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MILITARY AND VETERAN SUICIDE: UNDERSTANDING THE PROBLEM AND PREPARING FOR THE FUTURE

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES

MEETING JOINTLY WITH THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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MILITARY AND VETERAN SUICIDE: UNDERSTANDING THE PROBLEM AND PREPARING FOR THE FUTURE

HOUSE OF REPRESENTATIVES, COMMITTEE ON ARMED SERVICES, SUBCOMMITTEE ON MILITARY PERSONNEL, MEETING JOINTLY WITH THE COMMITTEE ON VETERANS' AFFAIRS, SUBCOMMITTEE ON HEALTH, *Washington, DC, Tuesday, May 21, 2019.*

The subcommittees met, pursuant to call, at 3:22 p.m., in room 2118, Rayburn House Office Building, Hon. Jackie Speier (chairwoman of the Subcommittee on Military Personnel) presiding.

OPENING STATEMENT OF HON. JACKIE SPEIER, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, SUBCOMMITTEE ON MILITARY PERSONNEL, COMMITTEE ON ARMED SERVICES

Ms. SPEIER. Thank you, ladies and gentlemen.

The joint hearing of the Military Personnel Subcommittee and the Veterans' Affairs Health Committee will come to order. I am Jackie Speier, and we will now have a discussion on a very serious issue.

I would like to thank Chairwoman Brownley for partnering with us on this incredibly tough issue.

The statistics are staggering. There were 321 Active Duty suicides and 144 Reserve Component suicides in 2018. This is the highest number of suicides since 2012. An estimated 20 service members and veterans combined committed suicide a day. It is an epidemic, but it is more than an epidemic and it is more than numbers. These are people's lives and the lives of their families that are impacted by it. And we have got to come up with a means by which we can address this in a holistic fashion.

They are not numbers, but these are service members who were willing to die for our country, but took their own lives instead, service members we failed. Behind each of them is a person and their family, friends, and comrades in arms.

Two weeks ago, I met with Patrick and Teri Caserta. Their son Brandon was an Active Duty sailor in the Navy. He had high aspirations for a Navy career, but something changed and tragically he took his life. His parents knew something was wrong, tried to intervene and were turned away by the Navy. The request, so that other parents will not have to endure their grief and pain, was that Congress ensure that service members and veterans receive the help they need without fear of retribution. We must do everything we can to break the chain of suicide that has afflicted our military and veteran community. This problem could not be more urgent.

The reason we are here meeting jointly, the subcommittees responsible for tackling suicide in the DOD [Department of Defense] and VA [Veterans Affairs], is because we need to treat service member and veteran suicide as one issue. Veterans are about twice as likely as civilians to commit suicide. Military service appears to be a causal pathway for increased suicide risk, due to the access to and familiarity with firearms, post-traumatic stress syndrome, depression, loss of community, alienation, head injuries, and substance dependence.

These factors take root, manifest, and worsen across an individual's DOD/VA experience. We need to react to this reality by preventing, detecting, and treating suicide risk from the moment an individual signs up to well after they leave the service.

Today we will hear from a panel of experts from the Department of Defense and the Department of Veterans Affairs to help us understand the scope and magnitude of the suicide challenge affecting our military and veterans' communities. We will also learn about suicide prevention efforts within the Department of Defense and Department of Veterans Affairs and try to better understand ongoing collaborations and potential future partnerships related to suicide prevention efforts between the Department of Defense and the Department of Veterans Affairs to try and end the epidemic.

Before I welcome the panel, I would like to ask if Ranking Member Kelly would like to say some introductory remarks.

[The prepared statement of Ms. Speier can be found in the Appendix on page 39.]

STATEMENT OF HON. TRENT KELLY, A REPRESENTATIVE FROM MISSISSIPPI, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL, COMMITTEE ON ARMED SERVICES

Mr. KELLY. Thank you, Madam Chairwoman.

You know, I would first like to say I have had the opportunity to command at the battalion level in combat. And I was in Iraq in 2005 as an operations officer, and we lost 29 soldiers in our formation, our brigade formation.

Coming back in 2006, we buried way too many in that year following who had survived the traumas of war and who came back and who are no longer with us. And so unless you have experienced that firsthand, it is difficult to understand the impact on a family and on the soldiers, and on the hearts and minds of the community, knowing that they so bravely served this great Nation and then came home and something went awry, and we have to fix it. It is that important. I understand why we lose soldiers in combat. I cannot understand why we lose them when we get home.

I wish to welcome our witnesses to today's hearing and want to thank them for being here. The fact that we are holding a joint hearing with both the Department of Defense and Department of Veterans Affairs testifying together underscores the importance of suicide prevention and the need for a unified solution to the problem.

We are at a crisis point. Last year's suicide rate among Active Duty forces was the highest it has been since 2012 and ties for the highest on record since the services began tracking it. Meanwhile,

approximately 20 veterans commit suicide each day. This is unacceptable and we all have a responsibility to fix this issue.

I am concerned that the high rate of suicide among service members and veterans will soon become a fact of life and that we are beginning to accept it as a natural consequence of military service. We cannot let that happen. We must take decisive action to disrupt the status quo and reverse this epidemic.

When a service member takes his or her own life, it is a tragedy for both the surviving family and the unit. While suicide has an often irreparable effect on the service member's family, it can also cause lasting effects on the unit. In addition to the emotional impact on fellow service members, we know that one suicide in a unit can sometimes lead to additional suicides or the contagion effect. That is why suicide must continue to be treated as not just a personal mental health issue, but as a readiness issue.

I am interested to hear from today's witnesses about the behavioral health treatment available for service members and veterans. Particularly, I am concerned that there continues to be a stigma associated with seeking behavioral health treatment. In fact, as the VA notes in their written statement, over half of those who die by suicide had no mental health diagnosis at the time of their deaths.

I am interested to hear how the services mandate periodic behavioral health checkups for all service members and whether those interventions are effective. Just like required yearly physicals and dental checkups are not an option should a substantive session with a behavioral health provider, not just an assessment by a medical provider, be required.

I am also convinced that small unit leaders' involvement is critical to identifying behavioral health issues. The services must leverage the NCO [noncommissioned officer] leaders closest to the service members at the team and squad level to help identify self-destructive behaviors and get help for service members. I would like to know what training is provided to these leaders to help them in identifying problems and getting assistance.

I hope that today's hearing will bring renewed attention to the problem of military suicide. While I am interested in the actions that the Defense Department and VA have done to prevent suicide, I am also focused on the practical things we can do today to reverse this disturbing trend.

Thank you, Madam Chairwoman, and I yield back.

Ms. SPEIER. Thank you, Ranking Member Kelly.

Now we are going to hear from Chairwoman Brownley.

STATEMENT OF HON. JULIA BROWNLEY, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS

Ms. BROWNLEY. Thank you, Chairwoman Speier, and thank you for hosting us today. Your dedication to the prevention of suicide among not only veterans but also our service members is evidenced by your willingness to host this joint hearing among our subcommittees.

As a member of the Committee on Veterans' Affairs, our jurisdiction is limited to the Department of Veterans Affairs. While we may inquire as to the activities of the Department of Defense, I

cannot remember the last time we had the opportunity to receive testimony from the agency, so I thank the DOD for being here today.

Despite this, the actions of the Department of Defense significantly impact the lives of our veterans, from the status of the service member's discharge to the location of a service member's service to the responsibilities of a service member while on duty. All of these decisions have been shown to impact the likelihood that a veteran will experience suicidality.

According to VA, of the 20 veterans per day that die by suicide, nearly 4 are either Active Duty service members or members of a Guard that have never been activated, thus ineligible for VA healthcare. Yet, VA is committed to reducing this staggering statistic through a public health approach. By identifying which individuals are most in need and targeting effective preventive interventions to those individuals by creating a system of health throughout the population as a whole, VA is ensuring our most vulnerable and high-risk veterans and service members are surrounded by the resources they need most. The quicker VA is able to identify those in need and connect them to resources, the more effective suicide prevention efforts will become.

If the Department of Defense is willing to create a fluid movement of data between the two agencies, then the efforts of VA would only be magnified. VA would be able to identify high-risk service members before their transition is complete, and DOD would be better able to assist in ensuring vulnerable service members are aware of and have access to VA and community-provided resources that might reduce the turmoil caused by the service member's service and assist the veterans in his or her family as the veteran transitions home.

For instance, VA offers a variety of counseling services to Active Duty service members, members of the Guard, veterans and their families at Vet Centers throughout its Readjustment Counseling Service. However, service members only make up about 5 percent of the population that Vet Centers serve.

Also, in 2017, Congress expanded eligibility for mental healthcare to certain veterans with other than honorable discharge statuses. However, 2 years later, we are seeing in the media that veterans have not been adequately notified of this benefit. While VA was ultimately tasked with sending letters to veterans that may be eligible under the expansion, there is no reason the Department of Defense could not assist in ensuring that these former service members are connected with the care they qualify for.

Again, I am thankful for today's opportunity to engage in this much-needed dialogue and hope it is the beginning of a productive relationship between our two committees and our two agencies.

And I yield back, Madam Chair.

Ms. SPEIER. Thank you. Thank you, Chair.

Now we will hear from Ranking Member Dunn.

STATEMENT OF HON. NEAL P. DUNN, A REPRESENTATIVE FROM FLORIDA, RANKING MEMBER, SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS

Dr. DUNN. Thank you, Chairwoman Brownley, Chairwoman Speier. I am grateful to be here this afternoon with my colleagues from the Committee on Veterans' Affairs and the Committee on Armed Services to discuss the tragedy of suicide among service members and veterans.

Joint hearings like this are not standard for Congress, but the fact that we are holding one here today is testament to our dedication to address this crisis.

Congress has passed legislation and provided funding to stem the tide of suicide in military veterans' communities, but stubbornly, tragically, these rates have refused to budge. I am hopeful that by bringing subject matter experts from both departments here together and holding conversation that crosses our jurisdictional boundaries of both committees, we will be able to shed some new light on this complex topic and start saving lives among those who served and are still serving.

And I thank you, our witnesses, for joining us, and our audience for joining us. And, Madam Chair, I yield back.

Ms. SPEIER. Thank you, Ranking Member Dunn.

I ask unanimous consent to allow members not on the subcommittee to participate in today's hearing and be allowed to ask questions after all subcommittee members have been recognized.

Without objection. All right.

Now we welcome our panel. Thank you all for joining us. Dr. Elizabeth Van Winkle is no stranger to this committee. Thank you for joining us. She is the Executive Director of the Office of Force Resiliency in the Department of Defense.

Sitting next to her is Captain Mike Colston, M.D., United States Navy, Director of Mental Health Policy and Oversight at the Department.

Next is Dr. Keita Franklin, National Director of Suicide Prevention at the Department of Veterans Affairs.

And finally, Mr. Michael Fisher, Chief Readjustment Counseling Officer, Department of Veterans Affairs.

Welcome to all of you, and I think we will start with Dr. Van Winkle.

STATEMENT OF DR. ELIZABETH P. VAN WINKLE, PHD, EXECUTIVE DIRECTOR, OFFICE OF FORCE RESILIENCY, DEPARTMENT OF DEFENSE; AND CAPT MIKE COLSTON, USN, DIRECTOR, MENTAL HEALTH PROGRAMS, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. VAN WINKLE. Thank you. Madam Chairs Speier and Brownley, Ranking Members Kelly and Dunn, and distinguished members of the subcommittees, thank you for the opportunity to appear before you today with our colleagues from the Department of Veterans Affairs to discuss the Department of Defense's suicide prevention efforts.

As many of you are aware, I serve as the Executive Director of the Office of Force Resiliency, a portfolio that oversees several priority efforts, including the Defense Suicide Prevention Office, which

we commonly refer to as DSPO. As many of you also know, the Department recently announced a new Director of DSPO, Dr. Karin Orvis. Unfortunately, Dr. Orvis was unable to attend today's hearing, but would be happy to meet with you or your staff moving forward.

Today I can discuss the Department's efforts on suicide prevention from my role at Force Resiliency, where I oversee the Department's policies on the prevention of suicide, sexual assault, harassment, hazing, bullying, and drug use. I also oversee the DOD/VA Collaboration Office. In this position, I recognize the intersection of many of these difficult and challenging issues and work to align prevention efforts within this continuum.

Although each of us at the witness table represents different efforts within both the DOD and VA, we are all committed to the same critical mission of suicide prevention. Both departments work in strong partnership.

With me today is my colleague, Captain Mike Colston, the Director of the Mental Health Programs for Health Affairs. Captain Colston and I can discuss what we are currently doing within the Department to prevent suicide in our ranks.

We at the Department of Defense have vowed time and time again to ensure that we do everything possible to support our service members, and all of us work tirelessly to do just that. Yet, our rates of suicide are devastating and unacceptable, and they are not going in the desired direction.

Although our data helps drive and improve our efforts in this space, my colleagues and I know that every single life lost is a tragedy, and each one has a deeply personal story. With each death, we know there are families and often children with shattered lives. We cannot rest until we have pursued every opportunity to prevent this tragedy among our Nation's bravest.

We know this is a shared challenge. Nationwide, suicide rates are alarming and increasing. None of us has solved this issue and no single case of suicide is identical to any other case. The scientific research surrounding prevention of suicides is both complex and ever-evolving. Suicide is the culmination of complex interactions between biological, social, and psychological factors operating at individual, community, and societal levels. Our data also tells us it is often a sudden and impulsive act.

To address this complexity, we leverage scientific, evidence-informed practices to constantly pull every idea, every possible effective initiative into our toolkit to help service members and their families. We seek ideas and new solutions from everywhere, whether that is within the Department or from stakeholders, such as researchers outside of the government or within Centers for Disease Control and Prevention, and also from Congress. Indeed, your inputs and your engagement have been critical to our efforts.

Because data informs our ability to take meaningful steps and fulfill our commitment to transparency with you and the American public, the Department will soon expand our reporting on suicide-related data. This summer, we will publish our first annual suicide report, which will supplement our longstanding DOD suicide event report. We address this in our written testimony, and I am happy to discuss any questions you may have about our reporting and

how we use data to inform our research and initiatives in the area of suicide prevention.

We are grateful for the opportunity to speak with you today. Suicide prevention is among the most complex challenges we face and one of the most devastating to bear. The root causes vary from one individual to another, and the signs are often difficult to detect for friends, family members, and even for clinicians, who work so closely with many of these individuals. More than likely, each of us in this room has been impacted by suicide, friends, family, loved ones lost to this decision that will forever impact our lives, leaving us with far more questions than answers and a weight on our shoulder that often never recedes.

Within the military community, this loss reverberates beyond the unit, beyond the commander, and beyond the service. It is a loss for our country and one we cannot afford and we should not accept. Many of you have heard me say this before, but we truly must show as much commitment and dedication to the well-being of our service members as they have demonstrated on the day they stepped forward to volunteer and serve our country.

We must meet that sacred obligation because we need each and every woman and man who bravely signs up to fight for this Nation. Those who choose to serve are an inspiration to us all. They are the front lines. We depend on them and we need them. We must fight for their safety at least as hard as they fight for ours.

In closing, we thank you, Chairwomen, Ranking Members, and the members of your subcommittees, for your steadfast dedication and support of the women, men, and families who defend our great Nation. I look forward to the discussion today.

[The joint prepared statement of Dr. Van Winkle and Captain Colson can be found in the Appendix on page 41.]

Ms. SPEIER. Thank you, Dr. Van Winkle.

Dr. Colston, do you have a—do not, okay. Let's move then to—is it Keita, did I pronounce it?

Dr. FRANKLIN. Yes.

Ms. SPEIER. Dr. Keita Franklin.

STATEMENT OF DR. KEITA FRANKLIN, LCSW, PHD, NATIONAL DIRECTOR OF SUICIDE PREVENTION, DEPARTMENT OF VETERANS AFFAIRS; AND MICHAEL FISHER, CHIEF OFFICER, READJUSTMENT COUNSELING SERVICE

Dr. FRANKLIN. Good afternoon, Chairwoman Speier, Chairwoman Brownley, and members of the subcommittees. I appreciate the opportunity to discuss the critical work that the VA is undertaking to prevent suicide among our Nation's veterans. I am accompanied today by Mr. Michael Fisher, Chief Officer, Readjustment Counseling Service, who leads our Vet Center work.

