Member Walz 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 Bix Six Priorities for 2018 which are the Campaign to Combat Suicide, Defend Education Benefits, Support and Recognition of Women Veterans, Advocate 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.[1] And while suicide is an American problem, it is severely impacting the veteran population in particular. According to the most recent Department of Veterans Affairs data, twenty veterans and servicemembers die by suicide every day. Women veterans are two and a half times more likely to die by suicide than their civilian counterparts. And veterans aged 18 to 34, the Post-9/11 generation, had the highest rate of suicide.[2]

We've been watching this trendline for years. In our latest Member Survey, 58 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.[3] Our members intimately know the devastation of this act. And despite recent efforts around suicide prevention, an increasing number of our members have a personal connection to suicide.

Perhaps no one knows this better than our own IAVA team, many of whom have been personally affected by veteran suicide. Patrice Sullivan, IAVA's Senior Veteran Transition Manager within the Rapid Response Referral Program, knows first hand of the impact a veteran suicide can have on a community. Her story, in her own words, is below:

On March 13th, 2005, my best friend, my person, my Marine, my Thomas, died by suicide.

Thomas always knew he wanted to join the Marine Corps, and in June 2000, a week before our high school graduation, he was off to bootcamp. Thomas was stationed in Okinawa, Japan during the attacks on 9/11, and I remember him assuring me that everything was going to be ok. There was no fear in his voice, just genuine love and honor. Being a Marine gave him a level of confidence and self-worth I had never seen in him before, a feeling of true purpose.

I can honestly say I didn't see any of the signs, but that doesn't mean they weren't there. I can say that because I didn't know anything about suicide. Surviving a loved one's suicide is the most unimaginable hell. In that one moment, your world is forever changed and nothing makes sense. You grieve. You cry, scream, but you survive. Some days I wonder how I've made it through these last 13 years, and I am always brought back to my first step towards finding hope.

For me, that first step was finding a group of people that could relate. I found a local support group for suicide survivors on the American Foundation for Suicide Prevention (AFSP) Web site. It eventually became my "safe place" and I truly believe it saved my life.

Today, Patrice works on the front lines to combat suicide through our Rapid Response Referral Program (RRRP). The RRRP team connects veterans and their families to the support and services they need. Whether it's navigating the VA or confronting significant challenges like unemployment, homelessness, legal, financial or mental health injuries, the RRRP team connects clients to the quality resources

[1] https://www.cdc.gov/vitalsigns/suicide/index.html
[2] https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4074
[3] iava.org/survey

they need. As of September 14, 2018, the RRRP team has handled 8,895 cases and this year alone, the RRRP team has connected 24 clients to the Veteran Crisis Line at a critical moment in that client's life. [4]

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 signing of the Clay Hunt SAV Act into law was an important first step to addressing this. We thank you for your support of this legislation, and the VA for its commitment to fully implement this law. Over the past three years, 995 combat veterans have enrolled in VA health care thanks to the eligibility expansion under this legislation. Community partnerships and outreach have grown tremendously at VA, and a one-stop shop for mental health resources, called the VA Resource Locator, provides mental health resources for those searching for care. More recently, designated funding for the Clay Hunt provisions supported the law's implementation, and we appreciate Congress' support for this additional funding that will improve mental health services for the 1.6 million veterans who receive specialize mental health care at the VA. [5] We look forward to the final evaluation of mental health and suicide prevention programs called for under the Clay Hunt SAV Act, expected in December of this year.

The Clay Hunt SAV Act was a critical piece of legislation to target mental health and suicide prevention, and bring attention to the growing need for resources in this area. Since then, we've seen a number of advancements and many pieces of legislation passed addressing the issue. Since 2015, within the VA, 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 started using predictive analytics to reach out to veterans who show risk factors for suicide.

More recently, IAVA was pleased to work with the VA and other stakeholders on the plan put forth in conjunction with the Executive Order (E.O.), Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life. This plan involves a comprehensive and community based approach to suicide prevention, paired with targeted mechanisms for at-risk populations. As this plan is implemented, we look forward to being part of this continuing process with VA, Department of Defense, Department of Homeland Security, and Members of Congress.

We have come so far since the signing of the Clay Hunt SAV Act in 2015, but there is still much work to be done. Continuing to expand access to mental health care, easing transition stressors for servicemembers and their families, ensuring access to suicide prevention tools and programs, creating community based solutions, and ensuring high quality and timely data analysis are all essential in moving the needle on this issue.

Of note, ensuring adequate staffing of VA mental health care clinicians is imperative to address the issues of mental health and suicide prevention. Programs such as the loan repayment program for psychiatrists under the Clay Hunt SAV Act incentivize mental health professionals to seek a career at VA. We call on Congress to continue its vigilant oversight of the Clay Hunt SAV Act, ensuring the loan repayment program and other provisions are fully implemented in addition to ensuring these provisions are fully funded. We ask that Congress continue to work with IAVA, other Veteran Service Organizations, and the VA to fill the critical mental health vacancies at VA.

We look forward to continuing to work with you on this critical issue. Thank you for allowing IAVA to share our views.

Prepared Statement of the National Alliance on Mental Illness (NAMI)

Submitted by:

Emily Blair
Senior Manager, Military, Veterans & Legislative Affairs

Chairman Roe, Ranking Member Walz, and members of the Committee, thank you for affording NAMI, the National Alliance on Mental Illness, the opportunity

[4] http://iava.org/blogs/rrrp-weekly-impact-report-september-14/
[5] https://www.va.gov/opa/publications/factsheets/April-2016–Mental-Health-Fact-Sheet.pdf

to submit a statement for the record (SFR) on this important hearing examining the most recent Veterans Affairs (VA) data reports on Veteran suicides. This statement also seeks to cover NAMI's view of the ongoing efforts to address the crisis of suicide among Veterans at VA-including the predictive analytics modeling tool REACH–VET and readjustment counseling-as well as highlighting areas in which there could be improvement.

NAMI is the nation's largest grassroots mental health organization, dedicated to building better lives for the millions of Americans affected by mental illness. Our organization advocates for the promotion of innovation and research, improving care, and supportive recovery services for all Americans living with mental health conditions. NAMI envisions a world where all affected by mental illness experience resiliency, recovery, and wellness.

NAMI Supports Congressional Efforts to Bolster VA Mental Health Initiatives

NAMI appreciates that VA continues to designate suicide prevention as the Department's top clinical priority, the efforts made to implement suicide prevention programs and the larger focus on providing increased access to high-quality mental health care. Accordingly, NAMI applauds Congress for your continuous work on this important issue.

This Congress has made important contributions to this endeavor, including the substantial investments made in mental health research, expanding mental health care access at the Veterans Health Administration (VHA), the passage of the VA MISSION Act, and assuring Veterans with other-than-honorable (OTH) discharges can access mental health care at VA-as included in the FY 2018 omnibus. NAMI believes that all these efforts working together will aid in moving the needle towards the reduction of Veteran suicides in America-though we all know more work must be done to realize the goal of an America that no longer loses its Veterans to suicide.

Fully Funding the VA MISSION Act

NAMI was pleased to see an additional $1.25 billion included in the FY 2019 Military Construction and Veterans Affairs division of the Minibus I appropriations package that was recently passed by Congress and signed by the President.[1] While it does fall short of the $1.6 billion necessary to fully fund and implement the new Veterans Choice Fund as passed in the VA MISSION Act for FY 2019, it represents an initial good-faith investment by Congress to support the new and improved Veterans health care program.

While we understand and appreciate that Congress must be good stewards of U.S. taxpayer dollars, NAMI remains deeply concerned about the willingness of Congressional Appropriators to fully fund the remaining $18.2 billion-over FY 2020 and FY 2021-to cover the costs associated with the program. Since the current domestic discretionary budget cap for FY 2019, and the anticipated caps for FY 2020 and FY 2021, did not consider the increased costs associated with the VA MISSION Act, NAMI strongly encourages Congress to appropriate this additional discretionary funding to meet the new requirements, without triggering sequestration.

VA National Suicide Data Report, 2005–2015

When VA released the National Suicide Data Report for 2005–2015 at the end of June 2018, NAMI remained deeply disappointed and concerned that among "general trends in Veteran suicide, previously reported through 2014, remained consistent through 2015."[2] While we understand substantial efforts are being made to target this serious issue within VA, through identifying Veterans at risk earlier, readjustment counseling services offered at Vet Centers, and providing increased access to care-it's clear that much more must be done since the numbers remain the same. It is also understood that full-scale implementation across an organization as large and diverse as VA takes substantial time, and sometimes years to determine if efforts yield to positive outcomes.

NAMI appreciates the further stratification of the data in the 2015 report to include the specific numbers of suicides among Active-Duty Service Members, National Guardsmen or Reservists, and Veterans each day. This small distinction in

[1] Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act, 2019, H.R.5895, 115th Cong. (2018).

[2] (2018, June). VA National Suicide Data Report, 2005–2015. Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs. Retrieved August 2018, from https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP—National—Suicide—Data—Report—2005–2015—06–14–18—508-compliant.pdf

how the data is presented can aid in informing how we better identify and provide outreach to individuals who may be currently experiencing suicidal ideation.

However, as an organization uniquely aware of the toll one single suicide takes on a family and oftentimes an entire community, we encourage this Committee, Congress and VA to consider the following actions in order to reach our shared goal of the reduction-and eventual goal of zero-suicides among American Veterans.

REACH–VET & Predictive Modeling Analytics

While the Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH–VET) predictive model has shown early promise for identifying Veterans who could be at-risk for suicide at a much earlier stage, more must be done in the interim to identify and engage Veterans at more immediate risk for suicide. Data analytics and predictive models to determine suicidality can be very effective when utilized properly.

NAMI continues to be interested in the diagnosis piece of the predictive model and concerned that certain mental health diagnoses including post-traumatic stress disorder (PTSD), anxiety, bipolar disorder II, and incidences of traumatic brain injury (TBI) are not included. NAMI recommends that this Committee work closely with VA to determine why these mental health diagnoses were excluded from the REACH–VET suicide prevention predictive model. Additionally, NAMI recommends this Committee ask VA for written reports or briefings when components of the model is adjusted. Using data analytics and mining data from VA health records of Veterans who died by suicide to determine certain trends for risk is a powerful tool that when implemented correctly and precisely, can have very positive outcomes. As such, we also encourage the Committee to ensure VA is utilizing the best possible data analytics for REACH–VET.

Furthermore, recognizing the correlation between Veterans prescribed opioids and the high rate of suicides among Veterans, NAMI would encourage consideration of more collaboration between REACH–VET and the Stratification Tool for Opioid Risk Mitigation (STORM), a web-based dashboard that prioritizes review of Veterans receiving opioids based on their risk, who are receiving care through the Veterans Health Administration (VHA).[3]

Vet Centers

NAMI is increasingly pleased with the services provided by Vet Centers, and we refer eligible Veterans to seek care at Vet Centers on a regular basis because of the continuous positive experience Veterans report receiving. A trend that NAMI and our state organizations often see worth reporting is that many Veterans and family members are unfortunately unaware of the existence of Vet Centers and the incredible services they provide. Therefore, NAMI recommends that the Committee work more with VA, Vet Centers and stakeholder organizations to more widely-disseminate information about Vet Centers.

Rural Veterans

When reviewing the State data breakdown of the 2015 National Suicide Data Report, NAMI remains deeply concerned about the mental health of rural Veterans, and their access to high-quality care. Observing the top 10 rural states by population in the U.S., the suicide rate among Veterans ranges between 40.3% (40 per 100,000) to 52.3% (52 per 100,000).[4] In many rural areas and states, there are very few mental health professionals for hundreds of miles. As such, NAMI applauds the Committee's work and the passage of the VA MISSION Act which will, once implemented, greatly improve the care rural Veterans are able to obtain.

