AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 115–336

#BETHERE: WHAT MORE CAN BE DONE TO PREVENT SUICIDE?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

SEPTEMBER 27, 2017

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
31–567 WASHINGTON : 2018

COMMITTEE ON VETERANS' AFFAIRS

JOHNNY ISAKSON, Georgia, *Chairman*

JERRY MORAN, Kansas	JON TESTER, Montana, *Ranking Member*
JOHN BOOZMAN, Arkansas	PATTY MURRAY, Washington
DEAN HELLER, Nevada	BERNARD SANDERS, (I) Vermont
BILL CASSIDY, Louisiana	SHERROD BROWN, Ohio
MIKE ROUNDS, South Dakota	RICHARD BLUMENTHAL, Connecticut
THOM TILLIS, North Carolina	MAZIE K. HIRONO, Hawaii
DAN SULLIVAN, Alaska	JOE MANCHIN III, West Virginia

THOMAS G. BOWMAN, *Staff Director* [1]
ROBERT J. HENKE, *Staff Director* [2]
TONY MCCLAIN, *Democratic Staff Director*

Majority Professional Staff
Amanda Meredith
Gretchan Blum
Leslie Campbell
Maureen O'Neill
Adam Reece
David Shearman
Jillian Workman

Minority Professional Staff
Dahlia Melendrez
Cassandra Byerly
Jon Coen
Steve Colley
Simon Coon
Michelle Dominguez
Eric Gardener
Carla Lott
Jorge Rueda

[1] Thomas G. Bowman served as Committee majority Staff Director through September 5, 2017, after being confirmed as Deputy Secretary of Veterans Affairs on August 3, 2017.
[2] Robert J. Henke became the Committee majority Staff Director on September 6, 2017.

C O N T E N T S

SEPTEMBER 27, 2017

SENATORS

	Page
Isakson, Hon. Johnny, Chairman, U.S. Senator from Georgia	1
Tester, Hon. Jon, Ranking Member, U.S. Senator from Montana	39
Boozman, Hon. John, U.S. Senator from Arkansas	28
Blumenthal, Hon. Richard, U.S. Senator from Connecticut	30
Heller, Hon. Dean, U.S. Senator from Nevada	32
Manchin, Hon. Joe, III, U.S. Senator from West Virginia	34
Tillis, Hon. Thom, U.S. Senator from North Carolina	37
Cassidy, Hon. Bill, U.S. Senator from Louisiana	43
Moran, Hon. Jerry, U.S. Senator from Kansas	57
Murray, Hon. Patty, U.S. Senator from Washington	59
Brown, Hon. Sherrod, U.S. Senator from Ohio	64

WITNESSES

Daigh, John D., Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections, Office of Inspector General, U.S. Department of Veterans Affairs	2
Prepared statement	3
Response to posthearing questions submitted by Hon. Mazie K. Hirono	75
Bryan, Craig, Psy.D., ABPP, Executive Director, National Center for Veterans Studies, University of Utah	9
Prepared statement	11
Response to posthearing questions submitted by Hon. Mazie K. Hirono	76
Kuntz, Matthew, Executive Director, National Alliance on Mental Illness for Montana	16
Prepared statement	18
Response to posthearing questions submitted by Hon. Mazie K. Hirono	77
Shulkin, Hon. David J., M.D., Secretary, U.S. Department of Veterans Affairs; accompanied by David Carroll, Ph.D., Executive Director, Office of Mental Health and Suicide Prevention	47
Prepared statement	49
Response to request arising during the hearing by:	
Hon. Jon Tester	78
Hon. Bill Cassidy	89
Hon. Joe Manchin III	89

APPENDIX

Falke, Ken, Chairman, Boulder Crest & EOD Warrior Foundation; prepared statement	89
Keleher, Kayda, Associate Director, National Legislative Service, Veterans of Foreign Wars of the United States; prepared statement	92
Lloyd, Paul, State Adjutant, Department of New Hampshire, Veterans of Foreign Wars of the United States; letter	96
Smoker, Kenny, Jr., Director, Fort Peck Tribes Health Promotion/Disease Prevention, Fort Peck Indian Reservation, Poplar, Montana; prepared statement	97

Page

Somers SCVA; prepared statement 99
Attachment 1: Daniel Somers fairwell letter 110
Attachment 2: TRIBE white paper 113
Attachment 3: Support Network 132

#BETHERE: WHAT MORE CAN BE DONE TO PREVENT SUICIDE?

WEDNESDAY, SEPTEMBER 27, 2017

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Cassidy, Rounds, Tillis, Sullivan, Tester, Murray, Brown, Blumenthal, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. Let me call this hearing of Veterans' Affairs Committee to order. I thank all of you for coming today, especially our witnesses. We have a number of Members who are on the way, but in the interest of your time, we are going to go ahead and get started.

Today's hearing is about the issue of suicide. As many people in the room know, this month in America is National Suicide Prevention Month across the country. Suicide is a terrible, terrible, terrible loss, a wasteful loss of life, a preventable loss of life.

I think Jon will remember when we first came in as a Committee 3 years ago, our first bill that was passed was the Clay Hunt Suicide Prevention bill. It passed this Committee unanimously and the Senate 99–0. We will ask the Secretary and the other members from the VA who are here today to give us any report they might have on the progress on the implementation that is done in terms of the Clay Hunt Act. It is a very important Act.

In August 2014, I held a hearing at Georgia State University as a Member of this Committee. It was a field hearing on the issue of suicide. The reason I did was because in that years and the months leading up to August 2014, the Georgia principal VA hospital on Clairmont Road in Decatur had three suicides, two on campus, some of it from mishandling available tools for suicide like pharmaceuticals and things of that nature, others for a lack of awareness, and many for a lack of capacity. That was the real thing that concerned me. So we began working in the Clairmont VA hospital in Atlanta to improve VA's response to suicide and to mental health issues.

Suicide is a disease, and it is preventable, and there are many things that we can do. To set the example, our staff director, Bob

Henke, did a great job of seeing to it that every member of the staff, majority and minority, has been through the SAVE training for suicide prevention.

SAVE stands for signs of suicide thinking should be recognized; ask the most important question of all, "Are you thinking about committing suicide?," which is a tough thing to address but the key question to ask; validate the veteran's experience; and encourage treatment and expedited getting help.

I can tell you from what we learned in Atlanta and have learned in the VA, timing is everything, as it is in health care and most things, the golden hour we know about in health care, but when someone is contemplating suicide, it is not something you put off to an appointment on Wednesday or to another day. It is something you deal with immediately, you deal with quickly, and you expedite the response to it.

I want to thank the staff for going through the training, and just like the Heimlich maneuver has saved many a life in a restaurant when somebody was choking and somebody else knew how to apply that maneuver which freed their air passages, just like CPR has helped people who had untimely heart attacks, just like CPR has helped people who might be drowning or might have drowned and been brought back to life. But, being aware of the training that is necessary to save a life is critically important, and we are going to see to it in our Committee that we promote this training throughout the VA and throughout the government to see to it that we are saving lives and helping people to recover and restore their life.

I want to thank Bob Henke for his commitment to doing it on the staff and thank all the staff members for having done it and thank the Members of the Committee for their effort as well.

We have two panels today on the issue of suicide. Our first panel is Dr. John Daigh, Assistant Inspector General for Health Inspections. Second is Craig Bryan, Dr. Craig Bryan, Executive Director of National Center for Veterans Studies, University of Utah; and Dr. Matthew Kuntz, Executive Director of the National Alliance on Mental Health for Montana.

We appreciate all three of you being here today. You will be allowed to give up to 5 minutes of testimony. We do not have a whistle that blows at the end of 5 minutes, but after 10, you will be in big trouble. [Laughter.]

All your statements will be printed for the record and be memorialized in the record, and that will be by unanimous consent.

With that said, we will start with Dr. Daigh and your testimony and go down the list from there. Welcome.

STATEMENT OF JOHN D. DAIGH, JR., M.D., CPA, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. DAIGH. Thank you, Chairman Isakson, Ranking Member Tester, Members of the Committee. It is an honor to testify before you today on the subject of suicide prevention. This topic is important to Mr. Missal and all of the staff at the Office of Inspector General, OIG. We work to ensure veterans receive the highest-quality mental health care.

We have reviewed in-depth facts surrounding the death of many veterans who took their own lives. Often we find these veterans suffered the effects of chronic mental illness and substance abuse disorder.

In the aftermath of these deaths, we frequently hear from members of the veteran's family, significant friends, and VA providers that they would have acted sooner or differently, if only they had known.

After the Virginia Tech shooting, a serious review of the privacy laws that impact the disclosure of medical information was undertaken. My staff met with and talked with a number of the individuals who were involved in this review to determine if there were lessons learned that could be applied to VA.

Changes to law seem too difficult to design; however, changes in practice that utilize advance directives or similar devices may offer a way to improve communication at the critical point when the patient needs help the most. I think there is a chance to improve communication by expanding the situations under which these and similar devices are used.

VA has thoughtfully derived a model to predict who may suicide. The question is, When would an at-risk veteran take action to harm themselves or harm others? When would intervention be most effective?

Research using social media and other more timely data has shown promise in understanding the human emotional state and, therefore, may assist in identifying when intervention for these at-risk individuals would be most successful. I think research and pilot studies in this has great potential.

The testimony of others at this table point out that many veterans do not obtain their care primarily from the VA hospital system, and so an effort to reach those veterans who are at risk is most appropriate and essential if we are to make a significant improvement in veteran suicide data.

This concludes my oral testimony, and I would be pleased to answer your questions.

[The prepared statement of Dr. Daigh follows:]

PREPARED STATEMENT OF JOHN D. DAIGH, JR., M.D., CPA, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

MR. CHAIRMAN, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, Thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work on VA's efforts to prevent veteran suicide. Suicide is a serious public health concern. Beyond the loss of life to the victim, suicide takes a profound toll on survivors, caregivers, and the community. Likewise, incomplete suicides, taking the form of suicide attempts, gestures, and other acute self-destructive behaviors, are associated with injury, an emotional toll, and personal and societal financial burdens. Therefore, prevention initiatives and interventions that might reduce suicidal behaviors are of enormous importance.