I have been in this permanent position since April of last year, but like many in the room today, the military has always been a significant aspect of my life. My father is a 20-year Navy veteran and my husband is an Air Force veteran.

Prior to joining the VA, I served as a Director of the Defense Suicide Prevention Office, and my career has focused on deployment and trauma and how that impacts families and marital relationships.

I am a social worker by training, and I focused on child welfare and have led various programs around domestic violence, sexual assault, substance abuse, and combat operational stress before narrowing in on suicide prevention.

So this mission at the VA is both critical and personal to me, and I understand the urgency of it. At my level, I respond to texts, emails, and phone calls from service members, veterans, and their family members who are seeking support.

Just 2 weeks ago, I spent 2 days with one of our partners, the Independence Fund, and approximately 80 veterans who deployed together. And they faced an incredible amount of trauma in that deployment, the 3rd to the 67th Armored Regiment, the 4th Infantry Division, and led critical work to build resilience in that group. It was great to hear from those veterans how access to care and support from peers impacted their journey through recovery. And it is these stories that keep me focused on the work at hand.

I am pleased to talk about VA's continued partnership with the Department of Defense. Our collaboration with DOD personnel and readiness leadership is critical to our success as we continue to examine how best to address suicide prevention across our entire military and veteran community.

We are jointly committed to reaching those who have worn the uniform where they live, work, and thrive. Already, we have worked diligently on a number of important collaborations to reach people at risk of falling through the cracks, bolstering support for service members as they transition out of service and facilitating their access to care, and yet we realize there is so much work left to do.

We look forward to this continued partnership. Suicide is a serious public health tragedy. It affects communities across the Nation. In the United States alone, we know that there are 123 people that die each day by suicide. And globally, 800,000 people die by suicide. That is one person every 40 seconds. And we know inside the VA that an average of 20 people who have worn the uniform die by suicide. This is a figure that has remained relatively stable over the last few years, but that has not stopped us from learning everything we can about the data.

Of those 20 tragic deaths, we know only 6 have accessed VA healthcare in the 2 years leading up to the death by suicide. The majority, 14, have not. And when you look at this data even closer, and Chairwoman Brownley already mentioned it, two to three of those individuals that have died by suicide are former National Guard and Reserve members never federally activated. And if you account for the one that is on Active Duty status, you come to the four that the chairwoman mentioned.

This issue cannot be solved through mental healthcare alone. In fact, national data shows that more than half of Americans who died by suicide in 2016 had no known mental health issue at the time of their death. And this is also true for our veterans. A massive expansion of mental health providers and a world-class mental health access has done little to reduce the total number of suicides among veterans.

Maintaining the integrity of VA's mental healthcare system is vitally important, but it is not enough. The VA cannot end veteran

suicide alone. This understanding is why we have expanded our efforts into the public health approach. Our national strategy for preventing veteran suicide is a multi-year effort that provides the framework for identifying priorities, organizing our efforts, and focusing community-level resources to prevent suicide. It is intended to move us from a focus on crisis intervention to a set of bundled strategies across multiple sectors.

Our Readjustment Counseling Service is a critical element in our strategy to provide a wide range of confidential social and psychological services to eligible veterans, Active Duty service members, and members of the Guard and Reserve, and their families. These services are designed to increase barriers to care, such as providing services after nontraditional hours away from brick-and-mortar facilities. The Vet Centers aggressively focus on preventing suicide through partnerships, including with the National Guard and the Reserve.

And the Vet Centers have consistently increased services to veterans, service members, and families. In 2018 alone, we saw that increase by 4 percent with an 18 bump among service members. An 8 percent, I am sorry, not 18, 8 percent bump among service members.

We are also working with Federal partners, States, local governments to reach veterans in communities nationwide. In March 2018, we collaborated with the Department of Health and Human Services to launch our Mayor's Challenge. And in October of 2018 we took those efforts to the State level and we launched a Governor's Challenge. This initiative allows VA to work with 7 Governors, 24 local governments, chosen based on veteran population and veteran suicide prevalence rates, with a focus on all veterans, not just those that come into our VHA [Veterans Health Administration] healthcare system.

We have also recently implemented two Executive orders. Under the first one signed in January of 2018, we are partnering with the Department of Defense and the Department of Homeland Security around transitioning service members, trying to get after that first 12 months that we know is critical. We also executed a second one called PREVENTS [President's Roadmap to Empower Veterans and End a National Tragedy of Suicide] signed in March 2019 to further our efforts in this space through the development of a national roadmap. So we recognize that we must partner, empower, and engage communities to reach all veterans, not just the ones that come into VA for healthcare.

Our objective is to empower veterans where they live, work, and thrive whenever and wherever they are. So we thank the committees for their support of this mission, including the Members of Congress who have recently helped us to spread awareness of veteran suicide through our PSA [public service announcement] drive. Together, we know that we can make a difference.

Ms. Chairwoman, this concludes my statement. My colleagues and I are prepared to answer any questions you may have for us.

[The prepared statement of Dr. Franklin can be found in the Appendix on page 54.]

Ms. SPEIER. Thank you, Dr. Franklin.

Mr. Fisher.

Mr. FISHER. No statement, ma'am.

Ms. SPEIER. Okay. I would like to start by asking a few questions. And, unfortunately, at 4 o'clock I am going to have to leave for a meeting with the chair of the full committee, so I will turn it over to Ms. Brownley at that time.

Dr. Van Winkle, let me start off with the question of embedding behavioral health personnel within the units. Have we seen any benefit associated with doing that?

Dr. VAN WINKLE. Thank you for the question. And certainly, Captain Colston can talk specifically about that. I think anytime that we provide the opportunity for service members to receive support, we are working to prevent suicide. We do have embedded behavioral health, mental health individuals that Captain Colston can talk about. We also embed military family life counselors to provide support, and we allow for surge capacity if there has been a suicide in the ranks, that we provide more military family life counselors to support the unit at large.

And I can turn it over to Captain Colston to talk about the embedded behavioral health.

Captain COLSTON. So, ma'am, we embed behavioral health both into primary care clinics and into line units. I found in——

Ms. SPEIER. How many? Can you tell us how many you have in the line units?

Captain COLSTON. Of the 10,000 providers, it is over a thousand right now, ma'am.

Ms. SPEIER. In units?

Captain COLSTON. Yes, ma'am, or in primary care clinics. So we have 10,000 providers right now.

It is really useful. In some ways it is a loss leader because, of course, you are not seeing patients in and out in the clinic all day; but it really speaks to what Mr. Kelly spoke about, and that is interaction with those line commanders, that is vitally important, and really getting a pulse of the unit.

I found that my interaction with both commanders and chaplains in a deployed setting was really, really important. And it is something that we have endeavored to get into doctrine and standardize and optimize.

Ms. SPEIER. I was stunned to find out that there is such a high percentage of those who commit suicide who have never been deployed. So what can you say to that?

Captain COLSTON. So just historically in what I have seen, over 40 percent of people who commit suicide haven't deployed. They are white. They are male. They have GEDs or high school degrees, GEDs, and they are enlisted. The suicide rate in folks with GEDs was over 50 in the last DODSER [Department of Defense Suicide Event Report] in 2016.

One thing that I have seen over my service—and I was a line guy before I was a doc—is we have really tried to treat people, treat people on station. We used to separate over 4,000 people a year for personality disorders or adjustment disorders, under that type of rubric, a nonmedical separation. We have reduced that to 300 per year. And I think that finding—meeting people where they are, meeting those needs is going to be part of the suicide prevention equation.

Ms. SPEIER. Have you, in your evaluation of this population, determined what percentage of those that commit suicide commit suicide in basic training?

Captain COLSTON. It does happen, ma'am. And certainly, I have seen it. It is a very small number. And the only reason that it is a small number is because there is a great deal of supervision in basic training. And there are specific procedures in basic training. For instance, if you have a headache, you are only going to get 10 Tylenol. You are going to be monitored by your squad leader, things along those lines. It is the A schools and after that we really struggle.

Ms. SPEIER. And can you provide any light on the fact that there is a higher incidence of mental health services in the last year of service?

Captain COLSTON. Yes, ma'am. Our DMDC [Defense Manpower Data Center] records show that about 25 percent of folks avail themselves to care in the year before they leave. I think that is a good number inasmuch as it helps for continuity of care with our VA partners. But it also speaks to an opportunity that we missed, perhaps, in why didn't they come in earlier if they were struggling, or how was care stigmatized in a manner that made it hard for them to seek care earlier.

Ms. SPEIER. And have you asked those questions?

Captain COLSTON. Oh, certainly, ma'am. And I have certainly asked them as a clinician. You know, I think one of the things—let me just bring up an example. The incidence of depression in women is about 33 percent. And I have spoken to many women right before they leave service and, you know, why didn't you get care earlier? Well, you know, I think that care was stigmatized for them in one way or another. And certainly, we have made an effort to meet patients where they are. And, you know, just like we need to make sure that we take care of gynecological care for women, we need to make sure that we take care of mental healthcare for women.

Ms. SPEIER. Thank you.

Chairwoman Brownley.

Ms. BROWNLEY. Thank you, Chairwoman.

Over the weekend, there was yet another tragedy suicide on the campus of one of our VA facilities. And at that same facility, it was reported—I have an article here—reported that a veteran seeking mental healthcare was repeatedly, at least the article alleges, was misinformed of his eligibility due to his other than honorable discharge status.

So I wanted to first, Dr. Franklin, ask you, in terms of the VA's efforts, beyond letters, you know, what other initiatives are we taking to ensure that our veteran community are aware of the change in eligibility regarding other than honorable discharges?

Dr. FRANKLIN. Thank you. I appreciate the question, because it is an at-risk population group. We know that when people are leaving the military in a bad way, back in the day bad paper discharge they would call it, is definitely a high-risk group.

And we did mail out close to 500,000 letters. And of those, you should know 3,500 have come into care. And I have the breakout in terms of those, how many have come into mental healthcare

and/or had a diagnosis. It is 1,413 have a mental health diagnosis, and the other group have come in for some form of care and/or treatment.

And I think that there is work to be done to continue to get the word out. So far, above and beyond just the letters, we are educating all 400 of our local suicide prevention coordinators so that they know they have a requirement to do 5 outreach events a month. So if you just do the math, over 400 of them, 5 a month at key places across a State or a community where there are known populations at risk, where they are educating community members on the fact that if people leave with this type of discharge that they can access care and that we want them to access care. Otherwise, we are trying to hit the media with broad articles and educational spots, where we describe the fact that we are open to this type of care.

I don't know if Mike Fisher, you may have some other specific examples.

Mr. FISHER. Absolutely. Thank you. Our focus is also on outreach, and our definition of outreach is going out and creating face-to-face connections with those that we are trying to create access to care. About 99 percent of our outreach workers are fellow combat veterans, so we are able to speak that same language. Last year we did 35,000 outreach events, where we were able to create those face-to-face connections.

And actually, Vet Centers have had the ability to provide services to people with problematic discharges for several years, and that, really, we make sure that we focus explaining that when we go out. And then also now with the updates over on the medical center side is making those connections as well.

Ms. BROWNLEY. Thank you.

And just the same question to Dr. Van Winkle. I feel like this can be a collaborative effort in terms of outreach and certainly before someone leaves the military that may be dishonorably discharged. How can you help us to inform this population of veterans?

Dr. VAN WINKLE. Thank you for the question. I think that as we start to work within the transition space in some of our governance structures, including the Joint Executive Committee, we have been having these conversations with the VA about how can the Department work better to transition our folks and provide them all the information that they need.

One of the things that we have been doing, and I have been working directly with the Veteran Benefits Administration under the guidance of the Joint Executive Committee, is to codify a transition framework that goes from 365 days prior to separation to the 365 days post separation.

And the goal of this is to make sure that service members leave the military with an understanding of and easy access to all of the benefits and resources that they require. And this includes those subpopulations who may have been other than honorably discharged or dishonorably discharged.

We are considering those subpopulations and making sure that the Department of Defense and the VA has the burden to get this to a place where they have that access, that it is not up to the serv-

ice member to have to do the legwork to figure out all the different resources available to them. So this is something we are working on and the Joint Executive Committee has taken on.

Ms. BROWNLEY. Thank you. I wanted to ask another question. This is with regards to MST [military sexual trauma]. And there has been peer-reviewed research that repeatedly finds that the experience of MST elevates the risk of suicide. And the risk is even higher for MST survivors who are also members of marginalized groups, women, racial minorities, LGBTQ [lesbian, gay, bisexual, transgender, and queer or questioning], service members.

So in over half of the service members who report MST experience retaliation by their chains of command. So this is—you know, I know it is a question that is always asked, but I think we have to keep asking it, because it is such a huge cultural change within the military.

But what are we doing to help to create that environment in the military to make it safe, safe for survivors, and really safe for anyone to reach out for help?

Dr. VAN WINKLE. So I appreciate that question as well, considering my position where sexual assault policies and the suicide policies both fall under me, as well as the policies on harassment, hazing, bullying, drug use, and the reason being is because we know there is an intersection between all of these behaviors. And when you have an individual who has experienced a sexual assault, this is extremely fragmenting and shattering, and often they may cope by drinking more or having other experiences which will put them in a place of experiencing depression and potential suicidal ideation/attempts.

We work within this space on the policy level under the Prevention Collaboration Forum which I run, where all of these policy offices work together to align our prevention strategy, so that we make sure we close any loopholes for those individuals who may be experiencing multiple issues at once.

In the Prevention Collaboration Forum is also the Family Advocacy Program, talking about domestic violence, the care that we provide to our families and to our children. And that is one of the structures that we use in order to address these co-occurring issues.

Captain Colston also can talk a little bit about the behavioral health treatment targeting towards these individuals.

Captain COLSTON. So every evidence-based treatment for sexual assault trauma is available in DOD: cognitive processing therapy; prolonged exposure therapy, which is an especially good therapy, from Edna Foa's lab in University of Pennsylvania; medication; and certainly wraparound services for these folks.

Ms. BROWNLEY. I am convinced that there are lots of programs and supports around there. I still just continue to be concerned around the environment. And I just think there is a lot more—I hear it anecdotally time and time and time again about retaliation and the chain of command.

And I just think that we have to, I mean, truly address that in a way that we are really drilling down every single place within the military that it is just unacceptable that that would happen. And I still hear over and over again that members of the military,

men and women, around mental health or MST, the fear of just reaching out to ask for help.

And so I know cultural changes are really, really hard, but unless the leadership is completely committed to it, it is not going to happen. And certainly on the VA side, we have, you know, the same kind of cultural issues, you know, that we have to address.

So I feel like I have never been in a committee where the chairpeople weren't limited by time. So I want to be respectful of the time, so I will yield back.

Ms. SPEIER. Captain Colston, along those same lines, I visited a VA program in Menlo Park for MST survivors. Not one of them was going to be able to leave the program and go to a home. They were all homeless when they were going to leave the facility.

And I am also concerned that for a long time—I don't know if we are still doing that and maybe one of you can enlighten us—many of them were discharged with what was called a personality disorder. And I am curious whether or not they were, in that status, able to access services?

Captain COLSTON. So under that rubric, they got a general discharge. But we did make a very large effort to address injustices in that regard. I think that I have spoken in other committee meetings about how we have evolved around that particular type of discharge, going from 4,000 a year to 300 folks a year.

In about 2013, Secretary Panetta made a promise at Senate Appropriations Committee that we would review all of those cases. And, in fact, we did. So we looked at over 200,000 instances where folks didn't leave with medical benefits where they left less than 30 percent by our Physical Disability Board of Review.

And the Physical Disability Board of Review, which was run by the Air Force and overseen by Personnel and Readiness, scrubbed cases over 3 years and got benefits to lots of folks. And they also did a lot of outreach. So they went to homeless shelters and looked for those folks.

We have Boards of Correction for military records, and there is a presumption in those Boards of Correction that a mistake may have been made. So we have given specific guidance around those types of cases to our Boards of Correction.