Accordingly, NAMI believes that the provisions specifically removing barriers for VA health care professionals to practice telemedicine and treat Veterans across state lines, strengthening peer supportive networks for Veterans living in rural areas, and the authorization of access to walk-in community clinics for enrolled Veterans-will all be positive steps in the right direction for adequately addressing both the urgent and long-term mental health care needs of rural Veterans.

Improving Diagnostics through research on Psychiatric Biomarkers

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[3] Minegishi, T., Garrido, M. M., Pizer, S. D., & Frakt, A. B. (2018). Effectiveness of policy and risk targeting for opioid-related risk mitigation: a randomised programme evaluation with stepped-wedge design. BMJ Open, 8(6), e020097. http://doi.org/10.1136/bmjopen-2017–020097

[4] (2018, June). VA National Suicide Data Report, 2015 State Data Sheets. Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs. Retrieved August 2018, from https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP—National—Suicide—Data—Report—2005–2015—06–14–18—508-compliant.pdf

As an organization that promotes innovation to accelerate research and advance treatment for mental health conditions, NAMI remains very supportive of the research and development of psychiatric biomarkers for brain health conditions, and we encourage this Committee and Congress to make the necessary investments in research to begin to accomplish this goal.

Currently, the only tools available to diagnose a mental health condition are survey-based. This results in a large amount of misdiagnosis of conditions, and therefore lack of timely and appropriate treatment. NAMI continues to advocate for VA to work in coordination with the Department of Defense (DoD) to develop and carry out a longitudinal research study which will identify biomarkers or non-survey diagnostic tools, which will enable clinicians to make a more precise diagnosis. This will result in earlier identification of conditions, which will lead to better treatment outcomes for Veterans and servicemembers living with mental health and brain health conditions-to include TBI. Earlier identification and treatment for these conditions is essential, and we believe a necessary component to reducing suicides among Veterans.

Utilizing Evidence-based Treatments

As an organization, NAMI is proud that our advocacy North Star is always based upon the latest scientific research, and that we continue to be proponents of utilizing evidence-based treatments and interventions for individuals with mental health conditions. Therefore, NAMI strongly encourages the Committee to work with VA to ensure mental health professionals within the walls of VA and community providers enrolled in the Choice Program, delivering care to Veterans are trained in and administering the latest evidence-based treatments for those at-risk of suicide or experiencing suicidal ideation.

Two evidence-based treatments specifically designed to address to unique needs of an individual who is struggling with suicidal ideation or has a prior suicide attempt is Cognitive Behavioral Therapy for Suicide Prevention (CBT–SP) and Dialectical Behavior Therapy (DBT). CBT–SP is based upon the principles of cognitive behavioral therapy (CBT) and can be used with adults and adolescents. This treatment includes cognitive restructuring strategies, such as identifying and evaluating automatic thoughts from cognitive therapy; emotion regulation strategies, such as action urges and choices, mindfulness, and distress tolerance skills; as well as other CBT strategies, such as behavioral activation and problem-solving strategies. [5]

Dialectical Behavior Therapy (DBT) has four components, and numerous research studies including multiple randomized control trials, have shown DBT to be effective in reducing suicidal behavior and other mental health conditions. [6]

Conclusion

NAMI is grateful to Secretary Wilkie, Congress and this Committee for the continued focus on ending Veteran suicide and improving the lives and care of America's Veterans. We wish to express our gratitude to the Committee for the invitation to submit a statement for the record on this important topic.

It is a devastating tragedy that our nation continues to lose an average of 20 Veterans each day to suicide. This is an issue of personal importance to myself, the organization I represent and all NAMI members across the country. We continue to commit our organization to working shoulder-to-shoulder with Congress, VA, the Department of Defense, and our advocacy partners to achieve our shared goal of the reduction, and eventual elimination, of suicide among Veterans in America.

Prepared Statement of The American Legion (TAL)

Chairman Roe, Ranking Member Walz and distinguished members of the Committee, on behalf of National Commander Brett Reistad and our nearly 2 million members, we thank you for the opportunity to share the views of The American Legion regarding Veteran Suicide Prevention.

Introduction

Suicide prevention is a top priority of The American Legion.

[5] Zero Suicide Model Toolkit: Treat Suicidal Thoughts and Behaviors Directly: Evidence-Based Interventions for Suicide Risk. Retrieved September 2018, from https://zerosuicide.sprc.org/toolkit/treat/interventions-suicide-risk

[6] Ibid.

Deeply concerned about the number of military veterans who take their own lives at rates higher than that of the general population, the nation's largest organization of wartime veterans established a Suicide Prevention Program under the supervision of its TBI/PTSD standing Committee, which reports to the national Veterans Affairs & Rehabilitation Commission.

The TBI/PTSD Committee reviews methods, programs and strategies that can be used to treat traumatic brain injuries (TBI) and post-traumatic stress disorder (PTSD). In order to reduce veteran suicide, this Committee seeks to influence legislation and operational policies that can improve treatment and reduce suicide among veterans, regardless of their service eras.

This white paper report examines recent trends in veteran suicide and their potential causes and recommends steps to address this public health crisis.

Summary

"I hate war as only a soldier who has lived it can, only as one who has seen its brutality, its futility, its stupidity."

- Dwight D. Eisenhower

Since 2001, the U.S. military has been actively engaged in combat operations on multiple continents in the Global War on Terror. More than 3 million Americans have served in Iraq or Afghanistan through the first 17 years of the war. Traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) have become known as the "signature wounds" of the war, and in recent years, countless studies, articles and reports have documented an inordinately high suicide rate among those who have come home from the war, those of previous war eras and among active-duty personnel.

The American Legion is deeply concerned by the high suicide rate among servicemembers and veterans, which has increased substantially since 2001.(1) The suicide rate among 18–24-year-old male Iraq and Afghanistan veterans is particularly troubling, having risen nearly fivefold to an all-time high of 124 per 100,000, 10 times the national average. A spike has also occurred in the suicide rate of 18–29-year-old female veterans, doubling from 5.7 per 100,000 to 11 per 100,000.(2) These increases are startling when compared to rates of other demographics of veterans, whose suicide rates have stayed constant during the same time period.

In order to combat this crisis, The American Legion believes it is imperative to determine the causes of the increase in the suicide rate among these youngest of veterans.

With no current end date to the Global War on Terror in sight, the Post-9/11 cohort will continue to grow, as will the number of veterans who require psychological care. The Department of Veterans Affairs projects a Post-9/11 veteran population of just under 3.7 million by 2020.(3) As our nation deals with the effects of nearly two decades of conflict, the need for mental health services to care for U.S. military veterans is certain to increase in the years to come.(4)

It is difficult to determine if the suicide rate among veterans is higher now than it was after previous wars, mainly due to the quality of data previously collected. In the past, bias and stigma against mental injury prevented accurate data collection, research and treatment. After World War II, those suffering from PTSD symptoms were often labeled as malingerers, neurotics, having moral turpitude, or as latent homosexuals.(5) Accurate numbers may also have been hard to determine after previous wars due to classifications of suicide as deaths by motor vehicle accident, poisoning, drowning or as other accidents.

High suicide rates among veterans are not a recent phenomenon. In 1922, The American Legion declared the "worst casualties of World War are just appearing" as high rates of veteran suicide were gaining national notice four years after the armistice that ended World War I.(6) In 1921, The Washington Herald reported that the state of New York lost more than 400 Great War veterans to suicide in that year alone.(7) Similarly high rates of suicide emerged after the Second World War, the Korean War and the Vietnam War.(8)

Historically, the peacetime suicide rate among American military personnel has been much lower than the civilian rate. Experts have explained this phenomenon by invoking the "healthy soldier effect" which suggests that sound emotional, psychological and physical fitness are necessary for an individual to serve in the military. This healthy baseline is then complemented by the sociocultural protective factors of gainful employment, stable housing, additional education and good leadership.(9) Supporting this premise is the fact that the suicide rate in the U.S. Army remained stable from 1977 to 2003 before jumping 80 percent in 2004. In 2008, the suicide rate among Active duty military personnel exceeded that of the civilian pop-

ulation for the first time in history.(10) This sharp increase corresponded with the beginning of the Global War on Terror, the longest war in American history.

Suicidal behavior is complex. There is no single cause. Multiple factors instead feed into four primary causes discussed in this report:

- Post-traumatic stress disorder
- Traumatic brain injury
- Loss of a sense of purpose
- Loss of a sense of belonging

This report concludes with steps The American Legion recommends to help prevent veteran suicide and reduce a rate of self-inflicted death that in recent years has risen to a crisis level.

Causes
Post-traumatic Stress Disorder

PTSD, which was first accepted as a recognized diagnosis by the American Psychiatric As-sociation in 1980, has become a household term since the terrorist attacks of Sept. 11, 2001. The condition, however, is as old as warfare itself.

PTSD symptoms among those who have conducted or witnessed the trauma of battle are addressed in some of the earliest literature. Reactions to trauma, for example, are described in The Epic of Gilgamesh, The Odyssey, The Old Testament and Shakespeare's Henry IV. Among the symptoms recorded in these earliest accounts are reoccurring nightmares, anxiety, loss of interest and feeling of hopelessness in reaction to traumatic events.(11)

Suicidal behavior is multi-factorial, and the exact cause of the high veteran suicide rate remains a matter of considerable debate. However, what cannot be disputed is the truth that combat is an extremely stressful and traumatic experience. Exposure to combat can result in significant psychological injury, which when left untreated can have a long-term effect on a veteran's health, well-being, family and society.

Since the Vietnam War, clinicians have noted that suicidal behavior is a frequent manifestation of PTSD. Multiple studies have clearly established that combat veterans have higher rates of PTSD when compared to veterans who have not seen combat.(12) The greater the exposure to combat the more likely the veteran's mental health will be negatively affected.(13) In addition, veterans who have sustained Military Sexual Trauma (MST) are at a higher risk for developing PTSD; studies have documented that sexual trauma is a risk factor for suicide.(14)

In 2008, the RAND Corp. reported that at least 20 percent of Iraq and Afghanistan veterans have PTSD and/or depression.(15) The current rate of PTSD is consistent with that of veterans from the Vietnam War and previous conflicts.(16)

The increased rate of veteran suicide since 2001 is often associated with an increase in PTSD due to combat exposure. A 2017 study of U.S. Army Infantry units, Special Forces personnel and combat medics revealed that suicide risk varies by military occupation specialty and combat experience. Troops in combat arms occupations had significantly higher rates of PTSD and higher rates of suicide.(17) The connection between PTSD and suicide may be explained by the symptoms of PTSD experienced. PTSD is correlated to mood alterations including anxiety, depression, irritability, insomnia and survivor's guilt. These symptoms and changes in mood have all been shown to be considerably related to suicide attempts.(18)

In addition to the symptoms, PTSD is also often accompanied by secondary effects, such as strained intimate relationships after deployment.(19) Research on combat veterans and their families has shown that veterans with PTSD are more likely to have severe relationship problems and higher divorce rates when compared to their peers without PTSD.

An anonymous and confidential study in 2009 showed that a relationship exists between PTSD in combat veterans and higher rates of substance abuse.(20) Substance abuse and relationship problems can subsequently lead to legal and financial problems, all of which can place a veteran at risk for suicidal ideation and behavior.

In order to better understand how PTSD is connected to suicidality, it is important to first understand the effects of PTSD on the human brain. PTSD should not be considered a mental illness but rather a psychological injury that alters the way an individual's brain functions. Traumatic and extremely stressful events are often associated with drastic changes in the human brain.

Research has shown that individuals with PTSD experience a hyperactive amygdala as well as volume reduction and decreased functioning in the hippocampus and prefrontal cortex. This is a troublesome combination because the amygdala produces conditioned fear and stress responses to stimuli. The prefrontal cortex keeps the amygdala's responses in check. A failure of the prefrontal cortex

to control the amygdala would cause a reduction in an individual's ability to self-regulate responses to mental and emotional stimuli.(21) The inability of the brain to function normally in its critical roles may place a veteran with PTSD at higher risk of suicide.