Since 2006, the Veterans Health Administration (VHA) has implemented several initiatives aimed at suicide prevention, including the appointment of a National Suicide Prevention Coordinator (SPC), the establishment of the suicide prevention hotline (Veterans Crisis Line (VCL)), the development of a patient record flagging system to identify high-risk patients, and the creation of suicide prevention programs in each facility. In addition, VHA expanded facility SPC roles, requiring them to participate in community outreach activities. The purpose of these initiatives was to reduce the stigma surrounding mental health (MH) conditions, provide access to MH services, and promote public awareness of suicide.

Recognizing the importance of this issue, the OIG has focused resources in conducting oversight of VHA's suicide prevention efforts. My statement today focuses on some of our more recent reviews highlighting opportunities where VHA can strengthen its suicide prevention efforts.

OVERVIEW OF VA SUICIDE PREVENTION EFFORTS AND DATA COLLECTION [1]

Our objective for this recent report was to answer several questions regarding VA's suicide prevention programs:

- How do you know if the programs are working?
- What percent of veterans who die by suicide have been under the care of VHA?
- Are data on suicides turned over to MH providers in real time?
- What risk factors associated with higher veteran suicides are being explored in depth, and by whom?
- What ways can be identified to gather more reliable suicide data?

How do you know if VA's suicide prevention programs are working?

Whether or not suicide prevention specific policies, programming, and strategies are having a positive effect may be ultimately reflected in outcome measures, specifically in identification of sustained downward trends in completed suicide rates, suicide attempt rates, and suicide re-attempt rates. There are limitations to determining the outcome measures of VHA's suicide prevention programs. The limitations included that VHA staff were not always notified when a veteran died by or attempted suicide, and suicide data were only as reliable as the information provided on the death certificate.

Population Based Measurement

We found that VHA staff tracked suicide rates of all veterans and other VHA users by matching suicide deaths from the National Death Index (NDI).[2]

When VHA leaders set up the VHA suicide prevention program, it was based on the hypothesis that improving access to high quality, evidence-based MH care, supplemented by specific suicide prevention programming, would affect suicide rates. However, capturing the impact of suicide prevention programming is challenging. While access and process measures identified variations in implementation of, or adherence to, MH and suicide prevention specific policies and programming, quantifying the impact of suicide prevention programming was more difficult.

Several VHA initiatives may have been simultaneously ongoing, thereby creating difficulties in teasing out individualized programmatic or operational impact at the individual facility and Veterans Integrated Service Network (VISN) level. In addition to not having a large enough population size to address global effect and co-occurring programming initiatives, site-to-site variability in population size, demography, and other variables rendered site-to-site comparisons problematic. For these reasons, evaluation of whether VHA efforts were working was most amenable to a national (or population level) analysis of the trend of suicide rates over time as a reflection of the impact of the portfolio of MH and targeted suicide prevention programming.

On a facility level, site-to-site variability impacted the accuracy in program evaluation-outcome analysis. This limitation may in part be circumvented by comparing intra-facility (same facility to itself) suicide rates over a several year period, or alternatively through use of predictive analytics based risk-modeling.

VHA Staff Measures Completed Suicide and Attempt Rates

The development and expansion of the joint VA/Department of Defense (DOD) Suicide Data Repository allowed for identification of suicide rates within the U.S. veteran population and other VHA users. VHA staff calculated completed suicide and attempt rates using both internal and external sources.

- *VHA Data Collection of Known Suicide and Suicide Events.* In 2008, VHA MH Services established an internal suicide surveillance and clinical support system. VHA SPCs enter data on suicides and suicide events (non-fatal attempts, serious suicidal ideation, and suicide plans) known to VHA into the Suicide Prevention Applications Network (SPAN) database, which is maintained on the VHA campus in Canandaigua, New York. Coordinators enter multiple data elements related to com-

[1] *Healthcare Inspection—Overview of VA Suicide Prevention Efforts and Data Collection*, https://www.va.gov/oig/pubs/VAOIG–16–00349–369.pdf, September 19, 2017.

[2] The NDI, a self-supporting service of National Center for Health Statistics (NCHS), is a component of the National Vital Statistics System. NDI is a centralized database of death record information compiled from state vital statistics offices. NCHS website, www.cdc.gov/nchs/data/factsheets/factsheet_ndi.htm. Accessed January 19, 2017.

pleted and attempted suicides. These data elements include the patient's medical and MH diagnoses; whether the patient had a history of previous attempts; whether the patient was seen at VA within 7 and 30 days of the suicide event; and the patient's military era.[3] The data limitation was that only suicides and attempted suicides known by VHA SPCs were captured in the data.

• *VHA Analyses of Known Suicide Attempts and Suicide Re-events.* Each year, the VHA Serious Mental Illness Treatment Resource and Evaluation Center and staff funded through the suicide prevention program at the Center of Excellence (COE) completes an annual analysis of non-fatal suicide attempts and re-attempts.

• *Matching to the NDI to Determine Rates among VHA Users.* The Serious Mental Illness Treatment Resource and Evaluation Center staff matched individual VHA services users with individual deaths coded as suicides in the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) NDI databases as a separate effort to calculate suicide rates. Veterans who stopped using VHA services in the prior year were considered possible deaths, and staff compared these veterans' information to the NDI database to determine actual veteran deaths and the subset of suicide deaths.

• Compared to the SPAN data, this methodology expanded the numerator from suicide deaths known to VHA to suicide deaths among all VHA services users. Compared to the state-based reporting agreement initiative, the NDI match captured deaths occurring within the U.S. that were reported by all 50 states.

What percent of veterans who die by suicide have been under the care of VHA?

On August 3, 2016, the VA Office of Suicide Prevention published the report, *Suicide Among Veterans and Other Americans 2001–2014*. This report provided a systematic assessment of characteristics of suicide among veterans—both those veterans who used VHA services and those who did not—and compared veteran suicide data, such as rates, to non-veteran suicide data. Key findings of the suicide mortality data in the report were obtained from the VA/DOD Joint Suicide Data Repository, which included:

• VA epidemiologists and other subject matter experts in the field conducted analyses of suicide data. The data showed that an average of 20 veterans died by suicide each day, 6 of the 20 were recent utilizers of VHA services—in the year of their deaths or the previous year.

• The risk for suicide was 21 percent higher among veterans when compared with U.S. civilian adults after adjusting for differences in age and gender.

Are data on suicides turned over to MH providers in real time?

We found that real time data on suicide, such as statistics on suicide rates by age, race/ethnicity, gender, suicide methods, and number of suicide attempts, were not available to MH providers in all states. Delays in collecting and sharing relevant data occurred in states that utilized paper-based reporting systems.

According to NCHS staff, approximately 75 percent of the vital records jurisdictions have implemented electronic death registration systems (EDRS). In jurisdictions with fully or partially functioning EDRS, funeral directors initiated the process by entering decedent demographic data. A medical certifier,[4] in the case of a natural death, or a coroner[5] or medical examiner,[6] in the case of an unnatural death,[7] then entered cause of death determinations into a computer data system. The completed record was electronically transmitted to the appropriate jurisdiction that, in turn, linked the information to the state's vital records statistics office. In jurisdictions with paper-based death reporting, the coroner, funeral director, medical certifier, and/or medical examiner filled out and transmitted paper forms via mail to the state's vital statistics office. The deployment of an electronic reporting system by all states and the use of such a system by funeral directors and medical certifiers allowed for the creation of more timely aggregate data. Such data was readily available to each state's vital statistics offices and to the NDI in near real time.

---

[3] Military era is the period in which a servicemember served in the military.

[4] A medical certifier can include physicians, nurse practitioners, dentists, and physician assistants.

[5] Coroners are not required to be physicians and typically have varied backgrounds; 80 percent are elected to their position, and they typically operate via a county-based system.

[6] Medical examiners are forensic pathologist physicians, typically appointed, and operate via a statewide system.

[7] An unnatural death can include drug overdose, suicide, or homicide.

What risk factors associated with higher veteran suicides are being explored in depth, and by whom?

We identified several VA and non-VA research projects and initiatives underway that included risk models, analyses of social media, and ongoing research by the COE and the Mental Illness Research, Education and Clinical Center (MIRECC).

VA leaders implemented a predictive analytics risk model to enhance clinical care. The model identifies which patients are potentially at highest risk of suicide and assists clinicians in implementing preventive interventions. At the time of our review, VA developed a model focused on providing individualized clinical and preventive care for patients who were in the highest 0.1 percent at risk for suicide. Another model in development focused on patients in the highest 5 percent at risk using a broader, population-based public health-oriented intervention.

We found non-VA researchers conducted pilot studies analyzing social media posts, aimed at identifying changes in patients' MH status and/or suicidal ideation to determine suicide risk factors. These researchers identified research barriers that included access to death and death-rate data, limited availability of grant funding, and privacy concerns. Other barriers included leaders' and clinicians' concerns regarding litigation, social media, and time and productivity allocations.

We found that National Center for Veterans Studies (NCVS)[8] researchers analyzed social media postings of military servicemembers who died by suicide and of a demographically matched control group. The research revealed that those who died by suicide were more likely to avoid interpersonal situations and/or lacked interest in participating in activities with others and had more frequent conversations about sleep problems. Researchers also found that immediately prior to a servicemember's death by suicide, the servicemember expressed difficulties related to interpersonal relationships and generalized stress. They were also less likely to communicate feelings of anger, which may suggest the military servicemembers had "resigned" themselves to their situation. Researchers found that servicemembers who died by suicide were less likely to express anger in their posts, but more likely to post about negative employment, access to or ownership of firearms, emotional distress, self-help, and implied suicide. An identified barrier with the research was the availability of grant funding and a "Catch–22" situation of needing pilot data to obtain grant funding for expanded research.

What ways can be identified to gather more reliable suicide data?

The collection of data related to suicide is useful in identifying and determining who is at the highest risk of attempting or completing suicide. Types of data collected included, but are not limited to, suicide rates by age, race/ethnicity, and gender; suicide methods; and number of suicide attempts. Once clinicians are able to determine who is at the highest risk for suicide, clinicians can then better target intervention and prevention plans.