Ms. SPEIER. All right. Maybe for the record, you could just provide us with the numbers. If you have looked at 200,000, could you let us know how many were changed?

Captain COLSTON. Yes, ma'am. I just got a FOIA [Freedom of Information Act] request on it so I think I have it.

[The information referred to was not available at the time of printing.]

Mr. KELLY. I would ask that there be equal time. And I know that the minority party probably is not entitled to any comments whatsoever, but this is ridiculous that we have gone through many, many minutes and we have not even been referred to, and it is very passive-aggressive behavior and intentionally leaving the minority out.

And this is not the first hearing, and I just ask that equal time be represented in this hearing and all other hearings.

Ms. SPEIER. Mr. Kelly, you are recognized, and you have as much time as you would like to ask your questions, as we always do in our committee hearings.

Mr. KELLY. Thank you, Madam Chair. Generally, it is the chair, ranking member, chair, ranking member, in all 4 years that I have been in every committee and subcommittee that I have been on.

With that being said, I would first say that I am very concerned about our Reserve Component service members and veterans, who return to their civilian communities where there may not always be good access to behavioral health resources and the support systems you find on military installations.

There is also the issue when Reserve Components come back, National Guard and Reserve, they don't demob [demobilize] at the same time. They go home to different locations. There is not that unit cohesiveness and the ability to talk with the soldiers that they serve with while they have done so.

What are we doing to reach out to the Reserve and National Guard and make sure that these veterans are getting the help that they need?

Dr. VAN WINKLE. Thank you for the question. We do have those concerns that you mentioned about the Reserves and the National Guard. Simply pragmatically, they don't have the access to the same resources that you may have in the Active Duty when you are under our purview 24/7. So that is on us to make sure that we provide them all of those resources.

And we do this in a number of ways. We do provide all of our resources in terms of the crisis lines and military family life counseling and peer-to-peer support that they can call in. We provide that. It is on us to make sure they recognize that that resource is available to them.

Captain Colston can talk a bit about how they target their efforts to the reservists and National Guard, and Mr. Fisher can talk also about the Vet Centers, which are available to our reservists and our National Guard.

Mr. FISHER. Thank you. One of the things that we are working on within Vet Centers is actually an initiative with the National Guard Bureau, where we are taking our assets, both our counseling staff, our outreach staff, our mobile Vet Centers, and we are going out to drilling units and spending time with them when it makes sense for them on a drill weekend. Our real job there is to go out and make those connections like we talked about before, but if they need services, connect them into services or provide the services on the ground.

Now, we recognize that there will be individuals that are not truly eligible for Vet Center services that we meet. And if they are in crisis we will meet that need, but our job then becomes where can we make that referral to, whether that is the VA or our partners in DOD, the National Guard Bureau, or other places within the community.

As we roll out the National Guard, our next step then is to go into the Reserve forces and do the same thing, but get connection to those locations. And really, what we are doing is we want to build relationships with leadership, so that when we are not there we can create bidirectional referrals.

Mr. KELLY. I thank you all. I just ask that you look at the soldier level, especially on combat veterans or like experiences, because I will tell you many combat veterans will not talk to noncombat veterans. More specifically, that subset is even smaller, the folks, the platoon or the squad that they actually serve with, they are willing to share with those like family members when they won't share with anyone else. So that is the key to identifying the issue is those small subsets which they will only share.

Dr. Van Winkle, thank you for your work in this area. What type of training did junior leaders in the military receive to help identify behavior in their troops that may be a sign of greater behavioral health issues, specifically suicide?

Dr. VAN WINKLE. There are a number of training efforts that we provide to both our junior leaders as well as our commanders and service members writ large. The idea is to make everybody part of the solution. And so when we talk about risk factors, we are looking at often situational factors that cause stress and can often predict whether somebody is going to get depressed and go on to die by suicide or attempt suicide. Those include relationship problems, financial problems, legal issues. And so when those issues arise and a commander or a lower level leader, the first-line supervisor is made aware of it, it is a call to action that we may need to provide additional support to that individual. But we have broadened that to be the service members themselves as well as the families to, again, be part of that solution.

Mr. KELLY. And I think, Doctor, Captain Colston, you made an interesting comment. And I can tell you in 33 years of military service and through going through PHAs [periodic health assessments] and everything else that we have had to go through on a yearly basis and also doing post-deployment stuff and seeing other soldiers do those, there is a reason that people wait until you are 19 or their last year before they report anything—and that is not just behavioral health issues, that is physical issues—and it is from the fear of being removed from the service. And that is the stigma which we must figure out how to stamp out, because they won't tell you they are hurting, they won't tell you either physically or internally, because they are scared that it will impact their career.

What can we do to make sure that they disclose this earlier to remove that stigma and that fear of being removed from service?

Captain COLSTON. I think the first thing is is we absolutely need to get the word out that it is almost impossible to lose your security clearance from endorsing a mental health history on your SF–86 question 21. And we really have data, a couple dozen out of nearly 10 million security clearances.

So when we look at the process of, okay, let's get down to the data, are we going to kick you out for having a mental health condition? Probably not. And, in fact, there is a presumption of nondisclosure with commanders. As a commander, do I want to know absolutely everything about anybody, any of my troops? I do. But there are all kinds of things that to create an environment of trust and an environment where you can come to see me that we need to delimit things that we speak to commanding officers about. So that is imminent harm to self, imminent harm to others, severe

substance use disorders. But we really need to have something that is, you know, very private between clinicians and soldiers.

Mr. KELLY. And I would ask the rest of you all submit that for the record so we can have other people ask some questions, but I would also, one thing for the record. Just someone give us the information on what the disparity and percentages for women and men committing suicide. I know there is a smaller number of women, but I would love to know the difference in women or any other differences that you can do for the record.

Thank you, Madam Chair.

[The information referred to was not available at the time of printing.]

Ms. BROWNLEY [presiding]. Thank you, Mr. Kelly.

And, Dr. Dunn, you have as much time also you need.

Dr. DUNN. Thank you, Madam Chair.

Dr. Franklin, please elaborate on some of the specific changes you are making to VA suicide prevention programs.

Dr. FRANKLIN. Sure. Absolutely. We have made a number of changes in the last year that I would be pleased to tell you about. I mean, the first is putting pen to paper on a national strategy. I think in times past, the VA's approach to suicide prevention has largely been focused on the veteran crisis line and on providing the best mental healthcare ever. And that alone we know will not prevent suicide.

And so this strategy really gets after making sure that we are doing broad sector engagement, and we are moving outside the four walls of the VA hospital system, which is new. Traditionally, we have, like I said, had an approach where folks come to us and we provide them the best care we can.

Dr. DUNN. Do you have metrics you are following those changes?

Dr. FRANKLIN. Yes. So this is all brand new within the last year. And our ultimate metric that we have come up with on this or the ultimate metric is to lower the 20 a day.

But left of that metric is a set of bundled metrics that we have come up with, and it is everything from making sure that we have an all-hands approach in terms of training. So a metric tied to training. We have a metric tied to increasing access to healthcare. We have a metric tied to our predictive analytics approach. When we identify through our predictive modeling—maybe you have heard of it, REACH VET [Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment]—that we get those folks into care, the high-risk folks.

Dr. DUNN. I think we would like to see some of that.

Dr. FRANKLIN. Absolutely.

Dr. DUNN. Just a white paper kind of answer at your convenience.

Mr. Fisher, here is a little good news for you. H.R. 1812, that allows the Guard and Reserve to access Vet Centers if they have been activated for national disasters, civil disorder, or drug interdiction operations, just passed the House by a voice vote.

Mr. FISHER. That is great news, sir. Thank you.

Dr. DUNN. In that vein, what percentage of your Vet Center counseling is provided to Active Duty or Guard?

Mr. FISHER. Well, like the chairwoman said before, last year it was 5 percent of the total uniques coming in were for Active Duty service members. The Guard is a little less than that. But what we are seeing is increases in those two populations.

So last year, we had a 9 percent increase in Active Duty service members coming—excuse me, an 8 percent increase in Active Duty service members come in. And over this past year, as we roll out this National Guard initiative, we have seen a 9 percent increase in National Guard individuals coming into Vet Centers or connecting with those individuals.

Dr. DUNN. Thank you. Captain Colston, what kind of outreach does DOD do to make sure that the Active Duty troops know that they can use the Vet Centers?

Captain COLSTON. So all kinds of outreach. I think with regard to military—all types of outreach. So in regard to military sexual trauma, Vet Centers have long been available. We make an effort to ensure that folks know there is continuity of care, that we have a warm handoff between our side and the VA side or our side and an ongoing TRICARE relationship or our side and the civilian side.

Dr. DUNN. I think your troops might be more interested in finding out there is confidentiality rather than continuity of care when they go to a Vet Center.

Captain COLSTON. And I agree with you, sir. And I think that is an important part of everything that we do. And also as providers, I think there needs to be a presumption of nondisclosure.

Dr. DUNN. So General Kelly mentioned that, you know, that people are afraid to self-report. And I can tell you that you know it is true, you don't need to hear from me, they are afraid to self-report.

Dr. Franklin, understanding the public perceptions are powerful, and that one of the VA's goals is to support responsible reporting of suicide, what advice do you have for media outlets reporting on this hearing and for our audience and members sitting here today?

Dr. FRANKLIN. They are critically important. I think the average public doesn't realize how much they can influence the suicide prevention space by safe reporting.

So I have all sorts of advice. I mean, first and foremost, I don't want the general public to think that the VA is ever limiting how folks should report, but following the national safe reporting guidelines is critically important. So making sure that headlines are accurate, that they are factual but that they don't glamorize, and making sure that we don't get into the details of the method. It is not important for the media, whether reporting out what type of—the method that occurred when the death occurred. I am hesitant to not want to say it just——

Dr. DUNN. I understand. Do you have a bullet point list like you would give——

Dr. FRANKLIN. Yes. We have safe reporting guidelines. We just published them in the last few months, and we are trying to get them out near and far so every reporter in the Nation knows. And we are also holding a media roundtable next week where we are bringing in all sorts of media outlets, and we are partnering with the national entities in this space to really just do an increased awareness and try to help us get it right session.

Dr. DUNN. I would, once again, appreciate sort of that in written to the VA Health Committee.

Dr. FRANKLIN. Yes, sir.

Dr. DUNN. We would be grateful.

And, Madam Chair, I yield back. Thank you.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Mr. Gallego, you are recognized for 5 minutes.

Mr. GALLEGO. Thank you.

Captain Colston or Dr. Van Winkle, I know that service members own firearms at a higher rate, and they come, of course, in contact with guns more regularly than the general population, and that guns are the particular preference in terms of use for deadly suicides.

Are there red flag powers that DOD has to seize guns from service members if they are deemed a risk? Obviously not the weapon you take out of the armory, but when I was in the Marines, even on base you were allowed to carry a personal weapon, provided you told your command about it.

Dr. VAN WINKLE. Thank you for the question. And Captain Colston can talk a little bit about how commanders work with behavioral health folks to make sure that they are making good decisions within the space.

Firearms are part of the conversation only insofar as they are the most common method by which a suicide will occur. They are the most lethal means by which you can attempt a suicide. And certainly, commanders have a responsibility to protect the military members under them.

If somebody is showing signs of imminent risk to themselves or another person, we always want to make sure that we take action across the board. And it is not only firearms, prescription drugs, any other method, but it is not done in exclusion of working with behavioral health individuals.

Captain COLSTON. And in regard to safety and care of service members, of course, commanders have an abiding interest in that. And as a psychiatrist, most of the time that someone is acutely suicidal, that precipitates an admission, an in-patient psychiatric admission.

Developing rapport with folks and rapport with commanders is really important to execute that. Certainly in policy, we have things along the lines of command-directed mental health evaluations. And, you know, certainly a young male patient who is acutely suicidal and has a weapon is someone that you are concerned about clinically.

Mr. GALLEGO. I guess, you know, what I am asking is if there is a formal process for this. I am sure some commanders understand that, you know, they have the right to do it, but is there some formal process or training that you could give to these commanders saying, like, if someone is suicidal, please, you know, inquire if they have a weapon in their dormitory or whatever they have?

Just because I feel, at least on the private sector side, what I have seen that has been successful when family members have identified people that are potentially suicidal, that they take their weapon away from them until they are stabilized again. And I am

just curious to see if at least on the on-base side if there is something of that nature or some program we could teach these commanders the process to go through.

Captain COLSTON. So means safety is part of all interactions with command, not only weapons, ligature risks, sharps, medications, things along those lines, and it is just part of the way that we do business.

Mr. GALLEGO. Okay. Is there any type of data that has been collected for us to be able to tell whether members of the military that saw combat have higher rates of suicide or just lower rates of suicide? Because I have seen conflicting data.

Captain COLSTON. Well, you are absolutely right, Congressman, so the data are conflicting. Reger, et al., did not find a nexus between deployment histories and subsequent suicides. There was a recent study, a STARRS [Study to Assess Risk and Resilience in Servicemembers] study, an Army STARRS study published by Ursano, et al., that said for folks who had deployed exactly two times, folks who deployed before the 12-month point or had less than 6 months of dwell time had higher suicide rates.

Mr. GALLEGO. And I guess this just has to be just purely asked. What is, in your opinion, the cause of the higher rates of suicide that has occurred in the last year?

Captain COLSTON. I have got to give you my very honest answer, Congressman, and that is that I——

Mr. GALLEGO. We appreciate that in Congress once in a while.

Dr. COLSTON [continuing]. I do not know. Obviously, there is a disturbing secular trend. We have seen our suicide rate double between 1999 and 2016, while the secular rate increased 25 percent, increasing in every State.

You know, when I was an intern, suicide rate was low. Military service was actually protective for suicide. So obviously, some set of circumstances have changed.

Mr. GALLEGO. Right.

Captain COLSTON. One thing I would say about suicide is there is over 300 separate forensic risk factors for suicide.

Mr. GALLEGO. Dr. Van Winkle, do you have an opinion?

Dr. VAN WINKLE. So I would concur with my colleague that when we are talking about suicide, it is an intersection of a variety of factors that are social, biological, psychological, that operate at the individual, community, societal levels. It is fairly complex and often difficult to determine exactly what is occurring within a whole population and even within subpopulations where I think there are unique considerations.

Mr. GALLEGO. Thank you. Thank you, Madam Chair.

Ms. BROWNLEY. Thank you, Mr. Gallego.

Mrs. Radewagen, you have 5 minutes.

Mrs. RADEWAGEN. Talofa. I represent American Samoa, and we have a very high percentage of veterans in our beautiful islands, and we will have perhaps even more in the future because we have such a very high enlistment rate in our Armed Forces. And, you know, it just breaks my heart to think of any of our veterans losing hope or struggling alone.

The problem of veteran suicides is a national tragedy, as we all know, and I do want to thank Chairwoman Brownley and Ranking

Member Dunn for their ongoing efforts on this issue. I also want to thank Chairwoman Speier and Ranking Member Kelly for holding this joint hearing. And I want to thank you and welcome the panel, everyone here, for their work on behalf of veterans.

A single veteran suicide is too many, and it is my hope that we can make some real changes this Congress. My question has been partially answered, but let me first direct it at Captain Colston on behalf of DOD and then to Dr. Franklin for the VA perspective.

Now, as I understand it, mental health is as complicated, if not more so, than bodily health, and varies from patient to patient. For example, some individuals respond well to pharmaceuticals, while others can suffer adverse side effects.

You may have touched on this in your statement so far, but could you please elaborate on the different types of treatments that each department makes available to service members and veterans? And what systems or procedures do you have in place for identifying whether a treatment option isn't working and adapting care to each individual patient's responsiveness?

Captain COLSTON. Thank you, Congresswoman. Well, first of all, we have a behavioral health data portal, so we measure outcomes on folks in regard to whatever the treatment regimen is. So for suicide, there are many approaches. There is cognitive behavioral therapy, there is problem-solving therapy. You can treat underlying depression.

As a psychiatrist, I see severely mentally ill people. So people with schizophrenia respond to a drug called clozapine. There are probably 12 evidence-based treatments for suicidal folks. The thing that we struggle with is they all have really small effect sizes, so you need to treat a lot of people to really help one person become less suicidal or, in fact, you know, not commit suicide.