Traumatic Brain Injury

TBI is the most common injury suffered by servicemembers in the current conflicts in Iraq, Afghanistan and across the globe. According to DoD, at least 370,688 servicemembers were medically diagnosed with TBI between 2000 and 2017.(22)

The detonation of improvised explosive devices and indirect fire account for over 60 percent of U.S. battle casualties.(23) Shock waves from blasts can cause severe injury to the human brain. Due to modern armored vehicles, protective body armor and improvements in battlefield care, servicemembers are surviving attacks that in previous conflicts would have proven fatal. The ratio of being wounded to killed in the war in Afghanistan is 7.4 in to 1, compared to 1.7 to 1 during the Second World War and 2.6 to 1 during the Vietnam War.(24) Saved lives of military personnel often means more return home with brain injuries.

In a 2008 study, military personnel with TBI were significantly more likely to report physical and mental health problems than those with other injuries.(25) This is because chronic neurodegeneration is often the consequence of traumatic brain injury. Symptoms of TBI may include memory and concentration issues, irritability and depression. Many also experience apathy, anger, disinhibition and a lower tolerance for frustration.

In 2009, a study of active-duty soldiers concluded that TBI contributes to an increased risk for suicide.(26) Distressingly, each additional TBI increases the risk. In 2011, research showed that among Veterans Health Administration users, veterans with TBI were nearly twice as likely to die from suicide as veterans without a TBI diagnosis.(27) Veterans with TBI are more likely to suffer from concentration issues and depression which place them at risk for suicide.

Sense of Belonging

In the late 19th century, Emile Durkheim, often referred to as a founder of the field of sociology, wrote one of the first analyses on suicide. Durkheim believed that one of the main causes was lost sense of belonging to society. Durkheim also noted that the transition to modern urban industrialized society had negatively impacted how individuals connected to their communities. Durkheim concluded that high levels of isolation and decreased social integration can lead to suicidal behavior.(28)

During the First World War, psychiatrists noted that "shell-shocked" soldiers treated near the frontlines with the support of their comrades had a high likelihood of recovery and mental health improvements. Soldiers who were evacuated away from their units and placed in hospitals often developed chronic symptoms and were eventually discharged from the military.(29) This indicates that a sense of belonging to a group or society contributes to a higher level of psychological well-being.

Today's veterans rejoin a civilian society which is largely disconnected from the current Global War on Terror and military service in general. Fewer Americans than in the past have direct family or social ties to the Armed Forces. War bond drives and the need for American workers to rush into factories to create munitions, planes, ships or tanks for the war effort are a thing of the past, which had previously connected U.S. society with the war effort. A smaller percentage of Americans serve in the military today than at any other time since the period between World Wars I and II.(30)

In a 2011 Pew Research Center study, 84 percent of Post-9/11 veterans said that the public does not understand the problems faced by those in the military or their families.(31)

Average Americans may view veterans as "damaged heroes" often portrayed in media as objects in need of charity and pity rather than as potential leaders, coworkers, peers and friends.(32) Research has shown that the current average American's perception of veterans is largely formed by how veterans, servicemembers and the military are portrayed in the media. Veterans are often portrayed as troubled individuals who struggle to readjust to civilian life due to mental health and substance abuse issues.

In a recent online survey, participants were asked to describe the way Post- 9/11 veterans are most often depicted in the media. Among the top responses were: PTSD, homeless, troubled, unemployed, injured, suffering, victims, and unstable. Forty-one percent of those surveyed stated that the way veterans are portrayed in the media is generally accurate.(33)

Stereotypes can affect how a veteran re-integrates into society. Research has shown that negative perceptions cause adverse outcomes in an individual's perform-

ance, motivation and self-esteem.(34) Public perceptions of veterans in need of charity and pity do not promote recovery from a psychological injury like PTSD but may actually act as a self-fulfilling prophecy. In order to facilitate recovery, individuals need social support and understanding. The kind of society that veterans return to can influence how quickly they recover from psychological injuries. The key piece is intimate connections and meaningful trusting relationships with others in society.

Israel has extremely low PTSD rates among its veteran population. A 2016 study in Israel surveyed veterans of combat operations in major wars from 1948 until 1982. The surveys showed that the probability of PTSD among those who had combat experience was less than 1 percent.(35) The low PTSD rates might be attributed to Israel's cohesive society, in which everyone shares a commonality of service and military experience. When Israeli veterans return home, they receive social support from family and loved ones who have served and understand the difficulties of transition, which may be a contributing factor to the low rates of PTSD.

Many veterans also face alienation when they enter academia. In a 2011 study conducted by the University of Nevada Reno, over half of student veterans stated that they do not fit in on campus, and almost one-third said they feel unfairly judged by their peers.(36)

When servicemembers transition from the military into civilian life, they undergo multiple personality and social identity changes. Losing camaraderie and belongingness to a unit can strip individuals of their social support; many veterans refer to their former military units as family. The loss of trusting relationships and a social support system can reduce the way a veteran manages intimate relationship stressors, financial instability and may lead to substance abuse or legal issues.

The severity of PTSD cannot be explained by merely looking at the source or causal event alone.(37) How PTSD manifests itself in an individual is also impacted by social support systems in place that a veteran can depend on. Veterans can be affected differently by similar traumatic experiences. The conditions may vary depending on their level of social support and solidarity in the society they return to. A close cohesive and understanding society enhances recovery and can help to reduce the symptoms of PTSD and help prevent suicide. Israel has extremely low PTSD rates among its veteran population. A 2016 study in Israel surveyed veterans of combat operations in major wars from 1948 until 1982. The surveys showed that the probability of PTSD among those who had combat experience was less than 1 percent.(35) The low PTSD rates might be attributed to Israel's cohesive society, in which everyone shares a commonality of service and military experience. When Israeli veterans return home, they receive social support from family and loved ones who have served and understand the difficulties of transition, which may be a contributing factor to the low rates of PTSD.

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Sense of Purpose

Many servicemembers find purpose and meaning during their time in the military. Serving our nation in uniform, whether here at home or in combat operations overseas, can be personally rewarding in numerous ways. Servicemembers often report that having a mission, working as a team, and completing daily tasks to be fulfilling. The military provides individuals the opportunity to contribute to something larger than themselves, to learn new skills and to grow.

The loss of the psychological benefits from their military obligations can lead some veterans to struggle with despair as they transition into civilian life. For many veterans, service is core to their identity and the way they define purpose in their lives. In a 2009 study, 92 percent of veterans surveyed stated that serving their commu-

nity was important to them.(38) Data from the same survey shows that volunteering in communities can help veterans transition smoothly into civilian life. Fifty-five percent of veterans who volunteer regularly said their transition was going well, compared to 46 percent of non-volunteering veterans.

A significant relationship exists between an individual's sense of purpose in life and his or her psychological well-being and levels of self-efficacy. The ability to maintain an understanding of one's purpose for existence has shown to be an important factor to protect individuals from suicidal ideation. Having a sense of purpose increases feelings of being able to deal with difficult life events, helps fight symptoms of depression, and contributes significantly to lower suicidal behavior and thoughts.(39) A renewed sense of purpose can also help mediate the effects of moral injury, guilt and cognitive dissonance felt after losing faith in what some Post-9/11 veterans have deemed to be a futile war.(40)

Post-9/11 veterans have stood out in the veteran community for their desire to continue to serve and give back, not only to local communities but across the globe. Veterans of Iraq and Afghanistan are finding ways to apply the skills they learned in the military in giving back to their communities in ways not seen before. Team Rubicon and The Mission Continues, non-profit organizations founded by Post-9/11 veterans, are challenging veterans to volunteer in disaster response, social services or youth programs. Research on The Mission Continues participants has shown dramatic increases in self-worth, strengthened relationships and enriched family life.(41)

In addition to volunteering on civic projects, Post-9/11 veterans are running for public office in record numbers. Until 2011, the number of veterans in Congress decreased every year since the end of the Vietnam War. The number of veterans running for public office significantly increased in 2016, and more veterans of the current wars entered races for public office in 2018. Veterans show through many avenues that they are a population that desires to continue to provide meaningful service to our nation.

In February 2015, the Joint Chiefs of Staff wrote a letter addressed to all of those who have served in the military since Sept. 11, 2001. In their letter, the Joint Chiefs challenged veterans to begin serving in their communities as soon as they take their uniforms off.(42) The Joint Chiefs astutely recognized that veterans need a sense of purpose to live fulfilling lives.

The American public should follow the Joint Chiefs guidance and encourage veterans to regain their lost sense of purpose through public service, volunteering, rewarding careers, learning new skills or crafts, or advocating for issues important to them, just to name a few options.

Risk factors for veteran suicide

Primary risks factors for suicide	Secondary risk factors for suicide

• PTSD & depression from
  ○ Combat
  ○ Deployment
  ○ MST
• Traumatic brain injury
• Loss of sense of purpose
• Loss of sense of belonging
	• Substance abuse
	• Financial distress
	• Intimate relationship problems
	• Legal issues

Progress by the Department of Veteran Affairs

The Department of Veterans Affairs (VA) has taken great strides to reduce veteran suicide. Of particular note, VA has expanded the Veterans Crisis Line (VCL), which responds to 500,000 phone calls every year as well as thousands of electronic chats and text messages. Since its launch in 2007, through September 2016, VCL staff dispatched emergency services to callers in crisis over 66,000 times.(43)

VA has hired hundreds of Suicide Prevention Coordinators (SPCs), mental health professionals that specialize in suicide prevention. SPCs are based in VA medical centers and local community-based outpatient clinics all over the country. Over 80 percent of the SPCs are conducting five outreach activities per month for at-risk veterans.(44) These events provide opportunities for VA to connect to veterans who may have fallen through the cracks and are not currently seeking VA health care.

In 2017, VA implemented REACH VET, a predictive analytics mechanism that utilizes existing data from VHA records to identify veterans who may be at risk for suicide. REACH VET measures variables such as age, gender, prescription medications, missed appointments, emergency room visits, and other variables to deter-

mine risk and notify primary care providers. By utilizing data and predictive analytics, VA is reaching more veterans who may have slipped through the system.

VA has made concerted efforts to destigmatize mental illness through its "Be There" campaign. This initiative seeks to teach community leaders, colleagues, friends and family members of veterans how they can make differences in a veteran's life. The campaign seeks to increase social cohesion by educating the American public.

In 2017, VHA had more than 1,100 veterans working as peer specialists, veterans with formal training who lead support groups, conduct outreach, case manage and help other veterans navigate the services available to them. A 2017 study showed that veterans who worked alongside peer specialists benefited and had increased levels of "patient activation" or buy-in. Veterans also showed increased levels of knowledge, self-efficacy and beliefs in managing their personal health.(45)

VA has implemented numerous successful initiatives and programs. However, as an average of 20 veterans a day continue to take their own lives, according to the June 2018 analysis, much more must be done, and VA must continue to strive to provide patient-centered care and improve the patient experience through adequately staffed and properly funded programs and services.

A June 2018 analysis by VA showed that veteran suicide has increased at a faster rate for those who have not recently used VA care and services available to them than for those who have used those services.

The American Legion's Concerns

Hiring Process

Despite VA's most recent hiring initiative, many hospitals and clinics are struggling with severe staffing shortages which can be attributed to the tedious hiring process, a high employee turnover rate and a significantly reduced recruitment, retention and relocation budget. The shortage of employees can lead to overworked staff, poor patient experiences and lower quality of care. Exemplary patient experience is vital to keeping veterans in the VA care network, which studies have shown significantly decreases risk of suicide.