We found that ways to gather reliable suicide data include:

Full Implementation and Use of Standardized Terminology such as the Self-Directed Violence Classification System and its Clinical Tool by VHA Clinicians[9]

Several definitions for suicide and non-fatal self-harm have been developed over the years. In 2003, CDC staff started work on what they called the self-directed violence surveillance that included uniform definitions and recommended data elements.[10]

In 2008, the then VA Secretary, Dr. James B. Peake, formed the "Blue Ribbon Work Group on Suicide Prevention in the Veterans Population" in order to improve VHA suicide prevention programs, research, and education. Unclear and unstandardized use of terms related to suicidal behaviors prompted the work group to recommend the adoption of a standard nomenclature for "suicide definition," "suicide," and "suicide attempts."

In 2009, MIRECC staff and other researchers in the field,[11] which included CDC researchers, collaborated to finalize terms incorporated into the Self-Directed Vio-

---

[8] NCVS is affiliated with the College of Social and Behavioral Science at the University of Utah and is not affiliated with the VA.

[9] The Self-Directed Violence Classification System (SDVCS) clinical tool is used by clinicians to help themselves, researchers, and others classify clinical cases. The tool is broken down into three decision trees: suicide thoughts only, behaviors without injury, and behaviors with injury.

[10] BB Matarrazo, TA Clemons, MM Silverman, LA Brenner. The self-directed violence classification system and the Columbia classification system algorithm for suicide assessment: a crosswalk, *Suicide Life Threatening Behavior*. June 2013; 43(3):235–249.

[11] CDC and the Senior Advisor to the Suicide Prevention Resource Center (and other research team members representing the VISN 19 MIRECC; the University of Colorado, Denver, School

lence Classification System (SDVCS). MIRECC staff developed a table to aid clinicians in understanding the SDVCS. The table is broken down into types, subtypes, definitions with examples, modifiers, and terms. The back of the table includes key definitions. MIRECC staff also developed the SDVCS clinical tool to help clinicians, researchers, and others classify clinical cases.[12]

In 2010, in response to a recommendation[13] by the Blue Ribbon Work Group, VHA announced the adoption of the SDVCS and the SDVCS clinical tool, which were adopted later by DOD. Implementation efforts have included promoting the use of the SDVCS clinical tool and distributing educational materials.

Medicolegal Death Investigation Reporting Training for Those Responsible for Completing the Medical Portion of the Death Certificate

A medicolegal death investigation is an investigation of a suspicious, violent, unexplained, or unexpected death. A medicolegal death investigator is responsible for the evidence and investigation related to the deceased person's remains and should have both a medical and legal educational background. In some states, centralized state medical examiner's offices perform death investigations, while other states utilize county/district-based medical examiner offices or a county-based mixture of medical examiner and coroner offices or county/district-based coroner offices. Completion of death reviews vary by jurisdiction. Investigators are responsible for determining and certifying the cause of death on the death certificate and reporting it to vital statistics.

Medicolegal death reporting is important because it is the responsibility of the death investigator to determine a cause of death and provide the information to the state's vital statistics department. Researchers and VHA staff use the information obtained from state vital statistics to determine suicide risk factors, and suicide methods or trends, which clinicians use to implement suicide interventions and prevention approaches.

According to NCHS staff, some challenges and training opportunities related to the difficulty in reporting suicides may include:

- Stigma—in small communities, medical certifiers may feel they are doing the family a favor if they do not choose suicide as manner of death. This could be for cultural or religious reasons, or because they believe, sometimes correctly, that the family will not receive death benefits if the death is ruled a suicide.
- Intent cannot always be determined—especially in deaths that involved high-risk behaviors such as single-car automobile crashes and drug overdose deaths.
- Some medical certifiers may have overly rigid or even incorrect standards by which they judge a death to be a suicide. For example, a medical certifier may require the leaving of a suicide note, when research has found that at most a third of suicide cases, confirmed in other ways, left notes.

According to National Association for Public Health Statistics and Information Systems staff, accurate reporting of the cause and manner of death is essential. Therefore, training of those who are responsible for completing the medical portion of the death certificate is critical to ensure reliable public health data.

DOD Sharing DOD Suicide Event Report Data with VHA

The DOD Suicide Event Report (DODSER) is the system of record for health surveillance of military servicemembers related to suicide deaths, suicide attempts, and suicidal ideation. The November 2014 DOD OIG report, *Department of Defense Suicide Event Report (DODSER) Data Quality Assessment*, stated:

> *DODSER data is not shared with VA for integration into VA's suicide surveillance database; the System of Record Notification limits DODSER data sharing and has prevented DOD from establishing a routine transfer of relevant information to VA; and VA is, therefore, not able to use DODSER data to better understand how military experience such as deployment history or in-service suicide attempts, impacts post-service suicide behavior.*

---

of Medicine; Wellstar Health System, Georgia; the University of Georgia; and the Department of Biostatistics and Informatics, Colorado School of Public Health).

[12] Bridgett B. Matarrazzo, Psy.D. The Self-Directed Violence Classification System (SDVCS), what it is and why it matters (PowerPoint presentation), VHA VISN 19 Mental Illness Research, Education and Clinical Center and the University of Colorado, School of Medicine Department of Psychiatry, developed in collaboration with CDC.

[13] The recommendation was to adopt a standard nomenclature/definition for suicide and suicide attempt that was consistent with other Federal organizations, such as the CDC and the scientific community.

The DOD OIG report also noted that section 1635 of Public Law 110–181 "...mandates accelerated exchange of healthcare information sharing between DOD and VA; and DOD Directive 6490.02E, Comprehensive Health Surveillance, requires the transfer of health surveillance data to VA, at a minimum when military servicemembers separate or retire from the service."

The DOD OIG report recommended that the Defense Health Agency update the appropriate System of Record Notification to:

- Allow for sharing of DODSER data with VHA staff, and
- Coordinate with VHA staff to ensure appropriate establishment of privacy policies to manage privacy issues while sharing DODSER data.

VHA staff attempted to obtain access to the DODSER data because it may provide useful information to VHA clinicians. Staff at the DOD National Center for Telehealth and Technology maintain the data; the Defense Suicide Prevention Office has a copy. At the time of our review, VHA and DOD Suicide Prevention program staff were developing a sharing agreement.

COMBINED ASSESSMENT PROGRAM SUMMARY REPORT—EVALUATION OF SUICIDE PREVENTION PROGRAMS IN VHA

In May 2017, we reported the results of our reviews at 28 VHA facilities through our Combined Assessment Program inspections conducted from October 1, 2015, through March 31, 2016, regarding suicide prevention programs.[14] We observed many positive practices, including that most facilities had a process for responding to referrals from the VCL and a process to follow up on high-risk patients who missed appointments. Additionally, when patients died from suicide, facilities generally created issue briefs and when indicated, completed mortality reviews or behavioral autopsies and initiated root cause analyses. However, we identified several system weaknesses.

- VHA requires that facilities complete five outreach activities each month for community organizations, MH groups, and/or other community advocacy groups; 18 percent of the facilities did not comply with this requirement.
- VHA requires that clinicians develop SPSPs for patients identified as at high risk for suicide; we found that 11 percent of high risk patients' EHR did not contain a suicide prevention safety plan. We found that clinicians did not document that they gave the patient and/or caregiver a copy of the plan 20.2 percent of the time for inpatients and 10.5 percent of the time for outpatients.
- VHA requires that facilities use Patient Record Flags (PRF) in inpatients' EHRs to identify and track patients at high risk for suicide. We identified several areas where improvement was required and recommended that when clinicians identify inpatients as at high risk for suicide, they place PRFs in the EHRs and notify the SPC of the admission. In addition, we recommended that when clinicians identify inpatients as at high risk for suicide, the SPC or MH provider evaluate the patient at least four times during the first 30 days after discharge. Further, when clinicians identify outpatients as at high risk for suicide, we recommended that they review the PRFs every 90 days and document the review and document justification for continuing or discontinuing the PRFs.
- VHA requires that primary care and MH providers receive training on suicide risk assessments and management of patients at high risk for suicide. Facilities generally provided suicide prevention training to new non-clinical employees (84.4 percent); however, 45.7 percent of the time clinicians did not complete suicide risk management training within 90 days of hire.

VHA agreed with our recommendations in this report. They provided action plans to address the recommendations and we are waiting for documentation of those actions to review and then we will determine if we can close the recommendations.

THE VETERANS CRISIS LINE

In the past 2 years, we have published two reports[15] inspecting the VCL in response to complaints about its operations. Both reports found organizational deficiencies and foundational problems in the VCL. All recommendations from the first report have now been addressed. The second VCL report, Healthcare Inspection—Evaluation of The Veterans Health Administration Veterans Crisis Line[16] identified

---

[14] https://www.va.gov/oig/pubs/VAOIG–16–03808–215.pdf. May 18, 2017

[15] *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York*, https://www.va.gov/oig/pubs/VAOIG–14–03540–123.pdf, February 11, 2016.

[16] *Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line*, https://www.va.gov/oig/pubs/VAOIG–16–03985–181.pdf, March 20, 2017.

a number of issues and that VHA is working on addressing the recommendations from that report.

Findings to Objective 1: VCL Failure to Respond Adequately to a Veteran Caller

We found that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. In addition to the failure to provide crisis intervention during the calls, VCL supervisory staff did not identify the deficiencies in their internal review of the matter.

Findings to Objective 2: VCL Governance Structure, Operations, and Quality Assurance Functions Have a Number of Deficiencies

Our inspection of the VCL governance structure, operations, and quality assurance functions identified a number of deficiencies. We found deficiencies in the VCL's processes for managing incoming telephone calls. We also found deficiencies in governance and oversight of VCL operations. The VCL staff did not have the capacity to answer all calls received, requiring VHA contract with four backup call centers not otherwise affiliated with VA to handle the overflow. We found that VHA contracting staff and Member Services and VCL leaders lacked an understanding of the contract terms and did not verify quality control aspects of contractor performance, resulting in deficient oversight. VCL Quality Management (QM) focuses on making and measuring improvements to a program with the prevention of problems being the primary objective.

We found continued deficiencies in the VCL QM program.

VCL policies were not consistent with existing VHA policies for veteran safety or risk management and did not incorporate techniques for evaluating available data to improve quality, safety, or value, to veterans.