So establishing a nexus between our treatments and a decrease in suicide has been extremely hard, and at the population level, we just haven't seen a signal yet.

Mrs. RADEWAGEN. Dr. Franklin.

Dr. FRANKLIN. Yes. The good news is that we use the same treatment methodologies as the DOD, so we train our providers together. We have the annual conferences and annual mini residencies where they are trained on the same set of evidence-based practices and protocols. And so that is, for what it is worth, part of the story in terms of how we train them on the evidence-based practices that Captain Colston spoke about.

From there, in terms of the latter part of your question which was really tied to how do you know what you are doing is working, we have a system in place similarly to this behavioral health portal that the captain mentioned that gets after quality reviews and monitoring sort of up the chain. And that occurs at the very local level in supervision between clinicians and mental health leadership, and then is monitored all the way up to VACO [Veterans Affairs Central Office] to make sure that the evidence-based practices are implemented with a high degree of fidelity to the model, sort of making sure they are implemented the way they were designed, the way that we know will produce the best results and get the client going in the right direction in relief of symptoms.

But Captain Colston is absolutely right. The sample—the efficacy is difficult over time, and the work needs to continue in this space. And I further offer that that is why we need to focus on additional capabilities in the fight for suicide, because the mental health work definitely is essential and needs to continue. We need to make sure they leave our offices with the veteran crisis phone number in hand, but then they need life supports throughout the course of the week. We need to make sure that our veterans are employed, that they have homes, that they are engaged in meaningful—in life that brings them purpose and passion, and that they have the supports to thrive during life above and beyond their mental health therapy.

Mrs. RADEWAGEN. Thank you, Madam Chair. I yield back.

Ms. BROWNLEY. Thank you, Mrs. Radewagen.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you all for being here today.

Dr. Van Winkle, first, how much funding does the DOD dedicate to suicide prevention research?

Dr. VAN WINKLE. I have to take that question for the record to get you an accurate number on that.

[The information referred to can be found in the Appendix on page 71.]

Mr. CISNEROS. All right. Dr. Franklin, can I get the same question, how much does the VA dedicate to suicide prevention research?

Dr. FRANKLIN. Just research? I would have to pull the thread on that as well and get it back. I have the entire budget here with me, but just research, I need to pull.

[The information referred to was not available at the time of printing.]

Mr. CISNEROS. Okay. I would appreciate that.

Dr. FRANKLIN. Yes, sir.

Mr. CISNEROS. Thank you.

What is the process, you know, Dr. Carlson or Captain Carlson—you said there was a handoff. Well, actually let me go back and ask this question.

When an individual is—whether they are coming back from overseas after serving in combat or they are getting ready to separate from Active Duty service, what is the process for helping to identify whether or not they are suffering from PTSD [post-traumatic stress disorder] or some other mental health issue? Are they self-identifying or do we actually have a process to figure this out?

Captain COLSTON. Well, both, sir. So the DOD cohort is the most screened cohort of folks in human history. So you will be asked about suicidality, PTSD, depression, and generalized anxiety disorder in a periodic health assessment, in a separation health assessment. And you will also be asked every time you go to the primary care doc. So when I just went to Walter Reed, all those questions got asked. So that is one opportunity where you are self-identifying through screening.

But it is also DOD policy that there is a warm handoff between clinicians. So you have an obligation as a clinician, including as a deployed clinician, to make sure, because we are all using the same health system, and I have access to the electronic health record as a deployed physician, to do everything that you can to make sure

that there is a clinic-to-clinic handoff, if not a provider-to-provider handoff.

Mr. CISNEROS. So once an individual is separating, and you talked about this warm handoff, and they are getting out, they are no longer seeking or getting DOD military healthcare and they are going to the VA, how is that handoff being done from DOD to the VA to making sure that that individual is going to continue to get care?

Because one of the things that really does disturb me is a number of those individuals that are killing themselves out of that 20 per day are not seeking VA healthcare. So how are we doing this handoff to make sure those individuals continue to get care?

Captain COLSTON. Well, first of all, we need to meet the patients where they are at, so they need to continue the type of care that they want to continue. A number of my patients who have severe mental illness will continue care at a high level, so psychiatrist to psychiatrist. And that would include a discharge summary, making sure that our formularies are aligned, which they are, between DOD and VHA, making sure the patient has enough meds when he goes to the next place.

But the folks who—the predominance of suicide risk in the population is in folks who are less mentally ill. And, in fact, we need to meet those patients where they are at, whether that is in credentialed healthcare, or like my colleague, Mr. Fisher, in confidential healthcare in Vet Centers or elsewhere or in community-based health.

Mr. CISNEROS. Dr. Franklin, how do you receive those individuals that need that healthcare or need that mental healthcare coming from the DOD?

Dr. FRANKLIN. Certainly. There is a program in the DOD called inTransition, and this is a capability that recognizes when people are on Active Duty status and they have a known mental health problem, they fall into this program. It is one word, the title of the program, inTransition, and this is a program that then carries them through over to the VA with frequent caring outreach and contact where they are getting actual phone calls and coached into the VA system. Above and beyond this process that Captain Colston talked about, which is provider to provider across DOD to VA, there is also this additional safety net, they call it, of this inTransition program.

But I think what you are getting at is this other part of the population that ties back to this other question that was asked earlier, which is when we have a known population that doesn't get mental healthcare over the course of their whole career and/or doesn't unpack it, doesn't have a known mental health problem at the time that they leave, they don't fall in inTransition. They don't fall clinician to clinician. There is no warm handoff because they are not known. Then they leave the DOD, and then life circumstances happen, unemployment, childbirth, divorce, good and bad that are stressful, and then the challenge is getting them into care at that point, if that makes sense, and I think that is where we could do better. We have work to do in that space, I think.

Mr. CISNEROS. All right. Yeah. You know, one of the worst things I had to do in my military service was to go home—or not go home

but to go to a mother and tell her son—that he had committed suicide. I feel for these families that are doing this and those individuals that are going through this, so we need to figure out what the problem is and get to that. So thank you very much.

My time has expired.

Ms. BROWNLEY. Thank you, Mr. Cisneros.

Mr. Gaetz, you are recognized for 5 minutes.

Mr. GAETZ. Thank you, Madam Chair. And I want to thank the chairs for coordinating this hearing.

I represent the district that has the highest concentration of Active Duty military and one of the highest concentrations of veterans in the country, and so this is very much a kitchen table issue in my district.

My first question, Dr. Van Winkle, is what do we know about the percentage of veterans who commit suicide who struggle with opioid addiction?

Dr. VAN WINKLE. I would have to take that for the record, unless Captain Colston has those numbers offhand. But I will say that the Drug Demand Reduction Program falls to me, so we certainly have ongoing concerns about opioid use in the military.

[The information referred to was not available at the time of printing.]

Mr. GAETZ. Would anyone on the panel disagree with the conclusion that opioid addiction contributes to suicide?

Captain COLSTON. I would agree with that, Congressman.

Mr. GAETZ. You would agree with that.

Captain COLSTON. The prevalence of opioid addiction in Active Duty military service members is——

Mr. GAETZ. What is our current most effective strategy to deal with opioid addiction?

Captain COLSTON. Medication-assisted therapy. Buprenorphine, methadone, or naltrexone.

Mr. GAETZ. So more pharmaceutical drugs. You know, I don't have—I mean, I—let me ask this question. Will access to medical cannabis reduce veteran suicides?

Captain COLSTON. In my view, there is far more research to be done, so there is insufficient evidence for or against that position.

Mr. GAETZ. Are you unpersuaded by the evidence by the National Academy of Sciences citing examples in Minnesota and other States where access to medical cannabis reduces the prescription rates of opioids and the use of schedule I drugs broadly?

Captain COLSTON. Well, certainly we are open to all types of research.

Mr. GAETZ. Okay. So you said more research needs to be done. What is that?

Captain COLSTON. Well, first of all, there are over 300 psychoactive substances in cannabis sativa, so——

Mr. GAETZ. How many psychoactive substances are in the medical therapies that we are using to replace opioids?

Captain COLSTON. There are no cannabis sativa——

Mr. GAETZ. No, no, no. Not cannabis sativa but psychoactive substances.

Captain COLSTON. So the three psychoactive substances are methadone, which is another opioid, a long-acting opioid; buprenor-

phine, which is an opioid agonist/antagonist, so it is an opioid that essentially you can't overdose on; and naltrexone, which is an opioid antagonist, which, in essence, takes the drug off of the brain receptors.

Mr. GAETZ. Right. So that is the current off-ramp for opioid addiction that we use. What evidence do we have that that is a more effective off-ramp than medical cannabis?

Captain COLSTON. I just think those are the three evidence-based therapies right now that meet the medical bar. Obviously, more research can change that.

Mr. GAETZ. How would you describe the VA's approach to researching the extent to which medical cannabis could be an alternative off-ramp for opioid addiction? Because, clearly, what we are doing now isn't working.

Captain COLSTON. Well, there is certainly no prohibition to any research around medical cannabis. And, in fact, there are two chemicals—or there is a chemical in CBD that is used for two pediatric seizure disorders right now.

Mr. GAETZ. So at the VA, can—at a local VA, can a physician recommend medical cannabis, if it is in a State where those recommendations are permissible under State law?

Captain COLSTON. I would defer that question to my colleagues.

Dr. FRANKLIN. No, they cannot at this time. There is a Federal law against it right now.

Mr. GAETZ. Right. So Federal laws prohibit—do those same Federal laws that you cite that prohibit prescription prohibit research?

Dr. FRANKLIN. No, they do not.

Mr. GAETZ. So you are saying that the VA is willing to engage in this research, willing now to post what federally approved clinical trials are available? Would the VA be willing to do that?

Dr. FRANKLIN. We have two ongoing research studies going on right now in this space, and so I think we are open to research, yes.

Mr. GAETZ. So the question is does any existing law prohibit the VA from publishing what federally approved clinical trials are underway or seeking participants?

Dr. FRANKLIN. You know, I am not a lawyer, so I don't know about the Federal law that may——

Mr. GAETZ. Is there any law of any kind that would prohibit the VA in any way from publicizing what federally approved clinical trials are available in the cannabis space?

Dr. FRANKLIN. I probably have to take that for the record. I am just not 100 percent clear on the exact laws.

[The information referred to was not available at the time of printing.]

Mr. GAETZ. Well, see—yeah, I don't think anybody is clear, which is the source of my frustration, because I think that there are a lot of these clinical trials that are seeking veterans. The VA, due to a lack of clarity, won't publicize that information or make it available, and then we are unable to do the research that Captain Colston says is necessary to advance additional options for veterans trying to get off opioids and to stop them from killing themselves.

In my district, there is overwhelming anecdotal evidence that when they are given the combat cocktail, when they are given

heavy barbiturates when they come home, they are more likely to trip into addiction, and if they have other therapies for PTSD or to alleviate that addiction that it is helpful. So I am very interested in getting that.

And, Madam Chair, I have a unanimous consent request that the op-ed written by our colleague, Congressman Seth Moulton, in the Washington Examiner entitled "Let's talk about cannabis and the VA" in which he details three bipartisan bills that he and I are sponsoring to advance the work of the VA in the areas of research and medical cannabis.

Ms. BROWNLEY. So ordered.

[The information referred to can be found in the Appendix on page 67.]

Dr. FRANKLIN. Yes, sir.

Mr. GAETZ. Thank you, Madam Chair. I yield back.

Ms. BROWNLEY. Thank you, Mr. Gaetz.

Mr. Lamb, you are recognized.

Mr. LAMB. Thank you very much, Madam Chair.

I do want to address the opioid topic first. And thank you all for your participation, especially Dr. Franklin, who we have had the chance to see and hear testify and meet with several times. You have brought a lot of energy to this office and this position, so thank you for that, and we look forward to working with you on this going forward.

On the opioid issue, I would say, Captain Colston, would you agree that we actually—we do have plenty of evidence that these three drugs that you talked about that are provided as medically assisted treatment, we have plenty of evidence that they work. First of all, just the model of how those drugs act on the brain compared to the opioids that were being abused is part of why they are used and used so successfully. Isn't that right?

Captain COLSTON. Yes, sir.

Mr. LAMB. Okay. And I would actually say that from where I sit in western Pennsylvania where the opioid crisis has really hit hard, the problem is really access. It is not that we don't know how to treat these people. You know, I have a friend who is a treatment provider who has told me if you are able to combine medically assisted treatment with some of the more traditional counseling and group-based therapies for folks, you can move the needle of survival and the ability to quit the addiction maybe from 10 percent to 25 percent or 30 percent. You may not save everyone the first time, but you are going to dramatically increase the odds that someone will survive and beat this disease.

Have you seen something similar?

Captain COLSTON. Yes, sir. That is absolutely true. And, you know, we have certainly on the Federal level done things to make it easier for prescribers to get buprenorphine in the hands of patients. And I think that has been, you know, a successful public health effort.

Probably one that is equally successful is the ability to get naloxone in the hands of first responders. And, in fact, cops and firefighters have saved numerous lives in this scourge; 47,000 opioid overdose deaths in America last year, 47,000 suicide deaths. These are national scourges that are on the order of swine flu.

Mr. LAMB. No. You are absolutely right, and it has been a great success. In our part of the world, we have had some of the highest death rates of anywhere in the country. And this year, for the first year, we are seeing reductions in many of the places that were the worst in deaths I would say probably almost completely due to the increase in naloxone, again, because the more complicated and sustained forms of treatment are not yet available. However, the VA provides it, and the VA can make this accessible to people who otherwise wouldn't get it.

I served with a Marine who came off of Active Duty addicted to a painkiller because he had been hurt in some training right before he left, and I don't believe he was medically discharged. I think he just sort of got through the injury and then left the service with a normal discharge, but he still carried with him the addiction to the opiate, and he went home and became addicted to heroin.

He showed up at the VA in Pittsburgh after having enough self-awareness to realize he didn't want to die that way, and at our VA, they gave him 30 days of detox and treatment and then moved him over to the other VA for another up to 6 months of treatment, ongoing therapy, and they actually gave him a place to live. He stayed there, and it is amazing. They had a community. They had a little rank structure. He was like the vice president of their group of folks that lived there.

And I learned all this because I just went to the VA for a normal tour and ran into him. I hadn't seen him in like 6 years.

So I always sort of hold up the VA as an example of the fact that we do actually know how to save people if we make the right treatment available. It just takes a really long time, and it is expensive and difficult, and it may take more than one round.

So the only thing I wanted to ask about that was, for this guy, I am not aware of whether any information was shared from DOD to the VA about the prescription painkillers that he received as a risk factor. I know, Dr. Franklin, you mentioned inTransition, which sounded like, from what you said, had to do with people who were actually receiving treatment on Active Duty for a mental health condition.

Do we have anything right now that would have constituted a warning from DOD to VA, here is a guy who received a heavy dose of painkillers. Someone might want to check once he gets out if he is enrolled in VA healthcare yet?

Captain COLSTON. So in the last year, we, DOD, takes part in PDMP, Prescription Drug Monitoring Program, so now that flashes for everyone. And it is an incredibly powerful tool, especially as you mentioned, General Kelly, for Guard and Reserve folks who are getting civilian care somewhere. Now I am able to look and see what their opiate history is, and a lot of times you don't get endorsements. You don't get someone who says, yeah, hey, I am struggling right now.

So it has been an incredibly powerful tool, and it is one that we have really only had online for about 9 months, but I think will save lives.

Mr. LAMB. Thank you.

And very quickly, time is expiring. Dr. Franklin, do you know, for someone like him, if he had never showed up for VA healthcare

on his own, is there any way right now for VA as an institution to know about him and know either for the VA or the Vet Center, someone to sort of reach out and say, hey, you might want to enroll here just to make sure everything is okay?

Dr. FRANKLIN. You perfectly described the nexus of our issue. We need to get out there and find those people and get them into our service delivery, whether that is through our suicide prevention outreach people that do five outreach events, our Vet Center outreach efforts that get outside the gates, our homeless outreach coordinators, our veteran justice. I am not sure if he was involved in the court system, but we have justice outreach. It is all hands on deck. We have got to, like, find these people and do everything we can to wrap our arms around them.