According to a 2018 evaluation by the National Academies of Science, Engineering and Medicine, the Department of Veteran Affairs has "difficulty recruiting, problems with retention, and lengthy hiring procedures that contribute to high vacancy rates throughout the system, and these vacancy rates can be a barrier to service."(46)

This is further supported by reports of veteran experience at VA. When veterans were surveyed, 54 percent stated that the process of getting mental health care was burdensome, and 49 percent stated that it was not easy to schedule an appointment. Seventy-seven percent of veterans said that improving customer service was an important change needed at VA.(47)

After applying for employment at VA through USAJOBS.gov, qualified medical professionals can wait multiple months to begin work or even receive notice. Many applicants report a tedious, confusing and bureaucratic application process. While waiting to hear back from VA, many potential candidates seek employment elsewhere.

VA also struggles with a high employee turnover rate. In 2016, GAO found that Veterans Health Administration personnel losses in key clinical occupations increased to 7,700 annually. These positions include physicians, registered nurses and psychologists. Dissatisfaction with certain aspects of work, dissatisfaction with senior management, burnout and lack of benefits were reported as top reasons for resigning. In addition, 50 percent of employees reported that one or more benefits, such as tuition reimbursement, would have encouraged them to stay with VHA.(48)

In order to discover and resolve the root cause of the current resignation rates, The American Legion recommends that Congress fund a nationwide VA climate survey of mental health professionals. The American Legion also urges Congress to pass legislation to improve VA's tedious hiring process and increase VA's recruitment, retention and relocation budget. These measures will allow VA to retain quality mental health providers, incentivize exemplary performance, and increase employee morale.

Dangerous Drugs

Starting in the late 1970s, benzodiazepines, commonly known as "benzos" became one of the most prescribed psychotropic drugs in the United States. Benzodiazepines are a class of psycho-active drugs that were initially well-favored due to their immediate effect on anxiety, insomnia and agitation. Xanax, Valium and Klonopin are a few well-known benzodiazepines. Beginning in the late 1980s, multiple studies revealed that benzodiazepines had severe negative side-effects, and high potential for

abuse and dependency. VA researchers published reports that cited studies highlighting the risks of benzodiazepines well before the Global War on Terror began in 2001.(49) However, despite knowledge regarding these dangers, VA medical providers have continued to prescribe benzodiazepines to veterans.

In 2010, VA Clinical Practice Guidelines for the Treatment of PTSD cautioned providers against the use of benzodiazepines, citing growing evidence of negative side effects, including an increase of PTSD symptoms, risk of suicidal thoughts and of accidental overdose. Despite the severe risks, over 25 percent of veterans newly diagnosed with PTSD are still being prescribed harmful and potentially deadly amounts of medications.(50) According to a 2013 study, 43 percent of servicemembers who attempted suicide between 2008 and 2010 had taken psychotropic medications.(51) The link between certain dangerous prescription medications and veteran suicide should be recognized, and steps should be taken to reduce unnecessary prescriptions.

Additionally, benzodiazepines can be extremely harmful to veterans who are already prescribed opiates for pain therapy. Sixteen percent of veterans with PTSD are prescribed a morphine-equivalent dose of opioids concurrently with a benzodiazepine.(52) The concurrent use of these two medications is extremely dangerous and puts individuals at increased risk for overdose. Combining these medications can lead to depressed breathing, affect heart rhythm, increase sedation and lead to accidental death. Despite this known risk, VA dispenses benzodiazepines and opiates concurrently to thousands of veterans every year. Multiple studies have shown that benzodiazepines have no health benefit in treating PTSD and that there is extreme concern for overdose among veterans who misuse alcohol while on them. This is especially worrisome, considering that nearly 50 percent of veterans with PTSD also struggle with comorbid substance abuse.(53)

Once initiated, it can be very difficult for veterans to stop or taper off from benzodiazepines. In many cases, providers prescribe medications they know are likely harmful to a veteran who is unwitting to the potential negative side effects. The American Legion recommends that written, informed consent becomes a requirement before a veteran is prescribed benzodiazepines.(54) In addition, providers should clearly document their clinical rationale on why they believe the potential benefits outweigh the severe known risks and have supervisors agree and sign off on the decision.

To minimize the dangers of benzodiazepine misuse, The American Legion recommends that mechanisms be put in place to track and monitor possible toxic prescription combinations that veterans receive.(55) An automatic flagging system would alert providers, their supervisors, and pharmacists of potential fatal prescription drug combinations. It is also important for state-level prescription drug monitoring program databases to share data. This can help cut down on doctor shopping and the unknowing prescription of dangerous drug combinations. This is especially important considering the potential impacts for many veterans seeking treatment through the Veterans Choice and Community Care programs.

Services to Veterans with Other Than Honorable Discharges

Despite reforms intended to halt administrative separations of veterans suffering from service-related conditions, over 62 percent of servicemembers separated for misconduct between 2011 and 2015 had also been diagnosed with PTSD or TBI.(56) Depending on the circumstances, veterans with "bad paper" discharges may not be eligible for a broad array of VA health care and benefits, including mental health services that may be critical for veterans with PTSD or suicidal behavior. This is troublesome because evidence collected by VA continues to indicate that there are decreased rates of suicide among veterans receiving VA health care, as opposed to veterans who do not.

The American Legion strongly urges VA to provide mental health care to any veteran who was deployed in a theater of combat operations or an area at a time during which hostilities occurred, or any veteran who participated in or experienced such combat operations or hostilities, including controlling an unmanned aerial vehicle from a location other than such theater or area.(57)

Gatekeeper Training

In response to the high suicide rate, it is now time to ensure that the necessary stakeholders are given training so they may use their knowledge and skills to identify and refer veterans with suicidal ideation to care. It is imperative that suicide prevention training is provided to community leaders, military officers, NCOs, combat medics, chaplains, human resources staff and office managers. VA and DoD suicide-prevention training programs such as SAVE or ASIST can provide those who may be able to intervene the tools they need to save lives.

Complementary and Alternative Therapy

Lack of access to alternative treatments may cause an increase in patient care program dropouts and a rise in prescription drug use. The American Legion commends VA for establishing its integrative health and wellness pilot program. Many veterans have reported great success with veteran-centric treatments such as acupuncture, yoga, meditation, martial arts and other forms of complementary and alternative therapies. It is our responsibility to our nation's veterans to expand this successful program and ensure all those in need have access.

The American Legion believes all health-care possibilities should be explored and considered, based on individual veteran needs, to find the appropriate treatments, therapies and cures for veterans suffering from TBI and PTSD. These treatments should be accessible to all veterans; if alternative treatments and therapies are deemed to be effective they need to be made available and integrated into veterans' current models of care. The American Legion requests that Congress provide VA the necessary funding to make complementary and alternative therapies part of its health-care treatment plan for veterans suffering from injuries such as TBI, PTSD and other mental health conditions.(58)

Volunteerism

Many veterans return home and miss the sense of purpose and belonging that they felt from military service. The American Legion is among the nation's leaders in providing volunteer service and believes that the nation depends on veterans to continue to engage in their civic duty. The American Legion recommends and supports any government efforts to create incentives to encourage volunteerism.(59)

The American Legion's Commitment

Chairman Roe, Ranking Member Walz, and distinguished members of this Committee, The American Legion thanks this Committee for holding this important hearing and for the opportunity to explain the views of the nearly 2 million members of this organization. The American Legion remains deeply concerned by the high suicide rate among servicemembers and veterans and is committed to finding a way to help end this crisis. To ensure that all veterans are being properly cared for at Departments of Defense and Veterans Affairs medical facilities, The American Legion has established a Suicide Prevention Program and aligned it under the TBI/PTSD Committee. This Committee is currently reviewing methods, programs and strategies that can be used to reduce veteran suicide. That work will help guide American Legion policy and recommendations.

For additional information regarding this testimony, please contact Larry Lohmann Esq., Senior Legislative Associate of The American Legion's Legislative Division at (202) 861–2700 or llohmann@legion.org

Supporting American Legion Resolutions

No. 19: Homeland Security and the Opioid Epidemic. Aug. 22- 24, 2017, National Con-vention, calling for increased federal surveillance and targeted local law-enforcement and public health intervention to curb opioid abuse.

No. 23: Department of Veterans Affairs Provide Mental Health Services for Veterans with Other than Honorable and General Discharges. May 10–11, 2017, National Executive Committee, calling for access to VA mental health care for qualified veterans who receive Other Than Honorable or General discharges and for qualified veterans deployed in combat

No. 2: Suicide Prevention Program. May 9–10, 2018, National Executive Committee, establishing an American Legion Suicide Prevention Program and aligning it with the national TBI/PTSD Committee

No. 28: Volunteerism. Oct. 14–15, 1981, National Executive Committee, encouraging and providing government incentives to increase volunteerism in the United States

No. 160: Complementary and Alternative Medicine. Aug. 30–Sept. 1, 2016, National Convention, calling for legislation to improve VA and DoD pain-management policies and acclerate government research into CAM treatment options for veterans

No. 165: Traumatic Brain Injury and Post Traumatic Stress Disorder Programs. Aug. 30–Sept. 1, 2016, National Convention, calling for comprehensive joint DoD–VA TBI–PTSD program in one office that provides oversight and funding for alternative treatment programs. enhanced research into effectiveness treatment programs

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Prepared Statement of TriWest Healthcare Alliance

Written Testimony

Mr. David J. McIntyre, Jr.
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Introduction

Chairman Roe, Ranking Member Walz and Members of the Committee, I deeply respect you for holding this hearing on the critically important issue of preventing Veterans' suicides. As long as there is even one Veteran suicide in any community anywhere in our country, we should not rest. We should treat the loss of even one Veteran to suicide as a national tragedy and the loss of 20 Veterans a day as a national crisis.

This topic is very personal to us at TriWest Healthcare Alliance; we have several employees who have lost family members to suicide, including some on our leadership team. Helping Veterans in crisis is the most privileged, sacred work we do. For us, it is not a business, but a mission. A mission to find and serve those in need, to ensure they have access to the right service with the right provider.

Veteran suicide is a heart-breaking issue, a complex issue that defies simple solutions. If the solutions were simple, Congress and the Department of Veterans Affairs (VA) already would have implemented those solutions. VA and the Department of Defense (DoD) deserve credit for having invested untold efforts and resources into solving the suicide crisis, but the crisis continues because each case can be different from every other.

While we might not ever be able to prevent every suicide, it should nevertheless be our goal. Striving for it should be our mission, together.

I wish I could offer you today a guaranteed solution to this crisis, but no one can do that. What I am grateful and humbled to have the privilege to do is to share with you some of the lessons learned by TriWest as we have worked for 22 years in partnership with DoD and VA to reduce suicides by those who wear or have worn our nation's uniform. If sharing our experiences with you can help save the life of even one Veteran, I will forever be grateful to you for holding this important hearing.

Mr. Chairman, I will share with you some background on TriWest Healthcare Alliance for one and only one purpose today: to help you understand the nature of our work and the lessons learned regarding suicide prevention.

If I could summarize the most important lessons learned from TriWest's many years of workingin support of VA's and DoD's suicide prevention efforts, it would be these:

1. First, when a Veteran or Service member is at the cliff's edge, it is critical that there is a clear, simple and quick way for them to reach out for help.

2. Second, it is crucial that a Veteran on the verge of committing suicide can talk to a peer who can relate to their service and situation. The insight of an Army General might explain this when he once said, "Before the soldiers care about what I say to them, they have to know I care about them." In short, the Veteran needs empathy from a fellow comrade, not sympathy from a well-intentioned civilian.

3. Third, the most effective way to prevent Veteran suicide is to intervene with accessible, timely and quality mental health care services long before the Veteran is seriously considering suicide. No health care system in our nation is better equipped to provide that expert care than our VA health care system. Its expertise in dealing with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), military sexual trauma and warrelated combat wounds is second to none. However, until the day when VA has enough mental health care providers within its system to handle all mental health care patients' needs on a timely basis, VA community care must be used, expanded and improved to prevent the tragedy of Veteran suicide.