Findings to Objective 4: A Number of Issues Raised by a Complainant and Referred by the Office of Special Counsel Were Substantiated

The OSC referred a complaint to VA on August 25, 2016 alleging inadequate training of VCL SSAs that resulted in deficiencies in coordinating immediate emergency services needed to prevent harm. We partially substantiated the OSC complainant's allegations.

IMPROVE COMMUNICATION BETWEEN PROVIDERS AND VETERANS' FAMILY

The OIG has reported on the death of many veterans with diverse mental health issues. Often, there is a significant communication gap between providers and the veteran's extended family. Communication regarding a veteran's mental health issues and related topics between providers and the veteran's extended family are restricted by a series of laws. The OIG believes that more effort should be devoted toward improving this communication. Efforts to pilot the use of advance directives and other mechanisms should be explored to determine if changes in information flow can improve the chances that a veteran will not choose suicide.

CONCLUSION

Strategies that envision extending VHA's efforts to prevent suicide to those veterans who do not receive care through VHA, that move beyond the prediction of who is at risk to an actionable timeframe when a veteran maybe at highest risk to attempt suicide, and efforts to advance communication through advance directives and related strategies may lessen the risk that a veteran will suicide.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee may have.

Chairman ISAKSON. Thank you, Dr. Daigh.

Mr. Bryan.

STATEMENT OF CRAIG BRYAN, Psy.D., ABPP, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR VETERANS STUDIES, UNIVERSITY OF UTAH

Mr. BRYAN. Mr. Chairman, Mr. Ranking Member, and Members of the Committee, I appreciate the opportunity to appear here today to discuss recent advances in veteran suicide prevention.

I will not read my written testimony in full but will highlight a number of key points.

In response to rising suicide rates, the VA has adopted and implemented numerous measures intended to prevent suicide among veterans. These efforts have led to improved access to care and serves as an example of how an agency can aggressively advance the cause of suicide prevention.

Several new studies reporting suicide-related outcomes among military personnel and veterans have been published in just the past 2 years. Although most of these studies enrolled military personnel, their findings are applicable to the VA and the veteran community as a whole.

As summarized in the attachment to my testimony, all of the interventions reduce suicidal ideation, but only two are associated with significant reductions in suicidal behavior—brief cognitive behavioral therapy and crisis response planning, which were found to reduce suicidal behavior by 60 to 76 percent. They are currently the only strategies shown scientifically to reduce suicidal behaviors among those who have served in the U.S. military. These treatments now serve as a foundation for several studies currently under way in the VA as well as in the DOD.

These latest findings not only confirm that suicidal behavior can be prevented among military personnel and veterans, they also show us how to do it. If these studies tell us anything, it is this: Some strategies work better than others, and simple things save lives. Tragically, few veterans are likely to receive these potentially lifesaving treatments for a number of reasons.

Today, I will focus on one particular barrier: inadequate training in mental health professionals. Two recent VA studies highlight this issue. In these studies, researchers found that a key suicide prevention strategy used by the VA was not associated with subsequent reductions in suicidal behavior, as was expected. The lack of effectiveness was attributed to poor quality implementation.

Of note, VA personnel often did not implement the procedure with sufficient reliability or specificity. Researchers from both of these studies concluded that the results pointed to insufficient training, and that additional training could actually change this course.

The problem of deficient training is not confined to the VA, though. Tragically, deficient training is endemic across our Nation's mental health professional training system.

A recent report from the American Association of Suicidology highlights this issue. The main findings of that report are also summarized in the attachment to my testimony. As you can see, a shockingly low number of mental health training programs provide any education or training about suicide to its students.

Furthermore, State licensing boards, the very bodies charged with protecting the public's health and safety from unqualified professionals, typically do not require any exams or demonstration of competency in suicide risk assessment or intervention.

The implications of this report are disturbing. The vast majority of our Nation's mental health professionals are unprepared to effectively intervene with suicidal veterans. This has critical implications for all veterans, both within and outside the VA.

We have long talked about the man barriers that stand in the way of a veteran receiving mental health treatment and have in-

vested heavily in removing those barriers. What unsettles me the most as a veteran is knowing that when a fellow veteran overcomes these barriers, he or she is unlikely to receive the treatments that are most likely to save their lives.

The sobering and uncomfortable truth is that we have made it easier for veterans to obtain treatment that does not work, especially those veterans who receive services from non-VA providers in their communities.

If we want veterans to benefit from the most recent advances in suicide prevention research, we will need to ensure implementation is accompanied by a comprehensive and robust training program.

Luckily, the past few years have also led to considerable advances in our understanding of the most effective ways of teaching these methods to others. Much of this knowledge has actually been obtained by the VA and their researchers.

In order to reverse the trend of veteran suicide, we must, therefore, think boldly and must be willing to disrupt the status quo. We need to adopt the newest strategies that have garnered the most scientific support, even though they may depart from existing procedures. We need to invest more heavily in training clinicians to use these procedures and create new initiatives to incentivize and support their implementation in clinical settings.

These changes should not just target the VA and the DOD, but all clinicians and all settings, as well as our universities and our training programs that are responsible for the readiness and preparedness of our mental health professionals.

In conclusion, we are at a critical turning point for veteran suicide prevention. Answers are now clear, and effective strategies have been identified. We must now take the steps needed to ensure these treatments and interventions are easily available to all veterans, both within the VA and in our communities.

Thank you very much.

[The prepared statement of Mr. Bryan follows:]

PREPARED STATEMENT OF CRAIG J. BRYAN, PSYD, ABPP, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR VETERANS STUDIES, ASSOCIATE PROFESSOR, DEPARTMENT OF PSYCHOLOGY, ASSOCIATE PROFESSOR, DEPARTMENT OF PSYCHIATRY, THE UNIVERSITY OF UTAH

Last year, the Department of Veterans Affairs released the results of the most comprehensive analysis conducted to date focused on suicide among U.S. military Veterans.[1] Building on previous findings, these analyses highlighted the continued problem of increased suicide risk among veterans, and yielded the frequently-cited statistic of "20 Veterans per day." Since 2001, the suicide rate among all Veterans has increased faster than the suicide rate among civilians, such that Veterans are 20% more likely than civilians to die by suicide. Differences across several Veteran subgroups have also been identified. Of greatest relevance to the current hearing, from 2001 to 2014 the suicide rate among Veterans who do not use VA services increased by 39% from 2001 to 2014, whereas the suicide rate among VA users increased by only 9%. For comparison, the suicide rate among civilians increased by 23% during this same period of time.

Taken together, this suggests a relative benefit for Veterans who have accessed and used VA services, although this observation is tempered by the fact that the suicide rate has nonetheless increased, rather than decreased, among VA users. Further tempering enthusiasm is the fact that only 30% of all Veterans who died by suicide were VA users, which means the considerable majority of suicides are occurring among Veterans external to the VA. This brings to the forefront a critical point about Veteran suicide prevention: our efforts must extend beyond the walls of our VA facilities. If we confine our efforts solely to the VA, we will not have a significant impact on overall Veteran suicide rates. We must therefore seek to com-

plement suicide prevention efforts in the VA with suicide prevention efforts in the community at large.

SIMPLE THINGS SAVE LIVES

Of all the many things we have learned about Veteran suicide over the past decade, the most important are the following: (1) some interventions work much, much better than others, and (2) simple things save lives. The past few years have been marked by dramatic gains in suicide prevention for military personnel and Veterans. In just the past two years, several treatments studies reporting suicide-related outcomes among military personnel and Veterans have been published,[2–8]proving us with critical information about how to most effectively save lives. Three of these studies tested treatments explicitly designed to reduce suicidal thoughts and behaviors, regardless of diagnosis, gender, age, or background.[2–4] Of these three, two proved to be especially potent: brief cognitive behavioral therapy,[2] a 12-session therapy that reduced suicide attempts by 60%, and crisis response planning,3 a single-session, 30-minute intervention that reduced suicide attempters by 76% as compared to typical treatment methods. Three other studies entailed PTSD-focused treatments[5–7] and one study entailed insomnia-focused treatment.[8] All found significant reductions in suicidal thoughts among servicemembers and veterans diagnosed with PTSD and/or insomnia, suggesting that other treatments targeting key risk factors among military personnel and veterans may also reduce suicide risk.

These results have prompted a new wave of research studies designed to build on these initial gains. For example, we are currently conducting a new treatment study in the VA testing a 3-session treatment that shares many of the elements of brief cognitive behavioral therapy and crisis response planning. In light of our previous research findings, we are hopeful that this new study will point us to a brief and cost effective method for reducing Veteran suicides that can be easily implemented within the VA.

The findings of the crisis response planning study hold particular promise for suicide prevention among Veterans, as this procedure can be taught to peer mentors, family members, teachers, and other non-healthcare providers. Just as we teach cardiopulmonary resuscitation (CPR) to non-healthcare providers so they are prepared to save a life in the event of a heart attack or other cardiac emergency, so can we teach crisis response planning to individuals within our communities to intervene with Veterans (and non-Veterans) experiencing mental health emergencies. No longer does suicide prevention have to be confined to hospitals and mental health clinics; all of us can learn the simple procedures involved in saving a Veteran's life.

The science is now clear: certain treatments save lives. The question we now face is how to use this knowledge. Training curriculum and methods already exist. We are therefore well-positioned to start teaching mental health professionals in the VA and our local communities how to put these practices into action.

ACCESS WITHOUT QUALITY ASSURANCE: MAKING IT EASY FOR VETERANS TO OBTAIN SERVICES THAT DON'T WORK

In order to advance Veteran suicide prevention, we must ensure that VA personnel and other members of the community are ready and able to respond appropriately. Over the past decade, the VA has adopted and implemented an impressive array of measures intended to prevent suicide including the expansion of the Veteran Crisis Line, improved same-day access for Veterans with urgent mental health needs, expanded tele-mental healthcare services, hiring of new mental health professionals and crisis hotline staff, and the establishment of collaborative relationships with community service providers. These efforts have collectively focused on improving access to care for all Veterans, but especially those Veterans who are eligible for VA services. Unfortunately, many of these initiatives have been aimed at improving access to care (i.e., making it easier for Veterans to "get in the door") with little to no structure or guidance for maximizing the effectiveness of these services. As a result, we have made it easier for Veterans to access services that do not work.