Mr. LAMB. Thank you.

And, Madam Chairwoman, I yield back. Thank you.

Ms. BROWNLEY. Thank you, Mr. Lamb.

Mr. Barr, you are recognized for 5 minutes.

Mr. BARR. Thank you, Madam Chairwoman. And thank you to Chairwoman Brownley and Chairwoman Speier for your leadership. And also, Ranking Member Dunn and Ranking Member Kelly, thank you for hosting this joint hearing. I think it is excellent to continue to shine the light on this national tragedy of 20 suicides a day.

Let me start with Dr. Van Winkle since I haven't had the benefit of your testimony as a member of the Veterans' Affairs Committee. I do want the DOD perspective here. As we are nearing 20 years of engagement in Iraq and Afghanistan, our longest engagement in U.S. history, it is my understanding that soldiers, particularly those in the Army, are deploying longer and for multiple deployments.

As the director of the Office of Resiliency, how is your office taking into account the effect of these multiple deployments on service members and their families, these long deployments? I know it is very, very difficult for a lot of the veterans in my district.

Dr. VAN WINKLE. Thank you for the question. It is certainly something that we are tracking, and with our collaborations with the family programs, we also track the impact on the families, understanding that that is an additional stress when the military member is overseas or deployed.

Within the suicide space, as mentioned, there is no simple and direct connection between suicide and deployments at the aggregate level, but what we know is this is an individual stressor, that for some, when we talk about suicide as a combination of individual factors that we are tracking, this can certainly be a stressor that impacts them negatively.

And so part of our work is certainly within the behavioral health side and within our leadership to have those conversations about the impact of deployment. And Captain Colston can talk a little bit more about how the deployment and behavioral health work together.

Captain COLSTON. One of the things that I just want to emphasize is we really make sure that we embed mental healthcare on deployments, so at the division level there will be a psychiatrist deploying with the unit. And, in fact, that is important because 18-

to 25-year-olds often struggle with things like not just suicidality, the first break psychosis, first break mania, things that are dangerous in folks who are there to kill the enemy. So it is vitally important that we do that.

Mr. BARR. Well, thank you for that. And I appreciate DOD paying attention that obviously operational tempo could play a role in some of the suicide issues.

Our colleague, Brian Mast, who, of course, is a combat veteran, a wounded warrior himself, he approached me last Congress with an idea and legislation to require an oath of exit so that service members obviously who are part of a team, part of a unit, a band of brothers who feel a strong sense of loyalty to each other would basically take an oath upon a transition and discharge to each other that before they would cause harm to themselves, they would at least contact one of their former brothers in arms and let them know in advance. I thought that was a good idea, and my understanding is that DOD has kind of taken on that idea.

Is that a good idea? Is that something that DOD is considering, an oath of exit so that, you know, men and women, service members who leave the military are pledging an oath to each other that before they take their own lives or before they harm themselves, they will contact one of their former soldiers or sailors or airmen?

Captain COLSTON. Well, I think in regard to all issues around safety, certainly, you know, for those of us that have deployed, you know, we met our affiliative needs with those folks that we were in the barracks with, that we were out in the field with, so yes. I mean, I think in regard to things like safety planning, which we do for suicidal people, that is a critical part of it. Telling your brothers and sisters that you are in pain is an important part of, you know, what we do.

Mr. BARR. I think that is something we ought to pursue.

Finally, Dr. Franklin, you talked about the inTransition program, but let me talk specifically about medical records. I know we have increased a real effort to have that interoperability between medical records. But if a service member commits an act of self-harm or attempts to commit suicide while in the military, how is that information or medical documentation of that transferred to the VA?

Dr. FRANKLIN. As we stand right now, not under the new system is what you are asking me? If they have made an attempt of harm to self, harm to others, it is in their medical record, and it travels with them as they leave the DOD over to the VA side through all the methods that we have discussed earlier.

Mr. BARR. Do we have confidence in that, that we are catching all of that?

Dr. FRANKLIN. I have quite a bit of confidence in it, but I am happy to also do a review, if that is something that would help, like just to do a random review. I can work with our DOD colleagues to scrub that.

Mr. BARR. Well, thanks. My time has expired, but obviously, it is critically important that as a soldier or sailor is passed on to the VA, that their history of suicidality would be also transferred with those medical records.

Dr. FRANKLIN. One of the highest risk factors for suicide is a prior attempt, so absolutely.

Mr. BARR. I yield back. Thank you.

Ms. BROWNLEY. Thank you, Mr. Barr.

Mrs. Davis, you are recognized.

Mrs. DAVIS. Thank you, Madam Chair.

And thank you all for being here. I am sorry I missed your testimony, but I think I have a sense of all that you have been trying to do lately, and a lot of that has to do with how well we connect in terms of the interagency, intra-agency, and what you see on the horizon.

What is it that you have felt you haven't been able to move forward with? You have talked about your aligning prescriptions and some of the issues about trying to catch individuals who might be really at risk. I am just wondering what is it that you feel has been a bit of frustration?

And maybe I can share with you having—I believe Dr. Franklin is familiar with some friends of mine, actually, who have been very engaged as parents in trying to be proactive, trying to find kind of a key, if you will, to keeping families, parents, particularly, engaged with the recruitment, with the service, with the deployments, and back home again transition so that they are more aware and can be more helpful to a loved one who may be a suicidal risk.

Are we doing more in that area? Are we just so prohibited because of privacy regulations that it is really difficult to do that?

Dr. VAN WINKLE. So I can speak to that latter point. We have been working with family members on a network of support, and I can provide you more information about where we are on that. But we know that one of the protective factors is simply the feeling of connectedness, often within the unit, but also ensuring that family and friends understand the military experience in a way that they can support the military member.

So we have been working on the network of support option. And I can provide—I can take for the record where we are with that.

[The information referred to was not available at the time of printing.]

Mrs. DAVIS. Anybody else want to comment on that?

Dr. FRANKLIN. I do continue to make contact with the Summers. Thank you very much, Chairman Davis, for introducing them to me so many years ago. I definitely appreciate it, and I probably hear from them once or twice a month. And lived experience is important in making sure we learn everything we can from moms and dads and brothers and sisters.

And the DOD and the VA has a joint panel now, since we last spoke, called the Lived Experience Panel, where we collectively bring leaders together and we pulse parents and survivors just to make sure our policies are right. Are we doing everything we can? Is there some small thing that a mom or dad could teach us so that we could do better? So that is important.

In terms of the first part of your question about what gives, what are your challenges that remain? I just offer to you that we have talked in the panel today about how complex suicide is, and it does call for bundled approaches, and it calls for them at full force over

time, like, full throttle, like, we have got to move out with educating every single family member in the Nation, and there are a lot of them.

Now that I am on the VA side, there is 20 million veterans, and they all have family members, and making sure that we have wrapped that into our protocol. And then just the bundled approaches have got to be pushed out over time. And I think about that in the context of leadership support. So on the DOD side, military leaders recognize their role on suicide prevention. And on the VA side, hospital leaders recognize their role. But I think there is work to be done on other sectors and making sure all leaders recognize their role and help with this work.

Mrs. DAVIS. Yeah. Thank you. And I know that a lot of work has been done in identifying the fact that mental health is physical health is everyone's health and the need to not be intimidated by sort of this perception of stigma. And yet at the same time, I often talk to people in the service, and they still raise those questions, that families are afraid to identify. So, you know, I think that we still have more work to do in that area as well. And I appreciate what you have been trying to do along those lines as well.

Do we know whether or not individuals who are able to transition relatively quickly, whether it is in something that is totally new to them, they have had training while they are waiting to complete their service? Are they doing better if they are actually in a job that they feel that they, even if recently, have been trained for versus they are still questioning what their future looks like? I know it is a complex issue, but is that better?

Dr. FRANKLIN. Yes. Those that are engaged in meaningful employment, not just any random job, but meaningful employment where they feel like they are part of a mission, and this is, I think, what is one of our most recent findings across the two organizations. We have a governance structure that we spoke about earlier. Dr. Van Winkle mentioned the JEC, this Joint Executive Council, and we have really been, over the last year, spent a significant amount of time tending to the social aspects of transition.

And so meaningful employment is part of that and just recognizing what it means to no longer wear the uniform as a community member.

Mrs. DAVIS. And I guess also, I would add quickly because of time, and also training business people to be able to identify and work with an individual as well as their family.

Dr. FRANKLIN. Those leaders, yes.

Mrs. DAVIS. Thank you very much. I yield back my time.

Ms. BROWNLEY. Thank you, Mrs. Davis.

Mr. Kelly has requested a few more minutes.

Mr. Kelly.

Mr. KELLY. I first thank the chairwoman, but I want to thank Mrs. Davis for her efforts, not only in this arena, but several arenas that are so important in military personnel, and she is such a great leader on this subcommittee in trying to get to solutions. I just want to thank you.

Second, on the PDMP [Prescription Drug Monitoring Program], as a former district attorney, there was a time when the VA did not share with other doctors, which led to them going and getting

at two different locations, so I thank you for that, and it helps with treatment as well as. And so I just thank you for doing that.

One of the things I think that is very confusing is on Guard and Reserve, and probably one-term enlistees on Active Duty don't understand what their veteran status is. And I know when I demobed in 2005 or 2006, they told us if you don't get a checkup every year, you lose your VA benefits, although I had spent a full year in a combat zone and 20-plus years in the military before. If that is still the case, we need to change it, because many of these problems don't manifest until years after. So if we are denying them because they didn't go get, quite frankly, a stupid checkup just to go in every year, they have earned their veteran status. They shouldn't lose that. Is that still the case, Dr. Franklin or Mr. Fisher?

Dr. FRANKLIN. I have to turn this over to Michael Fisher.

Mr. FISHER. I can speak to within Vet Centers. So Vet Center eligibility is lifelong, and it doesn't matter if you are accessing it today or 15 years from now. So you can leave—you can come into services, you can exit services, you can come back, and we can pick up wherever you left off.

Part of our job also is that if we identify other things together, other benefit services that you as a service member or former service member could benefit from, it is making those connections. That includes going back over to the VA medical centers, getting connected to a veteran service officer to work out claims issues so you can access the medical centers and those kind of things.

Dr. FRANKLIN. But I think you are absolutely right in terms of being onto something. If there is confusion on the status when they leave, it becomes a barrier to care and an access to care issue. And so if we inside the VA can do a better job of an awareness campaign and some educational rollout that educates people on the complexities of what their title is and what their access to before they leave in partnership with the DOD to make that access to care easier so that we are all clear, I take that for action.

Mr. KELLY. And I would just ask that—you know, like I said, I left in 2006, and that was the guidance we were given. And as a very high ranking officer, as an attorney and a Member of Congress, if I don't understand it, I assure you those 22-year-olds that left then probably don't, so let's do a good job.

And with that, I yield back, Madam Chair.

Ms. BROWNLEY. Thank you, Mr. Kelly. And I think before we adjourn, I just had a couple of quick questions that I wanted to ask as well.

Dr. Franklin, in your response to an earlier question, you were talking about the various metrics that the VA has set up. I was just wondering if you had a basic metric for a warm handoff. You know, I don't know quite how to quantify that, but do you understand what I am saying? You know, how are we measuring that in terms of men and women leaving the military, warm handoff, you receiving them, and then it may be another warm handoff after that? But it is mainly that transition between military and the VA.

Dr. FRANKLIN. Yes. So we get handoffs from other people other than DOD, but if you are wanting a figure on total number of warm handoffs that come from the DOD to the VA by type of hand-

off, mental health, primary care, the like, I am sure that we have that in our dataset.

Ms. BROWNLEY. So you would have that all in your——

Dr. FRANKLIN. I believe we do, yes, ma'am.

Ms. BROWNLEY. And so where do you receive other handoffs from?

Dr. FRANKLIN. So community members might refer veterans.

Ms. BROWNLEY. I see.

Dr. FRANKLIN. VSOs [veterans service organizations]. There is a whole——

Ms. BROWNLEY. And do you collect that data also?

Dr. FRANKLIN. You know, that is a piece I need to check by referral source.

Ms. BROWNLEY. Okay.

Dr. FRANKLIN. Over the years, as a mental health clinician in the field at the local level, I know that we captured it, but I need to make sure we are capturing it at the VACO level. I can check.

[The information referred to was not available at the time of printing.]

Ms. BROWNLEY. Great.

And, Dr. Van Winkle, I just wanted to know, so in a deployed setting, have any service members been sent home or to a military hospital because of a mental illness like you would if you had an injury and you might be sent to Germany or you might be sent back here to Walter Reed or——

Dr. VAN WINKLE. So that is a good question, and I would have to take it for the record. I think that there are certainly a spectrum when we talk about mental illness in terms of severity of mental illness and the impact on the mission and on the member themselves.

[The information referred to was not available at the time of printing.]

Dr. VAN WINKLE. Captain Colston, I don't know if you have any information.

Captain COLSTON. By all means. We have air evaced folks for mental health conditions, and the most common condition is actually not suicidality. In my experience, it was first break psychosis, first break mania. A lot of 18- to 25-year-olds there who had a predisposition for severe mental illness and then get in a really stressful type of situation and it manifests.

Ms. BROWNLEY. Thank you. Do you have the data on that? Is that something that you collect?

Captain COLSTON. I would imagine that it would be possible to do a dive, ma'am. I certainly don't have it on hand. I could take that for the record.

[The information referred to was not available at the time of printing.]

Ms. BROWNLEY. Very good.

Well, you know, I want to thank all the witnesses. I have a lot more questions, but I hope that we can have another meeting like this with both the VA and the DOD together. I know that with the Executive orders coming from the President's office, there is going to be more collaboration and more articulation, I think, about that

collaboration in that first year outside of the military. And I am looking forward to hearing more about that as you make progress.

But we all agree in this room that this is a real crisis and, you know, we must, we must make inroads, we must make progress. And one suicide a day is one suicide too many. And I know both of you sitting here on the dais are very dedicated to that, and I am looking forward to continuing that work.

So, again, thank you for providing the testimony today. And there is no further business, the subcommittee will be adjourned.

[Whereupon, at 4:59 p.m., the subcommittees adjourned.]

A P P E N D I X

MAY 21, 2019

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MAY 21, 2019

Statement of
Representative Jackie Speier

Military and Veteran Suicide: Understanding the Problem and Preparing for the Future

Military Personnel Subcommittee

May 21, 2019

The hearing will now come to order. I want to welcome everyone to this joint meeting of the Military Personnel subcommittee and the Veterans Affairs subcommittee on Health to discuss the epidemic of suicide that plagues military members and veterans every day.

I'd like to thank Chairwoman Brownley for partnering with us on this incredibly tough issue.

The statistics are staggering—there were 321 active-duty suicides and 144 reserve component suicides in 2018. This is the highest number of suicides since 2012. An estimated 20 servicemembers and veterans combined commit suicide a day. This is an epidemic.

But these aren't just numbers, these are servicemembers who were willing to die for our country but took their own lives instead. Servicemembers we failed. Behind each of them is a person and their family, friends, and comrades in arms.

Two weeks ago, I met with Patrick and Teri Caserta. Their son Brandon was an active-duty Sailor in the Navy. He had high aspirations for a Navy career, but something changed and tragically he took his life. His parents knew something was wrong, tried to intervene, and were turned away by the Navy. Their request, so that other parents will not have to endure their grief and pain, was that congress ensure that servicemembers and veterans receive the help they need without fear of retribution.

We must do everything we can to break the chain of suicide that has afflicted our military and veteran community. This problem could not be more urgent.

The reason we're here meeting jointly—the subcommittees responsible for tackling suicides in the DOD and VA—is because we need to treat servicemember and veteran suicides as one issue. Veterans are about twice as likely as civilians to commit suicide.

Military service appears to be a causal pathway for increased suicide risk, due to access to and familiarity with firearms, post-traumatic stress syndrome, depression, loss of community, alienation, head injuries, and substance dependence.

These factors take root, manifest, and worsen across an individual's DOD-VA experience. We need to react to this reality by preventing, detecting, and treating suicide risk from the moment an individual signs up, to well after they leave service.