Ensuring our nation's Veterans have access to the full range of timely, high-quality mental health services they have earned and deserve must be our collective mission. Meeting our Veterans' ever-growing demand for mental health services is an urgent, life-saving priority. We owe it to those who have sacrificed so much for us to provide them with the best care humanly possible.

We should strive to not only prevent tragedy from striking, but also afford our Veterans an opportunity to live a healthy, full life.

History

Twenty-two years ago, TriWest Healthcare Alliance was formed by a group of nonprofit health plans and university hospital systems. For the leadership team of TriWest and our 3,000 employees, most of whom are Veterans or family members of Veterans, what we do is more than a job; it is an honor to which we are steadfastly and passionately committed. Our first 18 years were spent helping DoD stand-up and operate the TRICARE program in a 21-state area.

Today, as you know, TriWest serves as a partner to VA, administering Patient-Centered Community Care (PC3) and the Veterans Choice Program in our geographic area of responsibility, which includes 28 states and three U.S. territories. Through these programs, TriWest serves as a relief valve to VA when it is unable to provide needed care to Veterans within a VA facility. TriWest now has over 210,000 community health care providers in our network, and we have helped over 1.2 million Veterans receive more than 9.2 million total medical appointments since the start of the programs we administer on behalf of VA.

While VA initially was reluctant to use PC3 and the Veterans Choice Program for mental health services out of concern that community providers were not familiar with, or fully qualified to address, the mental health challenges of Veterans, today every VA Medical Center in our area of responsibility is sending us authorizations for mental health services. Our network of 22,500 behavioral health providers now has delivered over 119,000 behavioral health care appointments to Veterans in their community when they cannot be seen by VA.

Of particular focus to TriWest over the past 22 years has been serving the mental health needs of our nation's Veterans, Active duty Service members and their families. During our 18-year engagement with TRICARE, we learned a great deal and built an extensive mental health network around military bases in the 21 states we served. We continue to leverage much of that network today in support of the Veterans Choice Program and every VA Medical Center in our region.

Key Mental Health Initiatives

Through our 22 years of operation, we have developed substantial experience in providing quality, accessible mental health care services and administering suicide prevention programs.

We offer the following initiatives for your consideration as VA and Congress continue their work together to improve mental health care services and to prevent suicides for at-risk servicemembers and Veterans.

1. Expand peer-to-peer support programs. In 2010, the U.S. Marine Corps asked TriWest for help in designing a pilot to increase access to mental health support for Marine Corps personnel returning from deployment(s). We were privileged to help create the "DSTRESS Line" pilot providing 24/7/365, Marine-to-Marine Peer-to-Peer Call Center access to stress/suicide prevention support, staffed by Veteran Marines, Fleet Marine Force Navy Corpsmen who were previously attached to the

Marine Corps, Marine spouses and family members, and licensed behavioral health counselors trained in Marine Corps culture. Under the program, we provided phone, chat and videoconference capability for non-medical, short-term, solution-focused counseling and briefings for circumstances amenable to brief intervention, including but not limited to stress and anger management, grief and loss, the deployment cycle, parent-child relationships, couples' communication, marital issues, relationships, and relocations based on the needs of the community being served.

The Marine Corps leadership believes the program has been hugely successful as an efficient, effective and innovative peer support program for Marines to access mental health support by talking with a fellow Marine they can trust. TriWest provides the staffing resources for these critical programs aimed at serving the U.S. Marine Corps.

The highly-effective service saved the lives of many. We are proud to share that no military member who sought support through the DSTRESS line was lost to suicide. On average, there are over 6,000 total program interactions each year through calls, chats, and Skype. We believe there are some valuable best practices learned in this program that could serve VA well as it continues to expand and enhance behavioral health services for Veterans.

Due to the success of the DSTRESS line, DoD's Defense Suicide Prevention Office (DSPO) chose TriWest to construct and implement a 24/7, global peer-to-peer support suicide prevention program to serve all military Service members, National Guard and Reservists, and their families through telephone, chat, text and email. Launched in October 2016, the BeThere Peer Support Call and Outreach Center was designed to recognize the risks of suicide within the military community and provide solutions for breaking through barriers when it comes to seeking help. This program, staffed by Veterans of all the Service branches and military spouses, builds on the success of the DSTRESS program providing confidential support from peers who understand military life. Calls to the peer assistance line have increased steadily since the program launched, with an average of 250 to 300 interactions per week.

2. Expand mental health training for community providers serving Veterans. With a desire to expand access to needed behavioral health services to give VA the critical services it needs, TriWest is moving beyond simply appointing to our substantial mental health network of 22,500 providers. We have invested in and are training our community mental health providers in evidenced-based therapies that are known to be maximally effective in meeting the needs of Veterans. In 2016, TriWest partnered with PsychArmor Institute, in collaboration with VA, to help prepare community primary care and behavioral health providers to most effectively serve Veterans who have so valiantly served our country. Together, we created a school—a suite of free online courses taught by nationally-recognized experts—to educate community health care providers on military culture and the unique experiences and challenges Veterans face.

Known today as "Veteran Ready" (formerly known as "Operation Treat a Veteran"), this collaboration between TriWest, VA, the Center for Deployment Psychology, and PsychArmor Institute offers evidence-based training to all community-based network providers in the 28-state TriWest Healthcare Alliance regions of care. Training covers two broad topics: Military Lifestyle and Culture; and Evidence-based Psychotherapy. The three learning paths have four levels of training. Each level of completion corresponds to a level of patient acuity. With the completion of each level, TriWest will refer Veterans who require primary or specialty care, or the treatment of PTSD with either Cognitive Processing or Prolonged Exposure Therapy. And, the Veteran Ready digital certificate and badge can be earned by providers who understand the value of military and Veteran cultural awareness in their practices.

3. Expand community-based tele-mental health care services serving Veterans. TriWest has designed and deployed a tele-behavioral health platform to connect community behavioral health providers with Veterans in need of counseling, who desire the use of this tested modality of care delivery. The initial rollout of this initiative was in Phoenix, San Diego and South Texas, and now we are expanding these services across all the regions we serve. Our telehealth initiative broadens and strengthens VA's current telehealth footprint aiding Choice Program Veterans for medication management and psychotherapy. Under this prototype, we now have approximately 1,500 unique Veterans appointed to tele-mental health services.

Telehealth increases access to care by increasing size and reach of each provider because it provides greater flexibility on timing and location, which lowers travel time and expenses for Veterans. TriWest continues to focus on expanding the network by assessing locations with high necessity and high returns, where we are collaborating with mental health leaders to educate providers and conduct outreach.

As long as there is a shortage of mental health care providers in many parts of our country, tele-mental health can truly be a life saver for Veterans who would otherwise not receive timely mental health care services.

4. Expand community mental health options for urgent care. To ensure that those who are presenting themselves in VA Medical Center Emergency Rooms, where there is a lack of inpatient mental health beds to meet the needs of Veterans, VA and TriWest designed and deployed a pilot program in Wichita, Kansas, that would enable us to place the Veteran in an inpatient bed with one of our nearby behavioral health network providers rather than letting him or her wander out the front door without receiving potentially life-saving services. This pilot builds on a successful, similar one we conducted in Phoenix. We have developed the prototype, and VA is using this valuable tool in Kansas today.

5. Increase VA and DoD collaboration to create a seamless transition for Veterans.

There is not one simple way to achieve success, and it will take a concerted joint effort of many to do so. That is why we highly encourage VA and DoD to streamline their efforts, as they are doing on Electronic Health Records (EHR), to create a seamless transition for Service members becoming Veterans. During our work with TRICARE we learned Service members often become disconnected once their physical wounds are healed. That is why VA and DoD absolutely need to collaborate to solidify continuity during the transition to ensure no Veteran is left behind. We are glad the Administration is spearheading efforts to consolidate suicide prevention initiatives by uniting multiple departments and leaders in this space. The Executive Order will provide a strong framework to create a public-private partnership from the community to federal level that will help bring resources and expertise forward to help combat and lower the number of Veterans committing suicide.

Conclusion

Mr. Chairman, I salute you and this Committee for placing a high priority on the critical issue of preventing Veterans' suicide. Our Veterans risk their lives to protect American values and society, so when their lives are at risk here at home, it is our moral obligation to protect them.

They have had our back, so now we should have theirs. Collectively, we must seize the opportunity to enhance access and make the health care delivery model more efficient and effective. I believe doing so will necessitate leveraging the best of both the public and private sectors. No private health care system in the country has more expertise than VA in addressing the mental health care issues that put Veterans' lives at risk. The work ahead should not be to replace the VA system, but to learn from it and to supplement that VA care in the community, when necessary.

We look forward to doing our part to support VA Secretary Robert Wilkie and his team in many areas going forward, including in the critical space of supporting VA in delivering on the mental health care need.

As TriWest has done for 22 years, we stand ready today to do whatever it takes to work with Congress and VA to help protect the lives of our nation's heroes. Together, we can succeed and we must succeed in this mission, because our Veterans and their families deserve no less.

Prepared Statement of Veterans Of Foreign Wars Of The United States (VFW)

STATEMENT OF
KAYDA KELEHER, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE

Chairman Roe, Ranking Member Walz, and members of the Committee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on veteran suicide prevention.

After examining more than 55 million records of individuals who served in the United States military from 1979 to 2015, VA released its most recent publication of veteran suicide data during summer 2018. This data mostly remained consistent from previous research.

This most recent data showcases that while veterans are 2.1 times more likely to die by suicide than non-veterans, that rate is highest for post-9/11 veterans ages 18–24. Yet, veterans over age 55 and those who served during peacetime experience the overall highest numbers of suicide.

Veteran suicide is an issue that plagues the veteran community. There is no justifiable reason for suicide to be in the top 10 reasons Americans die, let for veterans to be overrepresented in this daunting statistic—in 2015, veterans made up less

than 10 percent of the American population, yet 16.5 percent of all American suicides. Without changing, an average of 20 veterans will continue to die by suicide every day.

In order to address veteran suicide, Congress and the Department of Veterans Affairs (VA) must invest in more research, increase mental health providers employed at VA, and conduct better outreach to pre-9/11 veterans, women and LGBT veterans. There is also more work that can be done to improve the Veteran Crisis Line (VCL).

Research

Data provided by VA, with thanks to interagency cooperation, is critical in the hope of eradicating veteran suicide. A third of veterans, or six of the daily average, who die by suicide were active VA users. Research indicates that veterans who do not use VA for their health care are at an increased risk of suicide. Which comes as no surprise to the VFW, as our members have continuously told Congress they prefer VA health care.

Veterans service organizations, VA, and Congress must know more about the two-thirds of veterans who do not use VA and die by suicide. The VFW urges VA to analyze the demographics, illnesses, socioeconomic status, and military discharges of those 14. 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 related to sexual trauma or combat? Were they discharged for unjust and undiagnosed personality disorders due to transgenderism or during the era of "Don't Ask, Don't Tell?" If veteran suicide is going to be honestly combatted, we must know more about the 14 veterans who die each day without using VA.

As technology continues to improve, VA must continue funding new ways to reach those in need of mental health care. Over time, VA has offered computer and phone applications, such as PTSD Coach, for veterans to conveniently open in their time of need. Yet apps are not the avenue of prevention or intervention all veterans prefer. More must be conducted to find reliable statistics regarding what platforms of technology veterans prefer for all eras and age groups. Those technologies should also be analyzed by VA researchers to further understand key phrases and actions taken by those experiencing mental health crises and/or suicidal ideations. While most people know there are signs of possible suicide, such as an individual beginning to give their belongings away, linguistic psychologists in academia have found there are words used at increased frequency when individuals are experiencing suicidal ideations and mental health crises. These words are not the "cliche" words currently taught to Americans. The VFW urges VA to conduct linguistic psychology research, or to partner with schools, such as Massachusetts Institute of Technology, already doing so.

With the number of VA opioid prescriptions continuing to decrease, and the increased number of providers receiving training on effective psychotherapies specific to post-traumatic stress disorder (PTSD) and military sexual trauma (MST) patients, the VFW believes VA has made great strides in treating this population. Yet, it still has more work to do.