A recent study by VA researchers highlights this issue.[9] In that study, VA records were reviewed to assess the quality of safety planning, an intervention that is based on crisis response planning and, as such, intended to prevent suicidal behavior among high-risk VA users. Although the safety plan's efficacy has not yet been tested, it has nonetheless been recommended for use with suicidal patients based on expert consensus, and was implemented by the VA several years ago as a required part of a Veteran's comprehensive suicide prevention plan. Results of this study indicated that, on average, safety plans were of "moderate quality," showed consider-

able variability in quality, and lacked sufficient specificity to maximize its utility. For example, 23% of Veterans had "generic, copied and pasted statements" and only 29% showed evidence of ongoing review of the safety plan. In light of these findings, it is perhaps not surprising that safety plans did not correlate with the incidence of later suicide attempts. A second study conducted by an independent team of VA researchers has yielded similar findings.[10]

Researchers have concluded that high variability in the quality of safety plans are most likely attributable to insufficient training provided to VA healthcare professionals. In short, the VA mandated and implemented a suicide prevention strategy that was based on expert recommendations but no program was implemented to teach personnel how to effectively implement the strategy. Further compounding this issue was the adoption and implementation of standardized forms and templates, which fostered an understanding of safety planning as an administrative task rather than a suicide prevention intervention. As a result, a promising suicide prevention strategy was rendered inert. Simply put, creating forms and posting user manuals online are not enough to ensure that individuals know how to competently and effectively use the procedure. Reading books and filling out forms will not save lives; training matters.

TEACHING BAD MEDICINE: DEFICITS IN U.S. MENTAL HEALTH PROFESSIONAL TRAINING

The aforementioned training deficits associated with VA suicide prevention efforts are not entirely the VA's fault. A recent report from the American Association of Suicidology (AAS)[11] brings into focus the stunning inadequacies of our Nation's mental health professional training programs. As noted in this report, research studies have found that only half of psychology training programs, less than 25% of social work programs, 6% of marriage and family therapy programs, and 2% of counselor education programs provide any amount of education or training focused on suicide as a part of their curriculum. Relatedly, only 28% of psychiatry program training directors report the provision of skills-based suicide-focused to psychiatry residents. When such education is available, it is often very limited (i.e., less than a few hours over multiple years of training) and does not always include applied skills training. The AAS report further notes that state licensing boards for most mental health professions—the bodies charged with protecting the public's health and safety from unqualified professionals—do not require any exams or demonstration of competency in suicide risk assessment or intervention.

The AAS report highlights an urgent and shocking reality: the vast majority of our Nation's mental health professionals are stunningly unprepared to effectively intervene with suicidal individuals. In short, the mental health professionals and trainees hired by the VA are unlikely to have any exposure to contemporary, state-of-the-art practices in suicide prevention like brief cognitive behavioral therapy or crisis response planning, the only interventions to date that are proven to reduce suicidal behavior among military personnel and veterans.

Because most of the VA's mental health professionals were trained in U.S. programs, the near-complete absence of training and education in scientifically-supported methods for suicide risk, PTSD, and other such conditions means an unsettling number of VA employees have little to no education or practical experience using the most effective methods for suicide prevention. As a result, the VA must expend an inordinate amount of time, resources, and taxpayer dollars to provide training aimed at teaching its personnel the basic principles and concepts that should have been provided during graduate or medical school.

NEXT STEPS IN VETERAN SUICIDE PREVENTION

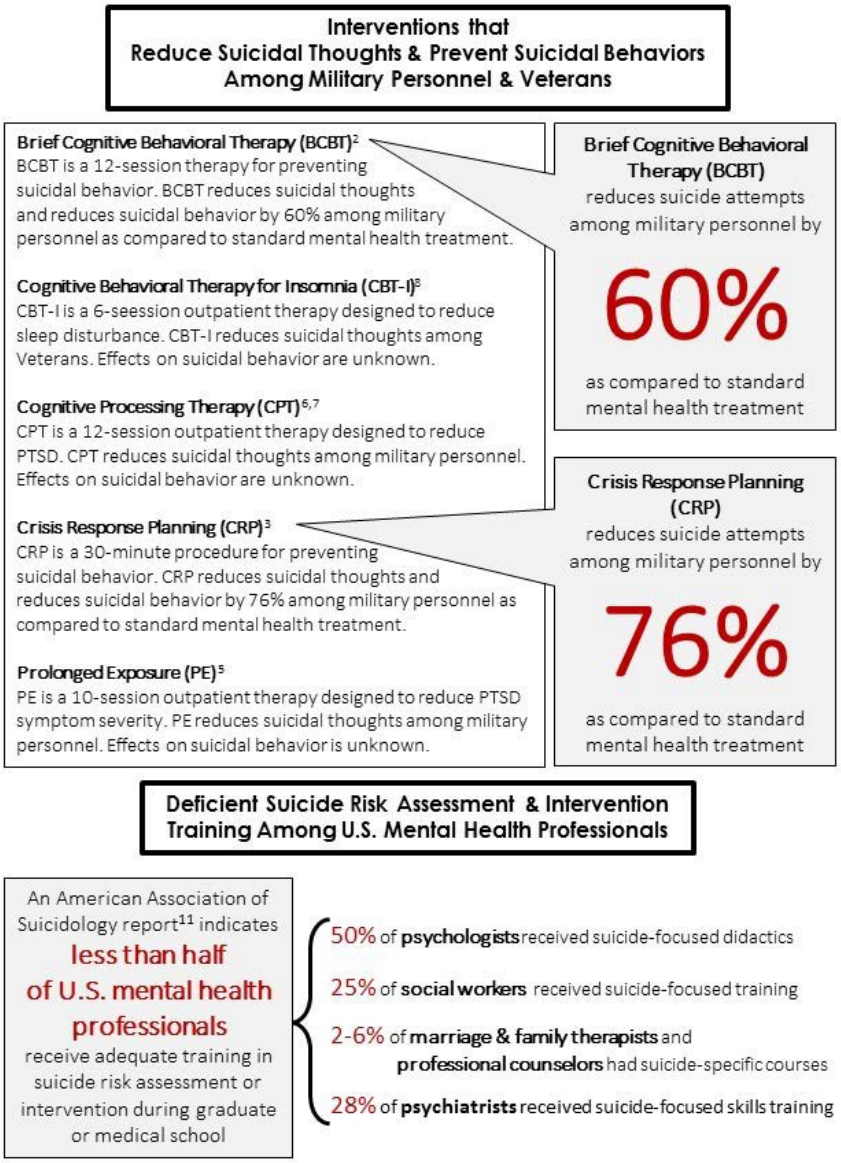
If Veterans are to benefit from the most recent advances in suicide prevention research, implementation of newer, more effective strategies like brief cognitive behavioral therapy and crisis response planning must be accompanied by comprehensive and robust training programs. Luckily, the past few years have also led to considerable advances in our understanding of the most effective ways for teaching these methods. Much of this knowledge has been obtained by VA researchers and staff as part of its various training programs and initiatives. These results and lessons learned can provide critical clues and guidance for effectively implementing new strategies and treatments.

Reversing the trend of Veteran suicide will require bold and innovative thinking that will undoubtedly shake up and disrupt the status quo. This may require changes to existing policies and procedures, and the development and creation of new initiatives. The next steps in Veteran suicide prevention will therefore require a combination of strategies that might include the following:

1. The adoption of new strategies that have garnered strong scientific support (e.g., brief cognitive behavioral therapy, crisis response planning), even though these strategies may depart from existing procedures;
2. Investment in mental health professional training to ensure competent and effective implementation of these procedures;
3. Creation of incentive programs that reward mental health clinicians for completing training and demonstrating competency in effective suicide prevention strategies;
4. Requiring mental health training programs to provide training in scientifically-supported suicide prevention methods;
5. Encouraging accrediting bodies of graduate and medical training programs across mental health disciplines to include requirements for the training of suicide risk assessment and intervention to students; and
6. Encouraging state licensing boards to require demonstrations of competency specific to suicide risk assessment and intervention.

SIMPLE THINGS SAVE LIVES

Of all the many things we have learned about Veteran suicide over the past decade, the most important are the following: (1) some interventions work much, much better than others, and (2) simple things save lives. The past few years have been marked by dramatic gains in suicide prevention for military personnel and Veterans. In just the past two years, several treatments studies reporting suicide-related outcomes among military personnel and Veterans have been published,[2–8]proving us with critical information about how to most effectively save lives. Three of these studies tested treatments explicitly designed to reduce suicidal thoughts and behaviors, regardless of diagnosis, gender, age, or background.[2–4] Of these three, two proved to be especially potent: brief cognitive behavioral therapy,[2] a 12-session therapy that reduced suicide attempts by 60%, and crisis response planning,[3] a single-session, 30-minute intervention that reduced suicide attempters by 76% as compared to typical treatment methods. Three other studies entailed PTSD-focused treatments[5–7] and one study entailed insomnia-focused treatment.[8] All found significant reductions in suicidal thoughts among servicemembers and veterans diagnosed with PTSD and/or insomnia, suggesting that other treatments targeting key risk factors among military personnel and veterans may also reduce suicide risk.