Today we will hear from a panel of experts from the Department of Defense and the Department of Veterans Affairs to help us understand the scope and magnitude of the suicide challenge affecting our military and veteran's communities.

We will also learn about suicide prevention efforts within the Department of Defense and Department of Veterans Affairs and try to better understand ongoing collaborations and potential future partnerships related to suicide prevention efforts between the Department of Defense and Department of Veterans Affairs to try and end this epidemic.

I would now like to welcome our panel.

Dr. Elizabeth P. Van Winkle, PhD
Executive Director, Office of Force Resiliency, Department of Defense

Captain Mike Colston, M.D., USN
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Department of Veterans Affairs

Mr. Michael W. Fischer, MSW
Chief Readjustment Counseling Officer
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I ask unanimous consent to allow members not on the subcommittee to participate in today's hearing and be allowed to ask questions after all subcommittee members have been recognized.

Before hearing from our first panel, let me offer Ranking Member Kelly, Chairwoman Brownlee and Ranking Member Dunn an opportunity to make any opening remarks.

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Statement of

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Executive Director

Office of Force Resiliency

Office of the Under Secretary of Defense (Personnel and Readiness)

and

Mike Colston, MD

Captain, Medical Corps, US Navy

Director, Mental Health Programs

Office of the Assistant Secretary of Defense (Health Affairs)

Before The

House Armed Services Subcommittee on Military Personnel

And The

House Veterans Affairs Subcommittee on Health

May 21, 2019

NOT FOR PUBLICATION UNTIL RELEASED BY THE COMMITTEE

Chairwomen Speier and Brownley, Ranking Members Kelly and Dunn, and distinguished Members of the Subcommittees, thank you for the opportunity to appear before you today, with our colleagues from the Department of Veterans Affairs (VA), to discuss the Department of Defense's (DoDs) suicide prevention efforts. We look forward to discussing what we are currently doing, including monitoring and planned reporting of data on suicide in the Armed Forces, deliberate efforts the Department has made to prevent suicide in its ranks, research advances and the evidence base for suicide prevention, what we plan to do, and our enduring commitment to protect our Country's defenders and their families.

The statistics are daunting – and unacceptable. And though our data helps to drive and improve our efforts in this space, as leaders in the Department, my colleagues and I know that every life lost is a tragedy – every one of them has a deeply personal story. Behind each death, we know there are families with shattered lives and we cannot rest until we have created every opportunity to prevent this tragedy among our Nation's bravest.

We at the DoD have vowed, time and again, to ensure that we do everything possible to support our Service members – and all of us are working tirelessly to do just that. Yet, the data is devastating and not going in the desired direction.

None of us has solved this issue, and no single case of suicide is identical to another case. Though many have similar patterns, which we can discuss today, in a great number of other cases, even the close friends and family members are initially surprised by an individual's suicide.

Scientific research surrounding prevention of suicides is both complex and ever-evolving. We leverage scientific, evidence-informed practices; partnership with Congress, Military/Veterans Service Organizations, research institutions, and other government agencies such as the Centers for Disease Control and Prevention – to constantly pull every idea, every possible effective initiative, into our toolkit to help Service members and their families.

The DoD supports and protects our country's defenders, so we must do everything possible to prevent suicide among their ranks. Underpinning our efforts is a recognition that most suicides, especially at the population level, are preventable. The challenge for DoD and the Nation is that suicide is the culmination of complex interactions between biological, social, and psychological factors operating at individual, community, and societal levels. But the DoD's commitment is absolute.

The DoD is dedicated to transparency in the reporting of surveillance data on suicide mortality. Nationwide, suicide rates are alarming, and increasing – a trend also evident among our Armed Forces. We provide below, in Tables 1 and 2, our most recent *counts* and *rates* for the Active Component, Reserves, and National Guard.

Table 1. Service and Component Suicide Counts, CY 2011-2018 Q3 [1-3]

	2011	2012	2013	2014	2015	2016	2017	2018 Q3
Active Component	**267**	**321**	**256**	**276**	**266**	**280**	**286**	**231**
Army	141	165	121	126	120	130	116	103
Marine Corps	31	48	46	34	39	37	43	40
Navy	52	58	41	54	43	52	65	48
Air Force	43	50	48	62	64	61	62	40
Reserve	**69**	**72**	**86**	**79**	**89**	**80**	**93**	**56**
Army Reserve	44	50	59	42	55	41	63	38
Marine Corps Reserve	7	11	11	12	11	19	10	9
Navy Reserve	7	8	5	15	14	10	9	8
Air Force Reserve	11	3	11	10	9	10	11	1
National Guard	**116**	**132**	**134**	**91**	**125**	**122**	**136**	**88**
Army National Guard	99	110	120	77	104	108	124	80
Air National Guard	17	22	14	14	21	14	12	8

1. Source: CY 2011-2018 Q3 suicide counts were obtained from the Armed Forces Medical Examiner System (AFMES); Suicide counts for CY 2018 only include deaths occurring in Quarters 1-3. The data presented represents the most recent published data available from the DoD Quarterly Suicide Report (QSR)).
2. Official CY 2017 and 2018 counts will become available in the inaugural Annual Suicide Report (summer 2019)
3. Data prior to CY 2011 was not standardized for all components to allow for trend analysis for the total force. Starting in CY 2011, the DoDSER included information on the non-activated Reserve and National Guard.

Table 2. Service and Component Suicide Rates (per 100,000), CY 2011-2016 [1-4]

	2011	2012	2013	2014	2015	2016
Active Component	**18.7**	**22.9**	**18.5**	**20.4**	**20.2**	**21.1**
Army	24.8	29.9	22.7	24.6	24.4	26.7
Marine Corps	15.4	24.3	23.6	17.9	21.2	20.1
Navy	15.9	18.1	12.7	16.6	13.1	15.3
Air Force	12.9	15.0	14.4	19.1	20.5	19.4
Reserve	**18.1**	**19.3**	**22.8**	**21.6**	**24.7**	**22.0**
Army Reserve	21.4	24.7	29.6	21.4	27.7	20.6
Marine Corps Reserve	*	*	*	*	*	*
Navy Reserve	*	*	*	*	*	*
Air Force Reserve	*	*	*	*	*	*
National Guard	**24.8**	**28.1**	**28.9**	**19.8**	**27.5**	**27.3**
Army National Guard	27.4	30.8	33.7	21.8	29.8	31.6
Air National Guard	*	19.1	*	*	19.9	*

1. Source: Suicide counts were obtained from the Armed Forces Medical Examiner System (AFMES); end strength counts (for rate calculations) obtained from the Defense Manpower Data Center (DMDC).
2. Data presented represents the most recent published data available from the Department of Defense Suicide Event Report (DoDSER). For example, data for CY 2014-2016 is published in the 2016 DoDSER.
3. Per DoDI 6490.16, rates are not reported when counts are less than 20 due of statistical instability. This is indicated by an asterisk (*).
4. Data prior to CY 2011 was not standardized for all components to allow for trend analysis for the total force. Starting in CY 2011, the DoDSER included information on the non-activated Reserve and National Guard.

The DoD has traditionally reported the suicide rates, and other pertinent data, for our Service members using the DoD Suicide Event Report (DoDSER). This report provides extensive data and analyses on suicides and suicide attempts to facilitate assessment of risk factors that includes a myriad of underlying risk factors and socio-demographic factors (e.g., reluctance towards help-seeking, relationship problems, financial difficulties, mental health issues, unhealthy alcohol or drug use, and access to lethal means). Over the past five years, the DoD has improved the quality of suicide-related data, and published guidance to ensure reliability and comparability of surveillance data across the military Services, including Reserves and National Guard. The DoD and the VA have jointly created a DoD/VA interagency Suicide Data Repository (SDR), which improves our ability to understand patterns of suicide both before and after military separation.

Data in both the DoDSER and SDR are made readily available to DoD and VA researchers in order to better understand the phenomenology of suicide and be better able to identify vulnerable populations prospectively in order to deliver evidence-based treatments.

The DoDSER provides extensive data and findings, which often take time to collect and analyze. In order to share transparent and timely top-line rates and counts of suicide, including data on dependents, the Department will release its first-ever *Annual Suicide Report* (ASR) this summer, with more up-to-date counts, rates, and trends of military suicide in order to better assess our progress and identify areas of concern in real-time. The DoDSER will follow to provide in-depth details of suicide events and deeper analyses in order to further expand our understanding of military suicides. The increased transparency and frequency of reporting will strengthen our program oversight and policies.

The Department's suicide prevention efforts are guided by the Defense Strategy for Suicide Prevention (DSSP), which was signed in December 2015, and created the foundation and alignment of efforts to focus on prevention activities with the greatest potential to prevent suicide. When developing the DSSP, we worked with the experts in the field and aligned our strategy to the National Strategy for Suicide Prevention (NSSP), as published in 2012 by the Department of Health and Human Services, Office of the U.S. Surgeon General. The DSSP uses the public health framework laid out in the NSSP. Hence, the DoD embraces both community-based prevention efforts and medical care and treatment to address suicidal thoughts and risk behaviors.

In November 2017, DoD published its first ever Department-wide policy on Suicide Prevention, the "*Defense Suicide Prevention Program*" (DoD Instruction 6490.16). This DoD policy establishes a public health approach model, inclusive of mental health treatment efforts, to address suicide risk and prevention across all Military Services. To that end, the Department's major lines of effort within the public health approach are: policy and advocacy, data and

surveillance, program assessment and evaluation, clinical interventions, and outreach and education.

Research, supporting whole population approaches that have shown to reduce suicide rates in various populations across the globe and DoD, continues to be assessed for feasibility and piloted. This includes a focus on:

- Messaging campaigns on how to talk about safe storage of lethal means of suicide in the military culture.
- How to safely talk about suicide prevention and a suicide death by working with public affairs, journalists, and Commanders. This includes strategies to refrain from glorifying or sensationalizing the death, or suggesting that suicide is an "easy way out" and instead talking about how asking for help early on can help mitigate crises.
- Ensuring every Service member, Commander, family member, and support personnel are part of the solution by:
    - Teaching emotion regulation, problem solving, and self-care skills, particularly to new recruits.
    - Training Service members and Commanders on how to identify the risk and warning signs of suicide on social media and intervening in an effective manner.
    - Working with Commanders to assess their unit connectedness and learning ways to increase connectedness.

As part of the public health model, clinical practices are also used, based on best-practices, to reduce suicide particularly in specific high-risk patient populations. It is important to note that all of the clinical practices noted to be somewhat effective have small effect sizes, meaning that a clinician must treat several patients to achieve one changed outcome. These interventions include:

- Cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence, which reduces incidents of future

self-directed violence.

- Dialectical Behavioral Therapy for individuals with borderline personality disorder and recent self-directed violence.
- Crisis response plans for individuals with suicidal ideation or a lifetime history of suicide attempts.
- Problem-solving based therapy for patients with a history of more than one incident of self-directed violence to reduce repeat incidents of self-directed violence; a history of recent self-directed violence to reduce suicidal ideation; and/or hopelessness and a history of moderate to severe traumatic brain injury.
- Ketamine infusion, in patients with the presence of suicidal ideation and major depressive disorder, has been shown to be an effective adjunctive treatment for short-term reduction in suicidal ideation.
- Lithium alone (among patients with bipolar disorder) or in combination with another psychotropic agent (among patients with unipolar depression or bipolar disorder) to decrease the risk of death by suicide in patients with mood disorders.
- Clozapine to decrease the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt.
- Periodic caring communications (e.g., postcards) as indicated for 12-24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt.
- Home visits to support reengagement in outpatient care is indicated among patients not presenting for outpatient care following hospitalization for a suicide attempt.

Much discussion has also focused on the value of predictive analytics for suicide, and indeed DoD's investment with the National Institutes of Health has yielded a multitude of useful

published studies on suicide that should help us better understand suicide and develop effective interventions. As an example, the Army Study to Risk and Resilience in Service members (Army STARRS) and its follow-on longitudinal study, STARRS-LS, has already generated more peer-reviewed publications than many of the most foundational medical studies in our history. Although this research has contributed to our knowledge base, it has not yet produced clinically proven suicide prevention interventions. Thus, while we all strive to prevent every Soldier, Sailor, Airman, and Marine from suicide, predicting who will ultimately make this decision, who will come to seek help, and who will stand resilient in the face of such desperation is currently more of an art than a science, but this science is ever-evolving as we learn more.

Our collaborative efforts with non-profit organizations, academia, the Military Services, and other federal agencies are critical to advancing our suicide prevention efforts. Partnerships with national and local organizations are essential in creating a robust safety net for our Service members and Veterans. These partnerships are especially important for the Reserve Component and National Guard members, who do not traditionally have as easy access to installation-level resources as the Active Component. We work closely with leadership in the Reserve and National Guard Bureau to ensure we understand the unique challenges of this population, and remove barriers to care. In addition, our partnership with the National Institute of Mental Health, which includes *ex oficio* membership in its National Advisory Council, guides research priorities for suicide prevention in a National Research Action Plan.

The DoD has particularly close collaborations with the VA. In addition to the Suicide Data Repository, we share a military suicide research consortium. We co-develop clinical practice guidelines, not just for suicide, but for conditions that increase suicide risk such as Post Traumatic Stress Disorder, Traumatic Brain Injury, depression, and substance use disorders. DoD and VA holds a biennial suicide prevention conference. This event is the only national suicide prevention

conference that specifically addresses suicide in military and veteran populations. In recent years, we have extended our suicide prevention conference reach by partnering with stakeholders across the suicide prevention space. The conference provides an opportunity for leaders, Service members, clinicians, behavioral health and suicide prevention experts, and community health providers to share their expertise and learn about the latest research and promising practices for preventing suicide in our military and Veteran communities.

The DoD has a robust effort with the VA and the Department of Homeland Security (DHS) focusing on the higher risk population of transitioning Service members. In 2017, DoD and VA leadership created an interagency governance structure to address this higher-risk population, which provided a formalized structure to facilitate cooperation and collaboration between the DoD and VA. These efforts received a boost when the President signed Executive Order (E.O.) 13822 in January 2018, requiring the Secretaries of DoD, VA, and DHS to work together to create a Joint Action Plan to ensure seamless access to mental health care and suicide prevention resources for transitioning Service members and Veterans during their first year after retirement or separation from the military. Completed initiatives to date include expanding Military OneSource to provide confidential counseling to Service members and their families from 180 days to now up to 365 days after separation or retirement and extending a warm handover to transitioning Service members in need of additional psychosocial support. Moreover, the VA, DoD, and DHS will continue strong collaborative efforts (in partnership with other federal agencies) specified in the recently signed E.O. 13861, focusing on veteran suicide prevention.

Whether within the DoD or the VA, we know that the more Service members, veterans, and family members we can encourage to come forward during dark times, the better able we are to support them. The Military and Veteran Crisis Line is a state-of-the-art system, and the line generates 50 assessments of individual welfare every day. However, a client on a phone gives a

practitioner far less information than a face to face encounter, and it's therefore harder to make adequate judgments about imminent potential for harm to self or others, treatment, and disposition. So we're creating messaging with our VA partners that emphasizes that care for suicidality is available in emergency rooms, mental health departments, and in primary care clinics.

To be successful in these endeavors, we must also address the perceived stigma we know our Service members and veterans face when deciding if and when to get help. Stigma reduction efforts need to be messaged with real data that make someone likely to seek care. A common misconception is that accessing credentialed mental health care will result in loss of one's security clearance. The reality is that among several million security clearance application questionnaires, only a small handful of individuals lost a security clearance by answering "yes" to questions about mental health history. Furthermore, about 25% of Service members access credentialed mental health care in the year before they separate, and far more access these services over the course of their career. The chance of being separated for a self-referred mental health condition, particularly one that is not a disability, is low.