The VFW's members believe medical cannabis must be researched to determine if it can be a non-pharmaceutical alternative. Conducting such research would not only provide better education for VA clinicians to remain informed and providing the highest quality of care, but it would also provide sound empirical data regarding the medicinal value of cannabinoids. Varying academic and state-funded studies have found preliminary results showcasing that medical cannabis may be helpful for veterans struggling with PTSD or MST, which are closely associated with increased risk of suicide. The VFW strongly urges Congress to pass H.R. 5520.

Throughout the years, research on mental health issues associated with combat or sexual trauma, such as PTSD and traumatic brain injury (TBI), has allowed providers and researchers to understand and diagnose mental health disorders in ways never before possible. This has been advanced by extensive genomic research conducted by VA for varying risk factors such as the SKA2 gene and RNA deficiencies. The VFW also urges VA to complete recruitment of the Post-Deployment Afghanistan/Iraq Trauma Related Inventory Traits study, which will provide a pool of 20,000 veterans of Iraq and Afghanistan to identify possible genetic variations that may influence risk of PTSD and TBI.

Increase Access

The entire nation is experiencing a critical shortage of mental health providers. In addition to this deficiency, applications to work at VA have significantly dropped

since the 2014 crisis in Phoenix. The Office of Inspector General determined that in fiscal year 2018, the Veterans Health Administration's number one shortage was psychiatrists, with psychologists as the fourth largest shortage. Congress must provide VA with the assets necessary to increase hiring and retention of mental health care providers, and to assure they are appropriately included in graduate medical education improvements passed in the MISSION Act. The VFW also urges Congress and VA to establish and monitor quality assurance metrics to hold non-VA community care providers accountable to.

Mental health providers within VA have continued to receive extensive training in areas such as prolonged exposure and cognitive processing therapy, which are the most effective and empirically proven therapies to treat PTSD. Medication treatments are also offered and, thanks to the VFW-supported Jason Simcakoski Memorial and Promise Act, medications are being more closely monitored. Through VA's Opioid Safety Initiative, opioids are being prescribed on a less frequent basis for mental health conditions and are better monitored for negative consequences such as addiction.

The VFW has long advocated for the expansion of VA's peer support specialists program, and thanks Congress for passing H.R. 4635. 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 woman—or any group within the veteran community which makes up a smaller population and can at times feel ostracized or as though nobody within their community understands them. This is instrumental in helping veterans avoid loneliness, which can lead to suicidality.

The VFW urges Congress to make sure VA has the resources required to continue expanding this effective, low-cost form of assistance. To ensure VA is offering a holistic approach in effectively addressing PTSD, VA must have the ability to provide peer specialists outside of traditional behavioral health clinics. Veterans overcoming homelessness, seeking employment, or in mental health crisis would benefit from these services. For these reasons the VFW calls upon Congress to pass H.R. 2452, and to further expand this program to other specific populations.

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.

Outreach to Women, Minorities, and Older Veterans

Outreach works. In August 2017, an entertainer named Logic performed a song on live television about suffering from suicidal ideation and mental health crisis, but then eventually getting help and recovering. The song was titled "1–800–273–8255"—the National Suicide Prevention Lifeline. In the days following the performance, the National Suicide Prevention Lifeline saw a 50 percent increase in callers. This is just one example showing that VA must conduct more strategic outreach.

Short of producing music, the VFW has partnered with VA and other non-government organizations for our Mental Wellness Campaign. Beginning in fall 2016, this outreach campaign was launched to raise awareness, foster community engagement, improve research and provide intervention for those affected by invisible injuries and emotional stress. Over the last two years more than 200 VFW posts and 13,000 volunteers have successfully reached 25,000 people through our annual Mental Wellness Campaign Event. This event consists of the VFW, VA, and other partners conducting community service, spending time with veterans, their families, and people in the community educating. Participants learn the five signs of emotional suffering—personality change, agitation, being withdrawn, poor self-care and hopelessness. VA also provides information about programs and opportunities for assistance from VA and local community partners.

In today's society, it seems as though many people assume veterans at the highest risk of suicide are men who were in combat roles and served during the post-9/11 era. That is where society is wrong. Veterans with the highest number of suicide are males over the age of 50, and women veterans who do not use VA.

Studies also show survivors of sexual trauma are among the highest for increased risk of suicide. With nearly a third of women who serve experiencing some degree of sexual assault in the military, and LGBT veterans being overrepresented in that as well, care for survivors of sexual trauma must remain a priority.

The rate of female veteran suicide since 2001 has increased by nearly 100 percent for women who do not use VA. Currently, women veterans are twice as likely to die by suicide as non-veteran women. While tracking of LGBT suicide data is not currently done by VA, there is data showcasing that LGBT veterans experience depression and suicidal ideations at twice the rate of heterosexual veterans. These numbers are atrocious and completely unacceptable.

The VFW urges Congress and VA to continue expanding telemental health programs. These programs are often invaluable in decreasing risk of suicide for sexual trauma survivors—who are overrepresented within the female and LGBT populations—wanting to use group therapy for mental health linked to sexual violence. In VA facilities where there may not be enough women or other individuals comfortable participating in group therapy, telemental health provides an alternative.

Better outreach must also be conducted to veterans who served prior to 9/11. Veterans who are age 50 or older make up approximately 65 percent of the total population of veteran suicides. More must be done to reach this population. Post-9/11 veterans are more likely to enroll in VA and VA has really excelled at providing access and conducting outreach to this population. Now it is time to expand these outreach initiatives and increase their access.

Joint Action Plan

VA is the largest integrated health care system in the United States. The number of veterans using this system to seek treatment for mental health care has also continued to increase as more veterans who served in Iraq and Afghanistan leave the military. This is part of the cost of war. Congress and VA must ensure those seeking treatment are provided timely access to VA care.

This year, at the request of the current administration, VA, the Department of Defense (DoD), and the Department of Homeland Security began implementing the Joint Action Plan to improve mental health care access for servicemembers transitioning out of the military for their first year out of uniform. This plan was set in place with the hope of annually reducing veteran suicides for a population at increased risk.

The plan focuses on universal access to mental health care for all veterans during their first year as civilians. Additional framework was also built for more support of veterans identified to be higher risk. This way of identifying varies from algorithms already set in place at VA to identify veterans using VA health services who are among the highest risk of suicide. The overall goals, which are still being implemented, include better assurance that all servicemembers leaving DoD know how to access VA, and streamlining access to their first year of mental health care.

There are also provisions in the plan that calls for increasing partnerships between VA and private sector providers. The VFW agrees that sometimes there is a need for care to be supplemented within the community, but also firmly believes that these non-VA providers must be held to a high standard of care. Current reports show the care provided by non-VA providers is of lower quality, and that these providers prescribe veterans opioids at an alarmingly higher rate than VA. When a veteran does require community care, empirically proven forms of therapy must be done, medical and pharmaceutical records must be shared with VA, and the non-VA providers must meet or exceed the same standard as VA. This is particularly true for mental health, as VA's suicide data shows that non-VA users are more likely to die by suicide.

Veterans who have deployed to a combat zone, but do not have a service connected disability, still earned the benefit of having access to VA for up to five years after leaving the military. The VFW supports all veterans having access to mental health care at VA for their first year out of service, but watches steadily to assure other veterans who may be older or combat hardened do not suddenly have to overcome new found access standards. For this reason, the VFW asks for proper congressional oversight of the Joint Action Plan and for VA to provide more transparency during this time of implementation.

Veterans Crisis Line

In 2007, VA established the Veterans Crisis Line (VCL). The hotline was established to provide 24/7 suicide prevention and crisis intervention to veterans, servicemembers, and their families. The VCL provides crisis intervention services to veterans in urgent need, and helps them on their path toward improving their mental wellness. The VCL plays a critical role in VA's initiative of suicide prevention and ongoing efforts to decrease veteran suicide. The VCL has answered millions of calls and text messages. It has also initiated the dispatch of emergency services nearly 100,000 times. Since opening its doors in 2007, VCL has expanded to three locations—Canadaigua, N.Y., Atlanta, and Topeka, Kan.

If a veteran currently calls a VA Medical Center or most Community Based Outpatient Clinics the veteran will receive the option to dial the number seven for an automatic transfer to the VCL. This technology has been successful, but the expansion is another example of VA struggling to keep up with modernized technology due to lack of funding and prioritization. The VFW believes all VA facilities, including Vet Centers, must have this capability sooner rather than later.

The VFW is pleased with other technology modernizations the VCL has made throughout 2018. This summer, Apple and Android smartphones developed the capability for Siri and Google Assistant to connect individuals to the VCL through voice command. Now a veteran can just say, "Call the Veteran Crisis Line" and be connected even if the number is not saved to their contact list. There will also be a three number dial-in, similar to 911, which will connect dialers with the VCL. Current estimates anticipate this new technology will launch in early 2019.

Prepared Statement of Veterans and Military Families for Progress (VMFP)

Statement of
Thomas E. Bandzul, Esq.

I thank Chairman Phil Roe, Ranking Member Tim Waltz, and members of the Committee for allowing Veterans and Military Families (VMFP) to submit this Statement for the Record on Veteran Suicide Prevention: Maximizing Effectiveness and Increasing.

VMFP has a long history on trying to promote suicide prevention because this issue has had a direct impact on members of our organization, including me. We have worked closely over the years with other Veteran Service Organizations (VSOs) and promoted legislation to increase suicide prevention awareness in all the communities we serve.

The suicide crisis has been going on for years, with little improvement. For example, a research article by Michael de Yoanna published in 2005 factually stated "78,000 Veterans and troops were lost to suicide"[1]. In following this trend in successive years, it was found that more veterans were dying from suicide than from combat. In 2007, CBS News devoted a long segment to challenges facing Veterans and families. This was followed up by the PBS News Hour in 2008.

https://www.cbsnews.com/news/the-veteran-suicide-epidemic/

http://www.pbs.org/newshour/extra/daily-videos/military-sees-rise-in-troop-suicides/

As an advisor to past Executive Director Paul Sullivan at Veterans for Common Sense (VCS), VMFP and VCS worked hand in hand with others in the Veterans community to expound on the need for more resources to help prevent suicides. In 2007, VCS filed a lawsuit specifically to increase awareness and raise the issues of this tragic and heartbreaking scourge plaguing Veterans and the Department of Veterans Affairs (VA).

The reason VCS took their action was the dramatic increase in the number of Veteran suicides, the long wait times for Veterans to see a health care professional, and the ever-increasing delays in processing valid disability claims. Evidence produced by VCS at trial included dozens of audits and investigations by the General Accountability Office and VA's Office Inspector General regarding long waits, improper appointment documentation (later called "secret wait lists" by CNN in 2014), and worse.

An article by Jeff Hargarten published by the Center for Public integrity, found that "Nearly one in five suicides nationally is a veteran; 49,000 took own lives between 2005 and 2011" and supported the finding in the VCS law suit[2]. Together with many of the other VSOs and the help of Congress, this travesty was deemed an "Epidemic" within the Veterans communities.

Every year since that time, steps have been taken by VA and the VSO communities to help promote awareness and institute legislation aimed at stemming this problem and ending suicides among Veterans. However, as the grim numbers have shown, the "epidemic" remains despite a 2007 law requiring the Department of Veterans Affairs to increase its suicide prevention efforts. In response to the Joshua Omvig Veteran Suicide Prevention Act (Public Law No: 110–110)—named for an Iraq War Veteran who committed suicide in 2005—VA's efforts include educating the public about suicide risk factors, providing additional mental health resources for veterans and tracking veteran suicides in each state. The VA's mental health

[1] VA National Suicide Data Report—2006
[2] VCS v Erick Shinseki—644 F.3d 845 (9th Cir. 2011).

care staff and budget have grown by nearly 40 percent over the last six years and more veterans are seeking mental health treatment.