References Cited

1. Department of Veterans Affairs Office of Suicide Prevention (2016). Suicide Among Veterans and Other Americans, 2001–2014. Washington, DC: Department of Veterans Affairs.
2. Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., . . . & Wilkinson, E. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. American Journal of Psychiatry, 172, 441–449.
3. Bryan, C. J., Mintz, J., Clemans, T. A., Leeson, B., Burch, T. S., Williams, S. R., . . . & Rudd, M. D. (2017). Effect of crisis response planning vs. contracts for

safety on suicide risk in US Army soldiers: a randomized clinical trial. Journal of Affective Disorders, 212, 64–72.
4. Jobes, D.A., Comtois, K.A., Gutierrez, P.M., Brenner, L.A., Huh, D., Chalker, S.A., . . . , & Crow, B. (in press). A randomized controlled trial of the Collaborative Assessment and Management of Suicidality versus enhanced care as usual with suicidal soldiers. Psychiatry: Interpersonal & Biological Processes.
5. Brown, L.A., McLean, C.P., Zang, Y., Zandberg, L., Mintz, J., Yarvis, J.S., . . . , & Foa, E.B. (in press). Does prolonged exposure increase suicide risk? Results from an active duty military sample. Journal of Affective Disorders.
6. Bryan, C.J., Clemans, T.A., Hernandez, A.M., Mintz, J., Peterson, A.L., Yarvis, J.S., & Resick, P.A. (2016). Evaluating potential iatrogenic suicide risk in trauma-focused group cognitive behavioral therapy for the treatment of PTSD in active duty military personnel. Depression and Anxiety, 33, 549–557.
7. Resick, P.A., Wachen, J.S., Dondanville, K.A., Pruiksma, K.E., Yarvis, J.S., Peterson, A.L., & Mintz, J. (2017). Effect of group vs individual cognitive processing therapy in active-duty military seeking treatment for Post Traumatic Stress Disorder: a randomized clinical trial. JAMA Psychiatry, 74, 28–36.
8. Trockel, M., Karlin, B. E., Taylor, C. B., Brown, G. K., & Manber, R. (2015). Effects of cognitive behavioral therapy for insomnia on suicidal ideation in veterans. Sleep, 38, 259–265.
9. Gamarra, J.M., Luciano, M.T., Gradus, J.L., & Stirman, S.W. (2015). Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA Healthcare System. Crisis, 36, 433–439.
10. Green, J.D. , Kearns, J., Marx, B., Nock, M., Rosen, R., & Keane, T. (2016). Evaluating safety plan effectiveness: do safety plans tailored to individual veteran characteristics decrease risk? In D.J. Lee (Chair), Preventing Suicide Among Military and Veteran Population. Paper presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York.
11. Schmitz, W.M., Allen, M.H., Feldman, B.N., Gutin, N.J., Jahn, D.R., Kleespies, P.M., Quinnett, P., & Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology task force report addressing serious gaps in U.S. mental health training. Suicide and Life-Threatening Behavior, 42, 292–304.

Chairman ISAKSON. Thank you very much, Dr. Bryan. We appreciate your testimony.

Now from the great State of Montana, the Executive Director of the National Alliance for Mental Illness, NAMI, in Montana, Mr. Kuntz.

STATEMENT OF MATTHEW KUNTZ, EXECUTIVE DIRECTOR, NATIONAL ALLIANCE ON MENTAL ILLNESS FOR MONTANA

Mr. KUNTZ. Yes, sir. Chairman Isakson, Ranking Member Tester, and distinguished Members of the Committee, on behalf of NAMI Montana and NAMI, I would like to extend our gratitude for the opportunity to share with you our views and recommendations.

We applaud the Committee's dedication in addressing the critical issues around veteran suicide. As someone who has personally lost a family member that was a veteran to PTSD, I just want to give you my sincere thanks.

Montana has the highest suicide rate in the country, with 68.6 per 100,000. This is significantly higher than both the National Veterans Suicide Rate and the Western Region Veteran Suicide Rate.

As an organization that is immersed in suicide prevention, we think it is very important that you have a framework to understand suicide. The model that we use is the Diathesis Stress Model, in which a combination of biological susceptibility and environmental factors then lead to malfunctioning neuron communications, which develop into suicidal ideation behavior and other symptoms.

Examples of the factors of biological susceptibility are genetics and physical trauma. Examples of factors on the environmental side are emotional trauma, but on the positive, therapy and support of family.

You will note that I will not be covering lethal means restriction because I believe it is incredibly hard to legislate that, but it is an important factor.

Montana is a very rural State, with an average of fewer than six persons per square mile. This creates unique challenges for our health care providers, and we are deeply in need of more mental health providers.

I will move on to our recommendations; first, to offer public health interventions proven to reduce suicide during critical points of the military and veteran experience.

NAMI Montana was influential in bringing the Youth Aware of Mental Health program to the United States, and we would like to offer it as a template of something that is proven to work in other populations. And it would be perfect to bring over to this one.

Second recommendation: establish a clear policy goal to improve the diagnostic treatment system. The target that NAMI Montana recommends to the Committee is to task the VA to work with the Department of Defense, the National Institute of Mental Health, and private partners to identify and prepare two additional brain diagnostic measurements for clinical work in the VA by the fall of 2020.

Our next recommendation is to develop a plan for treatment-resistant mental health conditions. Roughly a third of mental health conditions do not respond to traditional treatments, and this is a big issue. And it is an issue that is not addressed in Montana. The Montana VA has nothing in our State to address treatment-resistant depression.

This is very personal to me because I lost a dear friend who was a veteran in September 2015 to treatment-resistant depression, and to watch his options slowly slip away was one of the hardest things I have ever seen.

Montana Blue Cross and Blue Shield supports TMS treatment for treatment-resistant depression. I do not know why the Montana VA does not.

Next recommendation: expand access to tele-psychiatry, then make online cognitive behavioral therapy available to all veterans.

We also believe the VA should expand the availability of automated suicide risk assessment scales, develop a prize to create and validate a medical screening tool to determine which patients are at risk of developing side effects from clozapine, develop a public-facing online research directory for non-VA resources, create a more synergistic relationship between the VA and community mental health centers—there are over 1,300 community health centers across the country, and we should be working with those to care for our veterans—increase the VA's collaboration with outside researchers, and finally establish a continuity of care pipeline for veterans directly from the Department of Defense to VA/community providers.

Thank you again for the opportunity to testify in front of this honorable Committee. Your attention to this issue means a lot to me, our entire NAMI organization and their families.

[The prepared statement of Mr. Kuntz follows:]

PREPARED STATEMENT OF MATT KUNTZ, J.D., EXECUTIVE DIRECTOR, NAMI MONTANA, NATIONAL ALLIANCE ON MENTAL ILLNESS



I. INTRODUCTION

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND DISTINGUISHED MEMBERS OF THE COMMITTEE, On behalf of NAMI Montana, and NAMI, the National Alliance on Mental Illness, I would like to extend our gratitude for the opportunity to share with you our views and recommendations regarding "#BeThere: What More Can Be Done to Prevent Veteran Suicide?" NAMI Montana and the entire NAMI community applauds the Committee's dedication in addressing the critical issues around veterans' suicide. NAMI is the Nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support and research, and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

NAMI Montana is also a member of the Coalition to Heal Invisible Wounds (Coalition). The Coalition was founded in February 2017 to connect leading public and private scientific investigators of new PTSD and Traumatic Brain Injury (TBI) treatments with policymakers working to improve care for veterans. Coalition members support innovators at all stages of the therapy development life-cycle, from initial research to late-stage clinical trials. The Coalition aims to spur strategic Federal institution support to create better treatment and care for veterans suffering from PTSD and TBI. The Coalition seeks to work with VA and the Department of Defense (DOD) on immediate improvements to public-private partnerships for:

- Developing and validating PTSD and TBI biomarkers and diagnostics;
- Providing research access to PTSD and TBI datasets;
- Providing institution-wide support for PTSD clinical trials;
- Improving messaging of relevant policies and practice guidelines; and,
- Providing up-to-date education around clinical trial endpoints and drug therapy options.

The Coalition also seeks renewed investment in VA-funded PTSD research, and an expansion in the types of research supported. Through strategic collaboration between the public and private sectors, the Coalition believes that our Nation can improve treatments for servicemembers and veterans suffering from PTSD.

II. SUICIDE FROM THE MONTANA PERSPECTIVE

A. Montana's Veteran Suicide Rate

According to the U.S. Department of Veterans Affairs' recently released report, Montana has the highest veteran suicide rate in the country. This rate of 68.6 per 100,000 is significantly higher than both the National Veterans Suicide Rate of 38.4 per 100,000 and the Western Region Veteran Suicide Rate of 45.5 per 100,000.

Montana, Western Region[a], and National Veteran Suicide Deaths[bc], by Age Group, 2014

Age Group	Montana Veteran Suicides	Western Region Veteran Suicides	National Veteran Suicides	Montana Veteran Suicide Rate	Western Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	58	1,970	7,388	68.6	45.5	38.4
18–34	<10	276	1,171	--	64.7	70.4
35–54	21	559	2,193	117.1	56.0	47.7
55–74	19	692	2,594	46.6*	35.9	30.4
75+	10–20	443	1,430	--	45.2	32.0

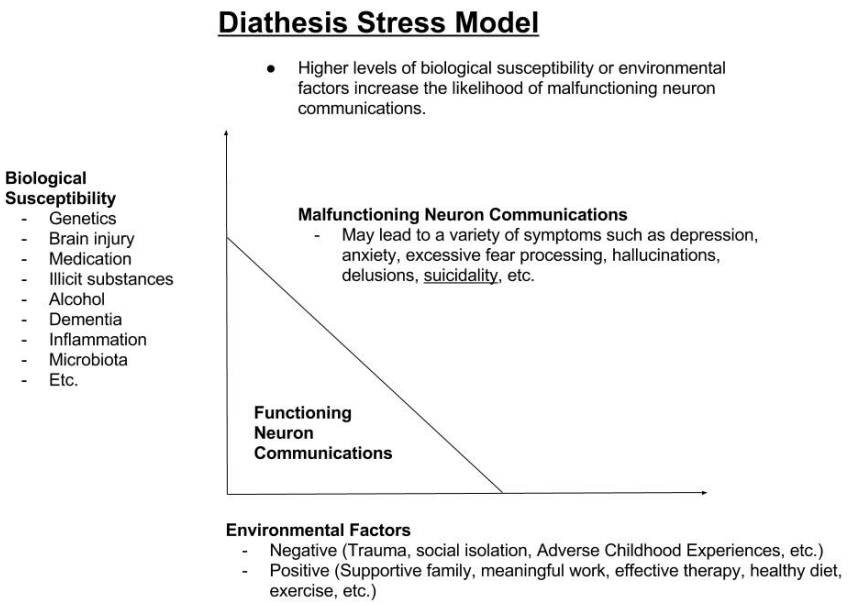
* Denotes that this rate was calculated with fewer than 20 in the numerator and the rate should be considered unreliable.

After accounting for differences in age, the Veteran suicide rate in Montana was significantly higher than the national Veteran suicide rate (p=0.0008)[d].