Gatekeepers are also a critical part of our solution for suicide. In a deployed setting, chaplains and mental health practitioners have a longstanding and critical alliance, with referrals between the practices both robust and nimble. Parent training by our base counselors and social workers has vast potential to support salutary outcomes for both military parents and military children, who form a large portion of our accession cohorts. We also have embedded Military Family Life Counselors to provide assistance to our members and families with an additional ability to "surge" if needed to locations where there is a heightened concern. Additionally, we are working with the Family Advocacy Program to ensure that families with children create safe environment—developing strategies with each family to secure poisons, medications, sharp objects, and firearms, and referrals from our community providers to our mental health system for mental health

conditions, imminent suicidality, and overdose potential. Drug overdoses are a commonly used method for suicide among Veterans and military Service Members. Access to opioid medications has been associated with increased rates of intentional and unintentional overdose death. DoD has an opiate overdose death rate that is one-fourth of the civilian rate, and its successful efforts can be considered a successful suicide prevention initiative. The pillars of success are:

-Random drug testing for all Service members

-Pharmacy controls for all opiate medications

-Ready access to stepped pain care for all individuals (100% of SMs get medical care annually)

-Wide availability of the opiate reversal medication, naloxone

We are grateful for the opportunity to speak with you today and discuss the Department's suicide prevention efforts. This is a complex problem. The root causes vary from one individual to another, and the signs are often difficult to detect for friends and family members, and even for clinicians themselves. As is the case with all of the programs within our purview, this is a national and a global issue that no one has solved. If there were a single solution, we would have found it and implemented it already. But we will not rest. Many of you have heard us say it before, but it bears repeating; we must show as much commitment and dedication to the well-being of our Service members as they demonstrated on the day they stepped forward to volunteer and serve our country. We must meet that sacred obligation.

In closing, Chairwomen, we thank you, the Ranking members, and the members of your subcommittees for your steadfast dedication and support of the men, women, and their families who defend our great Nation.

Dr. Elizabeth (Elise) P. Van Winkle
Performing the Duties of Assistant Secretary of Defense for Readiness

Dr. Elizabeth P. Van Winkle currently serves as the Executive Director of the Office of Force Resiliency for the Under Secretary of Defense for Personnel and Readiness (USD(P&R)). In this role, Dr. Van Winkle is the principal staff advisor to the USD(P&R) and the Secretary of Defense for developing policies, providing oversight, and integrating activities in the areas of sexual assault prevention and response; suicide prevention; harassment, including hazing and bullying; diversity management, equal opportunity; drug demand reduction; total force fitness; and the Department's collaborative efforts with the Department of Veterans' Affairs.

Dr. Van Winkle works with counterparts from across the Department of Defense, including the Office of the Secretary of Defense (OSD); the Military Departments (including the Chiefs/Directors of the Reserve Components); the Joint Staff; the National Guard Bureau; the Defense Agencies; the Combatant Commands; staff members from other Executive Branch Departments, and Members of Congress.

From January through November, 2017, Dr. Van Winkle performed the duties of the Assistant Secretary of Defense (ASD) for Readiness as the focal point within OSD, under USD(P&R), on the readiness of the Armed Services, including the development and oversight of policies and programs, including: Service and joint training, education, capability modernization, and the Defense Language and National Security Education Office. Additionally, Dr. Van Winkle developed and oversaw the Readiness Recovery Framework (R2F), allowing the Department to better assess readiness recovery across the Services. She also chaired the Executive Readiness Management Group, the National Security Education Board, and the Defense Language Steering Committee.

She also served on the Executive Joint Combat Capabilities Assessment Group and was the Defense Department's Senior Language Authority.

Prior to her current assignment, Dr. Van Winkle was the Director of the Health and Resilience Research and Surveys program within the Office of People Analytics (OPA). In this position, she oversaw the Department's survey and research efforts on topics of health, well-being, morale, and resilience. She served as the Principal Investigator for the Workplace and Gender Relations surveys (WGRs), Military Justice Experience surveys (MIJES), Service Academy Gender Relations surveys (SAGR), Workplace and Equal Opportunity surveys (WEOs), and related focus group studies.

Dr. Van Winkle holds a Ph.D. in Applied Experimental Psychology from The Catholic University of America, an M.A. in Sociology from Boston University, and B.A. in Psychology and English from Kenyon College. She is a published author on the impact of combat stress on symptoms of PTSD, the impact of deployments on military spouse well-being, and numerous technical reports on sexual assault and harassment in military populations.

Captain Mike Colston, M.D.

Captain Mike Colston, M.D., is the Director for Mental Health Programs in DoD's Health Services Policy and Oversight office. This office, under the Assistant Secretary of Defense for Health Affairs, seeks to improve the lives of our nation's service members and families through oversight, strategy management, program evaluation and policy regarding DoD's care of psychological health and substance use disorders, traumatic brain injury and the clinical management of suicidality. Captain Colston is stationed at The Pentagon.

In previous medical corps assignments, Captain Colston served as the Director of the Defense Centers of Excellence for Psychological Health (PH) and Traumatic Brain Injury (TBI), a 600-employee national laboratory focused on implementation science for PH, TBI, suicide and addiction. As Director of the Mental Health Program in the Office of the Assistant Secretary of Defense for Health Affairs, Captain Colston oversaw a mental health board project that reviewed over 200,000 cases involving PTSD and depression diagnoses, led a mental health team in the independent investigation of the Washington Navy Yard tragedy, and co-chaired DoD's Addictive Substances Misuse Advisory Committee, helping address the nationwide scourge of opiate addiction on several fronts. As Chair of the Mental Health Department at Naval Hospital Great Lakes, he oversaw a large-scale clinical integration of VA and DoD services at the Lovell Federal Health Care Center in the Chicago metro area. During deployment in support of Operation Enduring Freedom, he led a combat and operational stress team that supported a catchment of 10,000 service members.

Captain Colston has represented DoD in testimony to both chambers of Congress and at Executive Offices of the President including the Office of National Drug Control Policy, the Domestic Policy Council, and the National Security Council. He has served in study sections for federal research portfolios and on research advisory boards for the Congressionally Directed Medical Research Program and the NIH National Advisory Council on Neurological Disorders and Stroke. He currently serves on panels for the Military Suicide Research Consortium, the Consortium to Alleviate PTSD, and the National Academies of Medicine. He authored a chapter on the forensic aspects of PTSD in the Textbook of Military Medicine series, and has been published in peer-reviewed journals on uncertainties in diagnosis and treatment of mental illnesses and bioethical considerations related to PH, TBI and suicide research.

Captain Colston joined the Navy as a line officer, serving as a nuclear engineer and surface warfare officer aboard USS Carl Vinson (CVN-70), deploying twice to the Arabian Sea and completing a Pacific Rim Exercise. He then commanded a littoral patrol boat as an afloat officer-in-charge. Transitioning to Medical Corps service, he earned an MD from the Uniformed Services University of the Health Sciences, trained as a resident in psychiatry at Walter Reed Army Medical Center and completed a fellowship in child and adolescent psychiatry at Northwestern University. Captain Colston holds a BS in Industrial and Management Engineering from Rensselaer Polytechnic Institute and a master's degree in Marine Affairs from the University of Rhode Island. He is a fellow of the American Psychiatric Association and is board certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology.

Captain Colston is credentialed at Fort Belvoir Community Hospital, practicing inpatient adolescent psychiatry and step- down addictions medicine. His military decorations include the Defense Superior Service Medal and Defense Meritorious Service Medal, Surface Warfare and Officer-in-Charge Afloat devices, and campaign ribbons stemming from four overseas movements.

STATEMENT OF
KEITA FRANKLIN, M.D.
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SUICIDE PREVENTION PROGRAM
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
HOUSE COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL
AND
HOUSE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH

May 21, 2019

Good afternoon, Chairwoman Speier, Chairwoman Brownley, and Members of the Subcommittees. I appreciate the opportunity to discuss the critical work VA is undertaking to prevent suicide among our Nation's Veterans. I am accompanied today by Dr. Michael Fisher, Chief Officer, Readjustment Counseling Service.

Introduction

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

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

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

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

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

Mental Health and Suicide Prevention

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

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

When we look at our data from the years 2015 to 2016, we see a small decrease in the number of suicides; there were 365 fewer deaths by suicide in 2016 compared to 2015. This means we are moving in the right direction, but if there is still one suicide, we know there is significantly more work to be done. We are also concerned about the fact that we are seeing a rise in the rates of Veteran suicides among those aged 18 – 34 in the past 2 years. Efforts are already underway to better understand this population and other groups that are at elevated risk, such as women Veterans, never Federally-activated Guardsmen and Reservists, recently separated Veterans, and former Servicemembers with Other Than Honorable (OTH) discharges.

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

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

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

For all groups experiencing a higher risk of suicide, including women, VA also offers a variety of mental health programs such as outpatient services, residential treatment programs, inpatient mental health care, telemental health, and specialty

mental health services that include evidence-based therapies for conditions such as posttraumatic stress disorder (PTSD), depression, and substance use disorders.

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

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

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

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

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

there whenever Veterans need us. In FY 2018, VA's apps were downloaded 700,000 times.

A Public Health Approach to Suicide Prevention

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

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

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

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

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

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

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

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

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

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

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

VA relies on proven tactics to achieve broad exposure and outreach while also connecting with hard-to-reach targeted populations. Our target audiences include, but are not limited to women Veterans; male Veterans age 18-34; former Servicemembers; men age 55 and older; Veterans' loved ones, friends, and family; organizations that regularly interact with Veterans where they live and thrive; and the media and

entertainment industry, who have the ability to shape the public's understanding of suicide, promote help-seeking behaviors, and reduce the risk of copycat suicides among vulnerable individuals.

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

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

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

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

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

VA is also working with Federal partners, as well as state and local governments, to implement the National Strategy. In March 2018, VA, in collaboration with the Department of Health and Human Services, introduced the Mayor's Challenge with a community-level focus, and just last month, debuted the Governor's Challenge to take those efforts to the state level. The Mayor's and Governor's Challenges allow VA to work with 7 governors (from Arizona, Colorado, Kansas, Montana, New Hampshire, Texas, and Virginia) and 24 local governments, chosen based on Veteran population data, suicide prevalence rates and capacity of the city or state, to develop plans to

prevent Veteran suicide, again with a focus on all Veterans at risk of suicide, not just those who engage with VA.

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

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

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

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

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

- After the first year, eligible Veterans may still receive mental health care support through VA, Vet Centers, the Veterans Crisis Line, or from a referred community resource.
- Veterans will also be able to receive support through VA partners and community resources outside of VA, like VSOs.

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

On March 5, 2019, EO 13861, *National Roadmap to Empower Veterans and End Suicide*, was signed to improve the quality of life of our Nation's Veterans and develop a national public health roadmap to lower the Veteran suicide rate. EO 13861 mandated the establishment of the Veterans Wellness, Empowerment, and Suicide Prevention Task Force to develop the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) and the development of a legislative proposal to establish a program for making grants to local communities to enable them to increase their capacity to collaborate with each other to integrate service delivery to Veterans and to coordinate resources for Veterans. The focus of these efforts is to provide Veterans at risk of suicide support services, such as employment, health, housing, education, social connection, and to develop a national research strategy for the prevention of Veteran suicide.

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

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

or refresher S.A.V.E. trainings since December 2018. This training continues to be used by VA's Suicide Prevention Coordinators (SPC) at VA facilities nationwide, as well as by many of our VSOs.

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

Conclusion

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

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

Keita Franklin, LCSW, PhD National Director, Suicide Prevention
U.S. Department of Veterans Affairs
Office of Mental Health and Suicide Prevention

Dr. Keita Franklin, a member of the Senior Executive Service, is the National Director of Suicide Prevention for the U.S. Department of Veterans Affairs Office of Mental Health and Suicide Prevention. Dr. Franklin serves as the principal advisor to VA leadership for all matters pertaining to suicide prevention. She leads a team of experts engaged in research, program evaluation, innovation, program development, data and surveillance, and partnerships. Before joining VA, Dr. Franklin served as the Director of the Defense Suicide Prevention Office where she was responsible for policy and oversight of the U.S. Department of Defense suicide prevention programs.

She is a licensed social worker with a specialization in children and families, and has a PhD in social work with specialized training and certifications from the Center for Advancement of Research Methods and Analysis. Dr. Franklin received a leadership award from Virginia Commonwealth University for leading efforts to help train and advise the social work profession on working with military families.

Department of Veterans Affairs Senior Executive Biography
Michael W. Fisher, MSW
Chief Readjustment Counseling Officer Veterans Health Administration Readjustment Counseling Service, 10RCS

Michael Fisher was appointed as the Chief Officer of the Department of Veterans Affairs (VA) Readjustment Counseling Service (RCS) in May 2016. He has direct leadership and oversight of the 300 Vet Centers, 80 Mobile Vet Centers, and the Vet Center Call Center which all provide readjustment counseling to Veterans, active duty Servicemembers, and their families. RCS facilities are located in all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam, and American Samoa. As Chief Officer, Mr. Fisher also advises the Under Secretary for Health in policy issues effecting the readjustment of Veterans and their families and issues surrounding the combat experience.

Mr. Fisher began his career with VA in RCS as an outreach specialist at the Baltimore Vet Center ensuring increased access to care and services for his fellow Veterans. He performed local, Regional, and National roles of increasing responsibility within RCS culminating in his appointment as Chief Officer. Prior to his VA career, he served over 10 years with the Pennsylvania National Guard and was deployed to Iraq as an Infantry non- commissioned officer in 2005. Following this combat deployment he was medically discharged from the military. He holds a Master of Social Work (MSW) from the Catholic University of America.

DOCUMENTS SUBMITTED FOR THE RECORD

MAY 21, 2019

Rep. Seth Moulton: Let's talk about cannabis and the VA

by Rep. Seth Moulton | May 17, 2019 01:53 PM

Let's stop kidding ourselves: Americans are using cannabis, and many of them are veterans.

According to the American Legion, more than 1 in 5 veterans currently use cannabis. A vast majority of veteran households (93%) support medical cannabis research, and a large majority want the government to offer it as federally legal medical treatment.

I don't need a study to tell me that. I often hear about this from the Marines I served with and who either live in states where cannabis is legal, or wish they did. Many of them are using cannabis so that they don't get addicted to opioids or other more dangerous alternatives.

We talk to each other because none of my friends can talk about cannabis with their doctors at the VA. Despite the fact that cannabis is either legal or decriminalized in more than half the states in the country, they might lose their VA benefits if they do.

This is a big problem for a few reasons.

Firstly, because your doctor should know about the drugs you're taking, legal or otherwise. Veterans should be able to talk with doctors, not just fellow vets, to get basic medical advice.

More broadly, because veterans are twice as likely as non-veterans to die from accidental opioid overdoses, and many believe marijuana is a safer alternative.

The problems build upon each other. Last year, for example, the Boston Globe reported on a veteran who was stripped of a prescription that helped him fight an opioid addiction because he tested positive for cannabis. Another had his benefits cut in half after talking about his use of cannabis with his doctor.

Veterans seeking cannabis aren't druggies. Many are American heroes who deserve a VA that researches cannabis and protects veterans from opioids using any method that's safe. Federal drug laws currently prevent researchers from figuring that out.

It's time for change.

A few days ago, I introduced three bipartisan bills that would modernize the VA's cannabis policies. One would protect veterans who tell their doctors about cannabis usage from losing their benefits. The bill would also let doctors at the VA incorporate marijuana into veterans'

treatment plans.

The second bill would direct the VA to conduct a national survey of all veterans and VA healthcare providers to learn more about how many veterans are using cannabis, and why.

The third bill would expand access to educational resources, so VA doctors can learn more about medical cannabis.

I partnered with Rep. Matt Gaetz, R-Fla., to introduce these bills. We worked hard to make them something that members of both parties could support. Congress should also have a broader debate about legalizing marijuana nationwide.

Some in my party have questioned whether an incremental approach through the VA is a good idea. They have asked, "shouldn't we focus on sentencing reform and full legalization?"

That's a false choice. My experience as a resident of Massachusetts and an early supporter of legalizing cannabis there bears that out. In 2016, I broke with the establishment in my state to endorse the ballot measure that ultimately legalized cannabis, because I believed in its benefits for veterans and others.

The measure succeeded, and earlier this year, one of the first public dispensaries of cannabis opened in Salem, Mass., where I live. The incremental steps in states that legalized cannabis have advanced the nation's discussion about sentencing laws and other drug reforms like safe injection sites.