Since the VCS lawsuit in July 2007, the Veterans Crisis Line opened in August 2007 and experienced a steady increase in the number of calls, texts, and chat session visits from former soldiers and active military persons struggling with suicidal thoughts. The first year, 9,379 calls went to the crisis line. Over a period of more than 10 years, VA has answered more than three million calls. Even more impressive, VA's dedicated professional staff have dispatched emergency responders nearly 78,000 times in our view, saving the lives of the Veterans in crisis. One alternative that should be mentioned as a possibility is that VA's response to the VCS lawsuit has mitigated what may very have been a far worse suicide epidemic. VMFP expresses our thanks to VA staff saving Veterans' lives every day.

https://www.blogs.va.gov/VAntage/44327/veterans-crisis-line-answered-three-million-calls/ VA[3].

In 2009, the Secretary of Defense established a Task Force "to examine matters relating to prevention of suicide by members of the Armed Forces" and in 2010, the published report was the results of the two-year study of suicides in the military with a 12-point recommendation program to help identify people at risk of committing suicide and prevent future issues. While this was not a panacea, it was a great help[4].

The recommended programs were not implemented by all branches of the military but the two that did, the US Marine Corp. and the US Navy, showed dramatic results in lowing the number of suicides, suicide attempts and suicide threats. At the same time, these two departments significantly increased awareness programs, budgets for mental health professionals and cooperation from the highest level of command within their respective units. (The Commandant of the Marine Corp made a video on suicide prevention. This was distributed to all levels of all installations and was mandatory viewing by all Marines).

In each of the following years, this issue gets worse or at least, no better. The connection between military service and the Veteran community is tightly integrated and interwoven into this problem. The logical connection between military service and Veterans is so apparent that the need to examine the patterns between the two, most believe, would reveal significant details. This has not yet been fully developed by previous separate studies within VA and the Department of Defense (DoD).

VMFP submits this statement because we are deeply concerned about recent data gathered by VA that indicates the suicide problem remains. Our nation remains at war. Casualties return home every day, and the public has moved on.

The "elephant in the room" has often been the Veteran's tie to hopelessness and despair. One of the major driving forces deserving the attention of Congress and VA is the frustration a Veteran develops after filing a claim for disability benefits. VA still improperly denies claims, forcing Veterans into years of complex appeals before a valid claim is granted. VMFP asks this Committee to request that VA produce a report to Congress with counts, for the past five years of the number of Veterans who died waiting for a claim. Veterans have a right to know how many claims were resolved by death due to suicide or suspected suicide, for claims pending at every Regional Office, the Board of Veterans' Appeals, and the Court of Appeals for Veterans Claims. The five year look-back is important because VMFP understands there are more than 450,000 VA disability claim appeals now pending. We ask, how many are those for mental health? And how long have they been pending?

To VA's credit, based on the advocacy of this Congress and VSOs, new science-based regulations for posttraumatic stress disorder were promulgated in 2010. VA's new rules brought benefits to hundreds of thousands of Veterans with PTSD while also reducing VA's error rate.

https://www.nytimes.com/2010/07/13/us/13vets.html

Finally, we raise one last issue for your consideration: cultural competency training about Veterans, including suicide prevention. An issue seldom seen as a possible preventive measure is a level of improved training for first responders and clergy. In many instances, the first point of contact with a person in a crisis is either the police, a fireman, a paramedic, a nurse, or a member of the clergy. Other than referrals to VA's crisis line, there appears to be no unified training program used across states adaptable to the needs of meeting a Veteran contemplating suicide. This means Veteran suicide is not a Veteran / military / VA challenge. Rather, with our

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[3] Suicide Data Report, 2012 Department of Veterans Affairs Mental Health Services Suicide Prevention Program

[4] The Department of Defense (DoD) Task Force on the Prevention of Suicide by Members of the Armed Forces 2010

nation continuously at war and deployed in scores of nations, reducing and preventing Veteran suicide is a national problem that needs the attention of all of Americans. Thus, we call for more cultural competency training for first responders, clergy, plus state and local governments to identify and refer Veterans for care.

It is VMFP's sincere hope that the integration between VA, DoD, VSOs, and the public will take place in the near future to combat this epidemic. Until this becomes the active mission of every person, I believe there may be some improvements, yet the problem will remain

VMFP fully appreciates all the efforts and concern of Congress. Our hope is, collectively, we can gather enough resources to put an end to this forever.

If you have any questions, or if VMFP can be of further assistance, please contact us.

Prepared Statement of Whistleblowers of America (WOA)

Jacqueline Garrick, LCSW–C

Chairman Dunn and Ranking Member Brownley:

"Never think there was ever anything more that you could have done."

I've read that line a hundred times looking for some hidden clue that would tell me if it were true or not. One of my Vietnam veterans had died by suicide and left me a note. He had been a combat Marine suffering from Posttraumatic Stress Disorder (PTSD) and I was his assigned social worker. The survivor guilt over the men lost in the war and the nightmares filled with gunfire ate away his spirit. Any sparkle of kindness or hope he felt would flash across his face as quick as lighting. He was alienated from family and friends, so his treatment team was all he felt he had. He saw vodka as a refuge that let his mind drift back to those buddies on that battlefield. It eventually also took his body in 1989. The Vietnam War had ended 15 years before, but its body count was still rising.

For the better part of the next 30 years that statement would continue to puzzle me. Not because I think I failed him personally, but because I think that our health care professions and organizations failed him. I have dedicated my career to combat trauma recovery and resilience. I did my first (peer reviewed) clinical presentation on Suicide and Vietnam Veterans in 1990 at a Society for Traumatic Stress Studies conference. At the time, suicide was the 10th leading cause of death in America taking about 38,000 lives. For Vietnam veterans, it was the second leading cause of death behind accidents. The tools for assessing military combat trauma and PTSD were burgeoning with limited attention on addressing suicidal thoughts and behaviors. The best practice was a "no suicide contract."

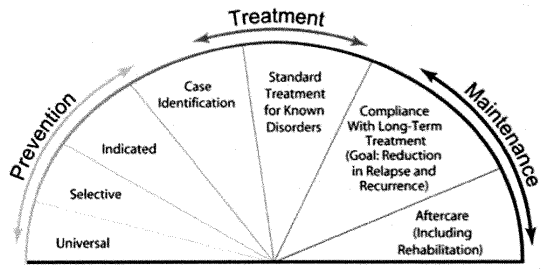
After the Gulf War, Clinical Pathways for PTSD treatment were being developed, and VA reported an increase in Gulf War Veterans who were dying by suicide. This was still a time when being in the military was a protective factor against suicide and the rates were significantly lower for the Active duty. However, I remember sitting in a meeting at VA Central Office while Dr. Han Kang noted that female veterans had died by homicide with greater frequency. When I questioned those suicide and homicide rates, I was told that it reflected lifestyle choices and maladaptive behaviors on the part of those veterans. VA was blaming deceased victims. VA refused to fund further studies to see if these female homicides were like "copicides.[1] " When I looked at the VA 2017 suicide data that showed an increase in women veterans who have died by suicide, I was left wondering if a generation later, women have moved from choosing dangerous relationships to their own firearm proficiency. I guess we will never know because, as with much of the VA data, it does not inform research or intervention priorities.

The June 2018 VA National Suicide Data Report; 2005–2015 is extremely confusing and contradictory to previous data reports released by VA in several ways. The report itself while describing methodologic enhancements says, "These were applied for all years to support comparisons over time." But then it says, "These updates may limit direct comparisons of current results with previously reported findings." How did VA make enhancements that limit trend analysis? The report then adds in military suicide data that it has never reported upon before. Did the Department of Defense (DoD) coordinate on this data release and where is their explanation of those numbers? Are these numbers duplicated in the DoD Suicide Event

[1] A method of attempting suicide by acting aggressively and violently toward a police officer to get them to shoot.

Report (DoDSER)? Are the agencies now double counting or over-inflating suicide mortality? The report notes that in some cases, the VA was unable to confirm Title 38 status, but given the advent of the Suicide Data Repository that matches to the DoD manpower data, how is this possible? Congress should ask DoD to comment on these military deaths being reported by the VA. Regarding opioids, Figure 31 seems to be erroneous in its reporting of Opioid Use Disorder as it appears to have flatlined at 0 for the last decade, which contradicts Figure 32. VA should be asked to explain or correct these data points given the deadliness of opioids in this country today. However, the most concerning statistic in this report is the notation that "Veterans who use VHA[2] services had a higher rate of suicide death than non VHA Veterans, overall Veterans and non-Veterans. Veteran VHA patients with a MH/SUD[3] diagnosis who accessed mental health treatment services had higher rates of suicide than other Veteran VHA patients." In its 2016 report, VA said, "VHA users has a decreased suicide rate with a mental health diagnosis. Overall VHA user rate decreased in suicide. In the 2014 report, VA said, "VHA reported decreases in suicide rates, including mental health." This reverse trend should be alarming. For several years, VA touted its successes in treating suicidal veteran. If this was in fact not true or mental health care had degraded so much so that veterans who use VHA are more likely to die by suicide, a true overhaul and immediate accountability is demanded. VA MUST be able to align suicide data to program effectiveness and the congressional funding allocated. Furthermore, this data is not the result of psychological autopsies, which would provide much more in-depth analysis of each veteran who has taken his/her own life, especially if they were enrolled in VHA.

Figure 1. Continuum of Health Care



Source: Reprinted with permission from Reducing Risks for Mental Disorders. Copyright 1994 by the National Academy of Sciences. Courtesy of the National Academy Press, Washington, DC.

Decades ago, the Institute of Medicine (now the National Academy of Medicine) developed a "protractor" framework for a continuum of health care. It is a simplistic model because it is easy to see where you should be as a clinician or an organization. It helps shape an understanding of mission and priorities so that the data can be used to inform funding decisions. Think of it more like a fan that opens and closes at the necessary points. I used it to inform a strategic plan, when the DoD asked me to lead the effort in establishing the Defense Suicide Prevention Office (DSPO) in 2011 and by 2014 we were seeing an eking downward in some of the mortality numbers. But 2 years later, when Pentagon experts classified military suicide as the "new normal"[4] because there was no clear pattern to the data that explained the increases in suicides, I was horrified because that simply was not true.

Today, the VA just as the Secretary of Defense needs "universal" suicide prevention policies and curriculums to standardize the messaging and training, but without over-using one tool, like the Columbia Suicide Severity Rating Scale as a panacea. It needs "selective" interventions that takes data points and creates opportunities for engagement, such as peer support. I once incorporated predictive analytics to assess wellness within the armed forces, so we could hone in on Service members with "indicative" accumulating risk factors and a velocity of change. I was glad to see VA embrace this approach even after it was abruptly cancelled by DoD soon after I left DSPO, wasting an invested $4 million in development and losing hun-

[2] Veterans Health Administration
[3] Mental Health/Substance Use Disorder
[4] Zoroya, G. Experts worry that high military suicide rates are "new normal." USA Today. June 12, 2016

dreds of nodes of wellness data on over 2 million active and reserve components. However, if VA could map wellness risks, it could use a peer support model to conduct well-being checks, which the Henry Ford Healthcare System was showing great success implementing. They had reduced their patient suicide rate to zero by providing caring contacts. It meant not waiting for someone to engage in help-seeking behavior but re-lensed the organization's focus onto its help-offering behavior. Encouraging help-seeking behavior and stigma reduction campaigns were getting to be too trite with little effectiveness.