[1]

B. General Suicide Prevention Framework

As an organization immersed in suicide prevention policy, in a state that regularly has the country's highest suicide rate, NAMI Montana has considered a number of different tools for helping explain the complex realities of suicide, suicide prevention, and treatment for suicidal behavior. We prefer to use a version of the Diathesis Stress Model to explain how suicidal behavior arises via malfunctioning neuron communications that stem from a combination of biological susceptibility and environmental factors.[2] This model has held up for years for the variety of suicide factor data that has arisen in both military and veteran populations. It is easily grasped by a wide variety of populations, from families affected by suicide, clinicians, and policymakers.



This model also explains other conditions that generally stem from malfunctions in neuron communications of the brain, such as depression, bipolar disorder, schizophrenia, substance abuse, etc. are substantial risk factors for suicide. These condi-

[1] Department of Veterans Affairs, "Veteran Suicide Data Sheets," https://www.mentalhealth.va.gov/docs/data-sheets/Suicide-Data-Sheets-VA-States.pdf.

[2] *See e.g.*, Gandubert, C., et al. "Biological and psychological predictors of Post Traumatic Stress Disorder onset and chronicity. A one-year prospective study." Neurobiology of stress 3 (2016): 61–67; Goforth, Anisa N., Andy V. Pham, and John S. Carlson. "Diathesis-stress model." *Encyclopedia of Child Behavior and Development*. Springer US, 2011. 502–503.

tions can be activated without trauma experience and are critical to understanding why some veterans are in danger of committing suicide even if they have not been in combat.

C. Treatment Challenge and Opportunities in Montana

Montana is the Nation's fourth largest state with over 147,000 square miles, and just over one million people residing in Big Sky Country. We are honored to have one of the Nation's highest per capita rates of military service in the country. Montana is home to more than 108,000 veterans, representing 16.2% of the total state adult population; the second highest population density of veterans in the United States.[3] Additionally, Montana is home to twelve tribal nations and seven reservations.[4] The reservations comprise nine percent of the state's land base. Montana is home to over 66,000 people of Native American heritage. The majority of Montana's native population live on reservations. Montana residents that qualify for Indian Health Services (IHS) are served by the Billings Area Indian Health Services, which delivers care to over 70,000 people in the states of Montana and Wyoming.[5]

The very rural nature of the state, with an average of fewer than six persons per square mile, creates unique challenges for our healthcare providers. It is very hard for rural Montana communities to recruit and retain healthcare workers. Our rural healthcare professionals have to walk a tightrope between finding enough patients to make a living and pay off their student loans, while not being overwhelmed by the workload. It is a difficult balance to strike due to variable patient rates and a shortage of relief for times of overflow.

These challenges are especially difficult for treating serious mental illness (SMI) because of the complex nature of these illnesses, the level of care required for mental health crises, and the ongoing treatment needs of persons living with these conditions. Our state is in desperate need of more mental health professionals, particularly in our more rural communities.

While the challenge of reducing Montana's veteran suicides can feel overwhelming due to the vast rural areas, it is important to point out that Montana's most recent Suicide Mortality Review Report illustrated that over half of Montana's veteran suicides, during the reporting period, occurred in Montana's six most populous counties.[6,7] Lewis and Clark County is the least populous of those six counties in the state, and it hosts the Montana VA Healthcare System headquarters and hospital. The remaining five counties has either a Vet Center,[8] a VA Community-Based Outpatient Center (CBOC),[9] or both. These communities also have psychiatrists, psychiatric nurses, and therapists available through private nonprofit mental health centers and federally Qualified Health Centers (FQHCs).

It is important to continue to extend effective care out into rural communities, but it is also clear that a lack of resources is not always the problem. There are many other areas that also need to be addressed.

III. SUICIDE AMONG U.S. VETERANS

The Interdepartmental Serious Mental Illness Coordinating Council (ISMICC), created under the 21st Century Cures Act of which NAMI is a non-Federal member, received an initial presentation from John McCarthy, Ph.D., M.P.H. of VA Office of Mental Health and Suicide Prevention at the Council's first meeting. NAMI Montana and our national organization was particularly interested in the data presented regarding mental health conditions and suicidality among VHA users. As the Committee is well aware, only 6 of the 20 veterans (approximately 30%) who die each day by suicide receive any care from VHA. The data presented and shared below illustrates that bipolar disorder (BPD) is consistently the mental health condition affecting most veterans utilizing VHA who die by suicide.

---

[3] Taken from the State of Montana's recent grant application to HRSA

[4] Indian Education for All, "Montana Indians: Their History and Location." (April 2009) http://opi.mt.gov/pdf/ indianed/resources/MTIndiansHistoryLocation.pdf

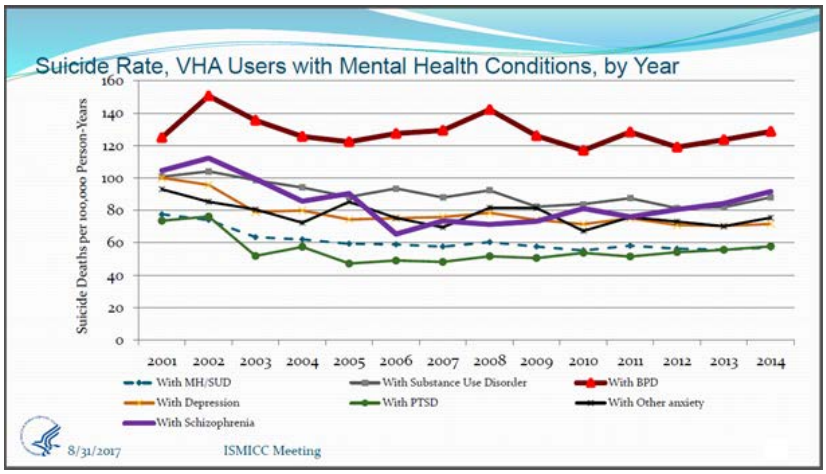
[5] "Montana Department of Public Health and Human Services Report to the 2013 Legislature: The Montana Medicaid Program State Fiscal Years 2011 and 2012." http://www.dphhs.mt.gov/publications/2013Medicaidreport.pdf

[6] 2016 Montana Suicide Mortality Review Report. Page 49. http://www.sprc.org/sites/ default/files/resource-program/2016%20Montana%20Suicide%20Mortality%20Review%20Report.pdf

[7] "Montana Counties by Population," https://www.montana-demographics.com/counties_by_population

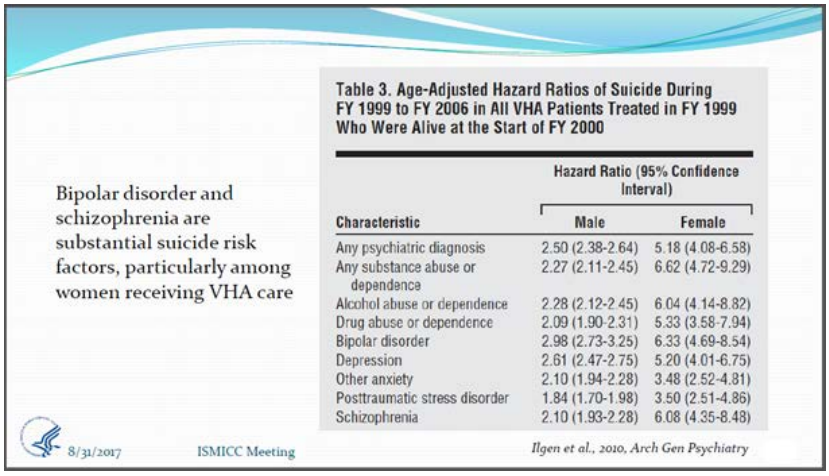
[8] "Montana VA Healthcare System," https://www.montana.va.gov/locations/other_facilities.asp

[9] "Montana VA Healthcare System," https://www.montana.va.gov/locations/Bozeman_VA_Community_Based_Outpatient_Clinic.asp



10

Additionally, when examining only female veterans utilizing VHA care, the data presented in the corresponding table illustrates a statistically significant finding that BPD and schizophrenia are among the highest associated mental health conditions for suicide risk.



11

NAMI Montana would like to underscore that by highlighting this data, we're not suggesting any research funding or focus be removed from PTSD. Rather, we are seeking to draw the Committee's attention to this data to illustrate the need for a more holistic and comprehensive research approach around mental health conditions not typically associated with the veterans community.

NAMI Montana applauds Secretary Shulkin for identifying veteran suicide prevention as his top clinical priority for VA, and placing it among VA's top 5 priorities overall. Considering 70% of veterans who die by suicide are not under VA's care, we agree with his assessment that VA cannot alone solve this crisis, rather "[vet-

[10] McCarthy, John. (2017). U.S. Department of Veterans Affairs. "Federal Advances to Address Challenges in SMI and SED." [Powerpoint slides]. Retrieved from: https://www.samhsa.gov/sites/default/files/meeting/agendas/ismicc-morning-slides.pdf

[11] Ilgen, et. al., "Psychiatric diagnoses and risk of suicide in veterans." (2010), Arch Gen Psychiatry.

eran suicide] is a national public health issue that requires a concerted, national approach."[12] While VA has taken positive steps to implement better suicide prevention programs at the national level, our organization firmly believes that we will not begin to truly make a positive, impact in ending this national tragedy until a national effort including all public, private and non-profit stakeholders are engaged and working together.

An effort we are interested in and believe may have promise to help in earlier identification is the REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment) Initiative launched by VA last fall. As the Committee is aware, REACH VET analyzes existing data from the health records of veterans to identify those at a statistically elevated risk for suicide, hospitalization, illness or other adverse outcomes—which allows providers to deliver, in some cases, pre-emptive care and support for veterans. As we know for certain and advocate for at NAMI Montana and throughout our larger NAMI organization, early identification and intervention of mental health conditions is a game changer in the ability to treat, and many times is the difference in life or death.