There are also valid concerns. Looser marijuana laws ought to come with increased accountability for bad decisions like driving under the influence or circumventing regulated dispensaries. Legalization would help the government regulate cannabis better, and we shouldn't stop enforcing other drug laws that keep people safe.

Ultimately, making the VA a place where veterans can discuss and maybe someday access cannabis, will help our country evolve on this issue too. Through that evolution, I believe we will be able to tackle bigger challenges together—like ending the fundamentally-unjust process of locking people up for possessing marijuana, and, in effect, sentencing them to a lifetime of fewer job opportunities. I support releasing people who are in jail for marijuana possession and expunging their records, especially because Americans in more than half the states in the nation voted to decriminalize this.

I suspect many will disagree. But cannabis use is something we should at least talk about with each other and as a nation— and it's especially something veterans should be able to discuss with our doctors at the VA.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

MAY 21, 2019

RESPONSE TO QUESTION SUBMITTED BY MR. CISNEROS

Dr. VAN WINKLE. The Department of Defense spends approximately $127M on suicide prevention research annually. [See page 22.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

MAY 21, 2019

QUESTIONS SUBMITTED BY MR. CISNEROS

Mr. CISNEROS. Explain how DOD screens and evaluates active-duty service members for susceptibility or risk factors for suicide prior to separation.

Dr. VAN WINKLE. The Department's suicide prevention efforts leverage a public health approach, which involves continuous surveillance of known risk factors (e.g., separation from service, types of separation including other than honorable discharge status) in an effort to prevent suicide. There is a standard process to screen all recruits for mental health issues, which is one of the leading reasons for separation during recruit training, at Military Entrance Processing Stations. Periodic health assessments, completed annually, are used to continue to assess mental health readiness while in service. Further, in response to Executive Order (EO) 13822, the Department has implemented a mandatory separation health assessment for all transitioning Service members prior to separation, which includes a mental health component to identify those at-risk and take appropriate action.

Mr. CISNEROS. What are DOD and VA's responsibilities for carrying out a "warm handover" of a service member from DOD to VA care?

Dr. VAN WINKLE. It is DOD policy that any Service member in active clinical care gets a warm handover to the next portal of care in the Department of Veterans Affairs (VA) or elsewhere. A health care liaison collects transitioning Service members' medical records, makes initial appointments in an appropriate VA medical center, and facilitates the handover to the new facility. DOD is also enhancing its programs and systems to improve and streamline the warm handover of Service members to VA resources in response to EO 13822. The new separation health assessment includes a mental health component, and those identified as at-risk or in need of additional support receive a warm handover to VA and/or other appropriate resources. The inTransition program provides post-service referrals (including to the VA), for transitioning Service members who have been identified with a mental illness or have sought mental health resources in the previous year. The Department has also enhanced the Transition Assistance Program (TAP), including adding facilitated registration for VA health care during the mandatory VA Benefits briefing. Additionally, an in-person warm handover to a VA Veterans Benefits Advisor (VBA) is initiated for transitioning Service members who are in need of additional support (e.g., with their VA benefits; those who have been identified to be at risk for homelessness by a transition counselor or Commander, etc.)

Mr. CISNEROS. Recognizing that there are a number of service members who do not self-report when in need of care, what are DOD and VA's policies and plans for pro-actively engaging and seeking out non-reporters?

Dr. VAN WINKLE. DOD promotes help-seeking and access to care by implementing a range of programs and activities to remove stigma to seeking care. DOD offers programs that build unit cohesion, target efforts to at-risk Service members, and provide quality behavioral health care across a Service member's military life cycle. Additionally, the Department has implemented a mandatory separation health assessment for all transitioning Service members prior to separation, which includes a mental health component to identify those at-risk and take appropriate action. One new program, currently being piloted, the Resources Exist and Can Help training, is designed to help Service members become more familiar with care-seeking resources by identifying different resources and addressing misperceptions of seeking care.

Mr. CISNEROS. Are there any suicide prevention initiatives or programs that DOD has not undertaken because of cost?

Dr. VAN WINKLE. Cost is not a factor in determining suicide prevention initiatives or programs. The DOD is expending significant resources to implement and evaluate existing suicide prevention programs, as well as piloting new evidence-informed initiatives and programs. If new initiatives and programs are shown to be effective in preventing suicide, the Department will explore how to best implement them across the Military Services.

Mr. CISNEROS. When asked what explains the increase in the number of suicides in 2018, both DOD and VA witnesses did not have an answer. What plans do each

of the departments have to investigate the reasons for the increase in the number of suicides among service members?

Dr. VAN WINKLE. Suicide is complex. Many biological, social, and psychological factors at the individual, community, and societal levels contribute to suicide. In recognition of this complexity, the DOD continues to implement a comprehensive public health approach to suicide prevention and conduct robust research and program evaluation efforts. The DOD is consistently analyzing suicide death data trends and reviews suicide death cases as an ongoing effort. In 2019, the DOD began piloting a comprehensive, 360-degree suicide death review process that will examine suicide cases from each of the Services. Additionally, the Department is publishing the inaugural Annual Suicide Report in summer 2019 that includes suicide rates for CY 2018, as well as trends over time.

Mr. CISNEROS. The DOD repeatedly mentioned the need to meet "patients where they're at." What is the Department doing to ensure they are meeting patients "where they're at"?

Dr. VAN WINKLE. In order to meet patients where they are, DOD has embedded behavioral health providers within operational units in each of the Services. These embedded providers can be found both in non-deployed and deployed settings. Because of their proximity and immediate availability to Service members, embedded providers are able to identify and treat initial signs and symptoms of behavioral health issues with the goal of rectifying the issues before they develop into larger problems. In addition, embedded providers' daily proximity to, and familiarity with, Service members helps to reduce the stigma associated with receiving behavioral health care. DOD has also integrated behavioral health providers into Primary Care clinics in order to meet Service members at a place they are most likely to be seen for related medical concerns, especially if they have mental health concerns and are hesitant to seek mental health care. This allows Service members easy access to Integrated Behavioral Health Specialists (IBHC) who are part of the Primary Care team. The IBHC can quickly address symptoms, reduce the stigma of mental health care, and provide health care that includes mental health care in a one stop location. DOD also provides treatments tailored to each individual patient's needs. Treatment tailoring includes matching treatments to symptomatology and symptom severity, accounting for prior effective and/or ineffective treatments, and respecting patient preferences, strengths, and limitations. In the future, tailored care will include precision medicine approaches across demographic cohorts that comport with available evidence. Each of the Military Services also has a Combat Operational Stress Control (COSC) program. COSC providers work to identify and manage the physiological and psychological stress that may be experienced by Service members during combat in order to prevent the development of harmful stress reactions, and to mitigate the potential development of mental health disorders post-deployment. COSC providers, including seasoned psychiatrists, are located forward with the Service member, typically in deployed locations.

Mr. CISNEROS. What are DOD and VA's responsibilities for carrying out a "warm handover" of a service member from DOD to VA care?

Dr. FRANKLIN. [No answer was available at the time of printing.]

Mr. CISNEROS. Recognizing that there are a number of service members who do not self-report when in need of care, what are DOD and VA's policies and plans for pro-actively engaging and seeking out non-reporters?

Dr. FRANKLIN. [No answer was available at the time of printing.]

Mr. CISNEROS. It was indicated that 500,000 letters were sent out to veterans with an other than honorable discharge to clarify their eligibility for care, but only 3,500 came into care. Why is that number so low and what can be done to increase the number of veterans in that group to enter care?

Dr. FRANKLIN. [No answer was available at the time of printing.]

Mr. CISNEROS. When asked what explains the increase in the number of suicides in 2018, both DOD and VA witnesses did not have an answer. What plans do each of the departments have to investigate the reasons for the increase in the number of suicides among service members?

Dr. FRANKLIN. [No answer was available at the time of printing.]

QUESTIONS SUBMITTED BY MS. ESCOBAR

Ms. ESCOBAR. Fort Bliss has exhibited heightened suicide rates over the past year. The Bliss population accounts for more than 5% of the Army's end strength and a disproportionate 11% of Army suicides. What are you doing to understand the cause of this alarming trend? What are the impact points for local commanders and Army leadership respectively?

Dr. VAN WINKLE. Because suicide is complex with many factors—and no two suicides are identical, the Department takes a comprehensive approach to suicide prevention, focusing on getting Service members to seek help and check in with each other, reducing barriers to care, while using simple safety measures and precautions to reduce the risk of suicide. Our comprehensive public health approach involves continuous surveillance of known risk and protective factors in an effort to develop, test, implement, and evaluate specific suicide prevention programs. The Army is currently conducting a Suicide Prevention Pilot at several installations, including Fort Bliss. Initiatives being executed through the pilot include Leader Education and Training and Command Visibility Tools. These initiatives are designed to augment leader capabilities and increase leader visibility of behavioral health problems. The Army's goal for these efforts is to see increased resilience, reduction in suicide and suicidal behaviors, and improved psychological health of our Soldiers. Army leadership is actively engaged in the Department's suicide prevention efforts through the Suicide Prevention General Officer Steering Committee (SPGOSC). The SPGOSC addresses present and future suicide prevention needs, employing data-driven, evidence-informed practices that are aligned with the Defense Strategy for Suicide Prevention and have DOD-wide applicability. Local commanders have a wide variety of clinical and non-clinical tools at their disposal for suicide prevention. In addition to military mental health treatment, commanders can make use of chaplains, embedded Military and Family Life Counselors, and other well-being programs focused on addressing stressors before they become crises (e.g., Military OneSource, financial readiness, family support programs).

Ms. ESCOBAR. Suicidal ideation rates at Bliss have increased 2.5 times over the 2016–2018 period. Some observers suggest this may indicate improved access to services and/or comfort accessing services. If true, increased access is of course positive. How we can leverage that contact to improve outcomes for service members?

Dr. VAN WINKLE. Suicide is a complex interaction of factors; while there is no one "fix," we are fully committed to preventing suicide and ending this tragedy. The Department has a number of efforts underway to support Service members who come forward and seek help. We are leveraging evidence-informed practices and implementing a range of prevention programs that have shown promise in the civilian sector.

- The DOD utilizes a comprehensive portfolio of suicide prevention initiatives and is committed to ensuring our Service members have ready access to quality mental health treatment, with effective and trustworthy providers.
- The DOD recently partnered with VA to complete a Clinical Practice Guideline (CPG) on the assessment and management of suicide. This evidence review found clinical practices that can reduce suicide—particularly in specific high-risk patient populations. The CPG is designed to ensure those who do come forward and seek help have high-quality, evidence-based care.

Ms. ESCOBAR. I noted the high prevalence of gunshot wounds in reported suicide data for Fort Bliss. What, if any, policy prescriptions does this indicate could improve service member safety?

Dr. VAN WINKLE. Data shows that the most common method of suicide death among Service members is by firearm. Gunshot wounds were reported in 62.5% of suicide deaths at Fort Bliss. This aligns with data on suicide deaths within the force at large. In CY 2018, 60.0% of Active Component suicide deaths, 61.7% of Reserve suicide deaths, and 69.6% of National Guard suicide deaths were by firearm. We have policies that allow commanders to refer, in a compulsory manner if necessary, Service members who need help for suicidality. Each Service has its own, specific regulations under the umbrella of DOD policy, but, generally, commanders are responsible for the temporary storage and accountability of privately owned fire arms and ammunition voluntarily relinquished by Service members, in coordination with installation law enforcement and in accordance with local installation procedures. All policies and procedures are, and must be, in compliance with Public Laws. In the Navy, guidance has been issued to go beyond the regular promotion of the voluntary use of gun locks and other safe storage methods. Commanders and health professionals may inquire about, collect, and record information about a Service member's privately-owned firearms, ammunition, or other weapons if the commander or health professional has reasonable grounds to believe the Service member is at risk for suicide or causing harm to others. Air Force commanders use Time-Based Prevention, which is an approach to suicide prevention focused on the means most often used during fatal suicide completions—personal firearms. Time-Based Prevention efforts are intended to eliminate the hazard of firearms being readily available during the first five minutes when an individual decides to perform a suicidal act. It is important to note Time-Based Prevention efforts do not limit or prohibit the legal ownership or use of firearms in any manner for individuals. Army

commanders must establish and publicize procedures for registering, transporting, and storing privately owned weapons. Soldiers, Family members, and personnel living on installations must register their privately owned firearm and ammunition within 24 hours. All privately owned firearms and ammunition will be stored in unit arms rooms.

Ms. ESCOBAR. Fort Bliss has exhibited heightened suicide rates over the past year. The Bliss population accounts for more than 5% of the Army's end strength and a disproportionate 11% of Army suicides. What are you doing to understand the cause of this alarming trend? What are the impact points for local commanders and Army leadership respectively?

Captain COLSTON. The MHS embeds evidence-based suicide prevention programs, which are supported by an interagency collaboration with the VA, in the delivery of mental health care services through a combination of policy, guidelines, and initiative implementation. Suicide prevention policies and programs within the MHS focus on preventing suicide deaths through the dissemination of effective interventions. Suicide Prevention Programs (SPPs) are administered by each military department, and include aspects of prevention within basic unit training. SPPs consist of a dedicated program office responsible for the application of a comprehensive public health approach to suicide prevention across DOD. Additionally, SPPs utilize clinical measures that monitor suicide risk for Service members accessing mental health care in the direct care system.

Ms. ESCOBAR. Suicidal ideation rates at Bliss have increased 2.5 times over the 2016–2018 period. Some observers suggest this may indicate improved access to services and/or comfort accessing services. If true, increased access is of course positive. How we can leverage that contact to improve outcomes for service members?

Captain COLSTON. There are a number of ways increased access to care can be leveraged to improve outcomes for service members. The DOD has invested in a number of programs that increase access to mental health care for Service members who are experiencing symptoms of a psychological health condition in order to improve outcomes. Service members are eligible to receive free, comprehensive behavioral health care (including clinical assessment, psychotherapy, and psychiatric treatment) at their local military medical treatment facilities. We also have programs that increase access to care by embedding psychological health providers in operational units to assist Service members in their everyday work environments. Access to care is increased by the primary care medical homes that provide follow-up when Service members disclose psychological health concerns to their primary care provider. Military OneSource is our 24/7 resource to connect Service members to information about their psychological health, non-medical counseling for stress management, and referrals to healthcare providers to increase access to care and improve outcomes.

Ms. ESCOBAR. I noted the high prevalence of gunshot wounds in reported suicide data for Fort Bliss. What, if any, policy prescriptions does this indicate could improve service member safety?

Captain COLSTON. The DOD aims to eliminate on and off-duty mishaps and related deaths, injuries, occupational illnesses, and lost mission capability and resources. Policy is currently in place, which: (1) Protect DOD personnel from accidental death, injury, or occupational illness; (2) Apply risk management strategies to eliminate occupational injury or illness and loss of mission capability and resources both on and off duty. (3) Perform analysis of safety and occupational data to highlight high-risk behaviors and facilitate risk-reduction measures; and (4) Engages at the operational level to seek initiatives and projects to reduce risk in areas of concern common to all Military Services.

Ms. ESCOBAR. We know from veteran data that suicide rates decline as contact with VA system increases. What lessons learned can the DOD can benefit from and seek to implement in their programming?

Dr. FRANKLIN. [No answer was available at the time of printing.]

Ms. ESCOBAR. We've seen a series of unfortunate stories about veterans taking their own lives on VA premises. Often a firearm is used. How will the VA address this troubling pattern to help keep veterans safe at their most vulnerable moments?

Dr. FRANKLIN. [No answer was available at the time of printing.]

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Mr. FISHER. [No answer was available at the time of prining.]

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Mr. FISHER. [No answer was available at the time of printing.]

Ms. ESCOBAR. I found the December 2018 reports of unspent VA suicide prevention outreach funds highly troubling. It's upsetting to think about how many more lives that $6.2 million, if put to good use, might have saved. But in the interest of moving forward: How can we do better at outreach? How else should we support veterans who may be struggling with suicidal ideation?

Mr. FISHER. [No answer was available at the time of printing.]

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