But, there is the rub. Senior leaders like awareness campaigns and spend millions of dollars on them. They make a big splash in the media. It is measurable in how many outputs—"views" or "hits" Web sites or social media pages get but does not generate outcomes. Leaders get to report to Congress on their success. Yet, suicide has been the 10th leading cause of death in America for 30 years. Research published by several sources including Stanford University, University of Michigan, and in a specific study on suicide published by the University of Southern California (USC) found that, ".suicides could be prevented if persons with mental illness were provided care. Instead of doing that, the mental health industry's main tool in reducing suicide takes the form of public service announcements, brochures, hotlines, and speeches targeted to the general population. .. But those charged with overseeing the funds, refuse to measure rates of suicide to see if the funds are having an impact. Instead they measure tangential issues like "attitudes" and number of presentations made. The money is wasted."[5] ese campaigns do not work because they cannot change behavior and sometimes the unintended consequence is that they normalize the suicidal behavior they are trying to abate—a phenomenon known as suicide contagion. Yet, VA has spent over $100 million on a "Digital Strategies" contract to contractors affiliated with a former Assistant Secretary for Public Affairs. Each year, the VA's Office of Suicide Prevention rebrands the Veterans Crisis Line Campaign with a new onslaught of slogans—this year's theme is "Be There". In years past, the slogan has been "It's Your Call", "The Power of One", and "It Matters". Each year millions of dollars are spent on new posters, magnets, brochures, coaster, and other giveaways. The Make the Connection campaign warehouses 736 videos[6] that are posted on Facebook and other social media platforms. These videos, albeit emotionally impactful, are only so until the viewer scrolls to the next posting. And upon searching the video "likes" and "shares" there are an inordinate number of VA employees and contractors in the mix—giving an inflated sense of impact within the veteran community. Comments are usually encouraging but are nebulous. Does VA really need to spend millions of dollars producing 700 videos while there is a shortage of clinicians?

Furthermore, the most recent IDIQ[7] contract vehicle created by VA; Veteran Enterprise Contracting for Transformation and Operational Readiness (VECTOR) will spend $25 Billion on 68 companies over the next 10 years. Billions of dollars will be spent on more management initiatives, that include deliverables like trade shows, conferences, advertising/marketing, public relations, outreach, video and film production, surveys and other management tools. It is unknown how VA will assure task order compliance and quality assurance oversight for 68 companies over the next 10 years to mitigate any waste, fraud, and abuse. It is also unknown if any of the billions spent on VECTOR will in fact demonstrate an ability to save a single life. Although the advantage of an IDIQ is it allows flexibility to get things done in a timely manner, it does not require enunciated statements of work with performance metrics that can track outcomes. Congress should hold annual hearings on VECTOR to know what outcomes VA is getting for the billions it will be spending on non-patient care activities. Will there be a report?

None of this facilitates treatment outcomes as described by the above-mentioned USC study in the same way that money spent on hiring mental health providers, upgrades to the Veterans Crisis Line, increasing peer support counselors and suicide prevention coordinators or conducting root cause analyses and psychological autopsies when a veteran has died by suicide could do. While billions of dollars are being divert from actual patient care, Whistleblowers of America (WoA) hears from providers all over the country on how those funding shortfalls have obstructed their ability to provide actual suicide prevention and intervention to veterans.

Staffing shortages exist throughout the VA system, including the Readjustment Counseling Services (RCS). While Vet Centers served a total of 287,095 Veterans,

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[5] Jaffe, J.D. (2014) Preventing suicide in all of the wrong ways. Center for Health Journalism. USC Annenberg. https://www.centerforhealthjournalism.org/2014/09/09/ preventing-suicide-all-wrong-ways

[6] https://maketheconnection.net/stories-of-connection

[7] Indefinite Deliverable/Indefinite Quantity

Service members, and Military Families in FY2017 and provided 1,960,900 no-cost visits for readjustment counseling, military sexual trauma counseling, and bereavement counseling services, it has done so at great compromise to quality care. Vet Centers are under a mandate to see 30 patients a week and meet other performance metrics, while still attending staff meetings, documenting chart notes, writing claims support letters or referrals, and providing case management services or face an adverse personnel action. One Vet Center counselor documented over 33 anonymous RCS employee quotes that categorized their work environment as, "ruthlessly fixated on productivity; not optimal for patient care; focus has changed from clinical care to cumbersome bureaucratic record keeping; unethical practices; coming in on my days off to catch up on documentation; sleepless; harassing; retaliatory; vindictive; or traumatizing. Counselors reported impacts to their own emotional and physical wellbeing and low morale because of the stress and many respondents were leaving or retiring so as not to burn out and make judgment errors. However, most compelling were those who reported on the numbers of veterans who stopped coming to the Vet Center because of the "impersonal environment." A veteran shared his protest letter to his Vet Center with WoA.

Other examples of observations shared with WoA:

A VA doctor recently bemoaned that she spends more time looking at her computer screen than at patients while in sessions, so she can answer all of the alerts. She believes that loss of eye contact and ability to read body language impairs her ability to focus on the veteran's mental status because her back is to the veteran most of the time.

At one VA Medical Center, a suicide prevention coordinator reported that they do not have time to complete suicide assessments or write prevention plans with every veteran who potentially needs one because of the case load and its complexity. She had 35 patients at one time. Administrators directed to note patients as "moderate risk" for suicide so as not to raise red flags in the system. When a veteran died by suicide on VA property, her supervisor refused to conduct a root cause analysis because that would be too time consuming. While on another ward across the country, a nurse reported that she is often left alone at night on a ward with seriously mentally ill patients and recovering addicts, if one of the patients attempts suicide, he/she must be sent to the Emergency Room, which requires the enlistment of another patient to push a wheelchair since she cannot leave the ward unattended and no other staff is available to arrive urgently. She has Narcan on the ward, but not the key to the cabinet to get it.

Community Based Outpatient Clinics (CBOCs) are just as challenged. One social worker reported that patients are not properly diagnosed, and some are in danger of not being properly followed up on. Another counselor commented that even when we have access to the Choice Program, the VA doctor still has to write the referral, it needs administrative approval, and then the contractor has to process the request and contact the veteran to schedule an appointment. By the time that happens months later, the veteran could be dead.

A father lamented that his son went to the VA hospital to get help, but he was turned away because there was no available bed. He was given an appointment for several weeks away. He went back to the ER and sat all night without being seen. In the morning, he killed himself in the parking lot. The father, also a veteran, felt enormous guilt for having sent his son to the VA and was now feeling suicidal himself. This highlights how family member suicide and survivors have little visibility in the VA system since their needs are mostly met in the private sector, which impairs a holistic approach to suicide prevention within the VA community and ignores a primary risk factor for a family history of suicide.

Additionally, it has come to the attention of WoA that the DSPO designated $5.5 Million from its DoD line item in its 2016 President's Budget for "Veterans Suicide Prevention." However, there is no audit trail for this money. What DoD or VA actually did and who spent the money is unclear. It is never mentioned again. However, no one yet at DoD has been able to explain why it needed VA to execute its funds or for what purpose. Was there a shortfall in the VA suicide prevention budget? Did Congress not provide VA enough funding?

WoA recognizes that suicide prevention is the new cottage industry. With government money flowing, there is no shortage of contractors, nonprofits, or private enterprises looking for those dollars. All too often appropriated dollars for quality of life programs, such as those set aside for suicide prevention are awarded by government officials for contracts and jobs to their friends and family. This practice is so commonplace, it's dubbed "the friends and family plan" by many throughout the system. If a program manager or contracting officer does not "go along to get along" then the retaliation can be severe as too many who have contacted WoA have come to

learn. WoA has heard from hundreds of VA whistleblowers that exposing medical errors, patient care mismanagement, waste, fraud, and/or abuse of funds or authority, or any other type of wrongdoing becomes an involved, complicated, expensive, and life altering process. This Committee has passed legislation in honor of Dr. Chris Kirkpatrick, a Tomah VA Medical Center psychologist who died by suicide after suffering retaliation in the wake of his reporting suspected overmedication of the hospital's mental health clinic's patients. So, you know that reporting wrongdoing is "career suicide" for those who place their patient's care above their own livelihood. These employees are the powerless in the face of institutional wrongdoing, incompetence, or bureaucratic policy when veterans' lives are at stake, but you are not. This Congress can do more to save veterans and their families from suicide and reducing program costs by exerting greater oversight and accountability over the funds appropriated to VA and the alignment of intervention programs to the data. There is more we can do.

Thank you for considering this statement.

Prepared Statement of Wounded Warrior Project (WWP)

Wounded Warrior Project Mental Health Continuum of Support

Wounded Warrior Project's (WWP) comprehensive approach to mental health care is focused on improving the levels of resilience and psychological well-being of warriors and their families. The 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 in order to better meet their needs. All programs are at no cost to the warrior or their families.

The programs within the continuum are designed to complement one another to foster momentum in the healing process. 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.

Inpatient Care

Inpatient care is the highest level of care offered on the continuum and is intended to meet the most urgent needs of warriors by providing immediate stabilization. Inpatient services are reserved for those who are actively suicidal, had recent suicide attempts, require drug or alcohol detox, or other similarly acute needs. WWP contracts with a number of vetted skilled facilities across the country. These warriors have usually exhausted all other resources for care and are in severe psychological distress.

Warrior Care Network

Warrior Care Network (WCN) is a collaborative program between WWP and four Academic Medical Centers (AMC)—Emory University, Massachusetts General Hospital, Rush University, and UCLA. Each AMC provides a 2-3 week long post-traumatic stress (PTS) centric intensive outpatient program (IOP) as well as regional outpatient (OP) services. The IOP is structured around a cohort model with clinicians who specialize in the care of veterans. WCN is designed for warriors who are not in acute levels of psychological distress but still have significant impairment due to PTS and/or other mental health conditions.

Project Odyssey

Project Odyssey (PO) is a 90 day program which includes a multi-day event led by WWP teammates specially trained in adventure based counseling and experiential learning. The strong mental health component fully integrated into PO is what separates it from other adventure based programs. here are male only, female only, and couples POs at multiple sites across the country designed around a cohort model leveraging the peer to peer support. During the event portion, participants are challenged through a variety of activities such as rock climbing, kayaking, high ropes courses, and the like, while continuously engaged in psycho-education. O not only improves mental and emotional well-being, but provides additional tools to help with PTSD, combat stress, and other invisible wounds of war. articipants engaged with PO are further along in their recovery journey and relatively stable but are still in need of mental health support. Following the PO event, participants are en-

gaged by WWP teammates, either telephonically or via the web, for 90 days to strengthen the skills learned during the PO, set growth goals, and receive support on goal achievement.

WWP Talk

WWP Talk is an internal program where WWP teammates, specially trained in active listening, reach out telephonically to warriors, family members and/or caregivers on a routinely scheduled weekly basis for 6-9 months. Participants are provided an empathic ear without fear of judgment and are provided assistance in establishing and achieving SMART goals. WWP Talk is often used simultaneously while participants are engaged in other programs and services throughout the Mental Health Continuum of Support.

Outpatient therapy

Traditional outpatient therapy is a resource available to warriors and families throughout the continuum. WWP engages with an external partner to provide individual, family, or couples therapy delivered by a military culturally competent therapist in the participant's local community. WWP refers warriors and family members to various external partners who have created a national network of therapists. WWP funds 12 sessions with the possibility to extend those sessions if clinically appropriate.

Independence Program

The Independence Program is a long-term support program available to warriors living with a moderate to severe traumatic brain injury, spinal cord injury, or other neurological condition that impacts independence. WWP has a partnership with specialized neurological case management teams at Neuro Community Care and Neuro Rehab Management to provide individualized services. These teams focus on increasing access to community services, empowering warriors to achieve goals of living a more independent life, and continuing rehabilitation through alternative therapies.

Living the Logo

Living the Logo is WWP's ultimate goal for all warriors—the WWP logo is much more than a trademark, it is a symbol of empowerment. Living the Logo refers to a warrior that was once being carried who has become empowered through the healing and recovery process and can now carry another warrior along their journey of recovery. As resiliency and psychological well-being reach the highest levels in the continuum, warriors become community ambassadors and engage as peer mentors and leaders.

Wounded Warrior Project Mental Health Continuum of Support