IV. HIGHLIGHTS AND RECOMMENDATIONS

A. Offer Public Health Interventions Proven to Reduce Suicide During Critical Points of the Military and Veteran Experience

In April 2015, The Lancet published an article on the "The Saving and Empowering Young Lives in Europe" (SEYLE) study. The SEYLE study is a multicenter, cluster-randomized controlled trial with a sample which consisted of 11,110 adolescent pupils, median age 15 years (IQR 14–15), recruited from 168 schools in ten European Union countries. In this study, the Youth Aware of Mental Health (YAM) program demonstrated more than a 50% reduction of incident cases of suicide attempts, and of incident cases of severe suicidal ideation and plans, as well as a significant reduction by 30% of incident cases with moderate to severe depression was observed.[13]

Dr. Matt Byerly, MD and his team at the Center for Mental Health Research and Recovery at Montana State University and the University of Texas—Southwestern, brought this innovative five-hour intervention to high schools in Montana and Texas during the 2016–2017 school year. The evidence resulting from this program was incredibly positive and will hopefully spur further expansion into a large randomized controlled trial which would support a large-scale roll out of this critical intervention.

NAMI Montana supported the effort to bring YAM to the United States. While this particular course is focused on suicide prevention in adolescents, there does not appear to be any reason why a similar program could not be customized and offered to servicemembers during Advanced Individual Training (AIT), and while discharging from the military. This five-hour course can be given over a series of three to five weeks. A program that had the similar effects as YAM on reducing suicide attempts, ideation, and depression among servicemembers and veterans could be a great step forward in our shared long-term goal in reducing veteran suicides.

B. Establish a Clear Policy Goal to Improve the Diagnostic Treatment System

In NAMI Montana's experience, effective mental health treatment is essential to the long-term reduction of a person's risk of suicide. One of the largest challenges in obtaining effective treatment is receiving an early and accurate diagnosis. The Federal Government has invested a significant amount of funds in a variety of agencies to make the brain condition diagnostic process more tangible and accurate than the current process, which relies almost solely on patient survey questionnaires. However, none of the agencies have received a clear policy target from Congress for achieving this goal.

The target that NAMI Montana recommends for the Senate Veterans' Affairs Committee is to task VA to work with DOD, the National Institute of Mental Health (NIMH), and private partners to identify and prepare two additional brain health diagnostic measurements for clinical work at all VA facilities by fall 2020. These tests are not to be based upon survey questions of the veteran or their family. Due to the short timeframe, the tests would have to be based upon existing technology that would support the current diagnostic process, rather than developing some new technology that would replace it.

---

[12] U.S. Department of Veterans Affairs. (March 9, 2016). "VA announces additional steps to reduce Veteran suicide." Retrieved from: http://www.blogs.va.gov/ VAntage/26330/va-announces-additional-steps-reduce-veteran-suicide/

[13] Wasserman, Danuta, et al. "School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial." The Lancet 385.9977 (2015): 1536–1544.

These tests could be as relatively uncomplicated as a computerized executive functioning test, hair cortisol test, or blood inflammation test. Or they could be more complicated like an electroencephalography (EEG) or functional near infrared spectroscopy (fNIRS) test. Researchers at Cohen Veterans Bioscience have analyzed this proposal and agree that it is ambitious but doable with the current state of technology.

C. Expand the Availability of Telehealth and Automated Care Services as Broadly as Possible

(1) Expand Access to Telepsychiatry

Telepsychiatry and other telehealth services are essential to providing effective care throughout Montana and other rural states. These services have been expanding throughout Montana over the last decade through Federal, state, and private investments and they appear to be hitting critical mass. The VA, AWARE Inc., American Telepsychiatry, and many other clinicians have all provided telepsychiatry services to Montanans suffering from SMI. The Montana Legislature recently passed a bill which requires all health insurers in the state to cover telemedicine services. Montana State Senator Ed Buttrey sponsored this legislation that easily passed both houses with bipartisan support. The Federal Government's investment in these services combined with a firm legal footing and ever-improving technology, has given telepsychiatry momentum in the push to provide more rural Montanans with effective psychiatric coverage. The VA should support these efforts as much as possible.

(2) Make Online Cognitive Behavioral Therapy (CBT) available to all Veterans

Another innovative suicide prevention program in Montana is a research project led by Dr. Mark Schure, Ph.D. at Montana State University which will complete a randomized controlled trial of THRIVE for adults across Montana. THRIVE is an interactive computerized Cognitive Behavioral Therapy program (cCBT) that helps people identify ways to improve their mood. It is accessed online via computer, tablet or smartphone. In other populations, THRIVE has been shown to decrease the frequency of depressive symptoms and improve quality of life.[14] In this study, participants will use the program for a year anonymously as often as needed during times of scheduled access.

This research project, funded by the National Institutes of Health (NIH), is a partnership between Montana State University (MSU) researchers, One Montana, and WayPoint Health Innovations, the program developer. This project is supported from MSU's Center for Mental Health Research and Recovery. The purpose of this research is to test the effectiveness of the THRIVE program to help Montanans decrease the frequency of depressive symptoms and improve their quality of life. While it is too early to tell the results of this particular iteration of cCBT research, the overall body of research of cognitive behavioral therapy (CBT) for health conditions that affect veterans is positive, including alcohol abuse.[15]

The VA should embark upon a process to make high-quality, engaging cCBT available to all veterans.

(3) VA Should Partner to Expand the Availability of Automated Suicide Risk Assessment Scales

Dr. Eric Arzubi, MD has brought the University of Vermont's Automated Suicide Risk Assessment Tool (Assessment Tool) to Montana's largest hospital system, the Billings Clinic. The Assessment Tool is designed to replicate the thinking of an experienced psychiatrist in the evaluation of near-term suicide risk.[16] The Assessment Tool uses a neural network-based algorithm to assess suicide risk in emergency department and medical inpatients. For levels of suicide risk, the model tool takes less

---

[14] *See e.g.*, Whiteside U, Richards J, Steinfeld B, et al. Online Cognitive Behavioral Therapy for Depressed Primary Care Patients: A Pilot Feasibility Project. *The Permanente Journal*. 2014;18(2):21–27. doi:10.7812/TPP/13–155.

[15] Kiluk, Brian D., et al. "Randomized Trial of Computerized Cognitive Behavioral Therapy for Alcohol Use Disorders: Efficacy as a Virtual Stand-Alone and Treatment Add-On Compared with Standard Outpatient Treatment." *Alcoholism: Clinical and Experimental Research* 40.9 (2016): 1991–2000.

[16] Jennifer Nachbur, "Study Shows UVM Suicide Risk Assessment Tool Performs Like Psychiatrist" (June 8, 2016) https://med.uvm.edu/com/news/2016/07/12/study_shows_uvm_suicide_risk_assessment_tool_performs_like_psychiatrist

than a minute to predict a psychiatrist's assessment at between 91 and 94 percent.[17] Patients reported that the tool was easy to complete.

The VA can adopt the Assessment Tool, or a similar model tool, in its emergency settings and partner with the developers to ensure that it can be easily and seamlessly utilized in a variety of electronic health record systems throughout the U.S.

D. Develop a Plan for Treatment Resistant Mental Health Conditions

Treatment resistance in mental health conditions is a significant barrier to effective care for recovery from these potentially fatal conditions. It is estimated that one-third of people diagnosed with schizophrenia have a treatment-resistant form of the condition.[18] Treatment resistance is one of the "the biggest challenges" in treating bipolar disorder, which as noted above affects many veterans.[19] It is also estimated that roughly one-third of individuals with depression "continue to be resistant to available therapeutic options, and hence pose a major therapeutic challenge to mental health experts." [20]

From my position in Montana, it appears that VA does not have a strategy to care for veterans with treatment-resistant mental health conditions. As an example, VA does not have any means or tools available to treat veterans with treatment-resistant depression within the state of Montana. The best option that a Montana veteran with treatment resistant depression may have to receive care is to travel to Wyoming or another state for Electroconvulsive Therapy (ECT). ECT can be an effective option for treatment-resistant depression, but it is invasive and can be debilitating between treatments, so traveling out-of-state to receive care can be particularly difficult.

This issue is dear to my heart because I lost my dear friend, colleague, and fellow veteran Mike Franklin to treatment-resistant depression in September 2015. In the two years since Mike's suicide, private payers and providers in Montana have taken major strides in opening up options for clients with treatment-resistant conditions such repetitive Transcranial Magnetic Stimulation (rTMS) and Ketamine infusions. Unfortunately, the Montana VA has not moved at the same brisk pace.

The Cooperative Studies Program within the U.S. Department of Veterans Affairs is launching a randomized control trial of rTMS for treatment-resistant major depression in veteran patients.[21] While this a positive step forward, I cannot help but wonder why this tool is not being adopted at a faster rate. I am increasingly frustrated by the puzzle of why Blue Cross Blue Shield of Montana has agreed that this treatment can be critical to the recovery of its members with treatment-resistant depression,[22] but the Montana VA has not. VA must work more expediently to provide access to this lifesaving treatment for veterans with treatment-resistant mental health conditions.

E. Prize for a Research Team to Create and Validate a Medical Screening Tool to Determine Which Patients are at Risk of Developing Side-Effects From Clozapine

The following block quote is taken in its entirety from the article "Clozapine: a distinct, poorly understood and under-used molecule" with references from Dr. Ridha Joober, MD and Dr. Patricia Boksa, Ph.D. from the *Journal of Psychiatry & Neuroscience*.

> Consensus of opinion is rare in psychiatry. Even in the field of clinical trials, where experimentation is tightly controlled and regulatory bodies scrutinize the proof, controversies are frequent and difficult to resolve.[23] One issue for which there is a widespread consensus is the unique place that clozapine occupies in the treatment of severe mental illnesses, particularly refractory schizophrenia. This molecule is distinct because of its effec-

---

[17] Desjardins, Isabelle, et al. "Suicide Risk Assessment in Hospitals: An Expert System-Based Triage Tool." *The Journal of clinical psychiatry* 77.7 (2016): e874–82.

[18] Sinclair, Diarmid, and Clive E. Adams. "Treatment resistant schizophrenia: a comprehensive survey of randomised controlled trials." *BMC psychiatry* 14.1 (2014): 253.

[19] Bauer, Isabelle E., et al. "The Link between Refractoriness and Neuroprogression in Treatment-Resistant Bipolar Disorder." *Neuroprogression in Psychiatric Disorders*. Vol. 31. Karger Publishers, 2017. 10–26.

[20] Al-Harbi, Khalid Saad. "Treatment-resistant depression: therapeutic trends, challenges, and future directions." *Patient preference and adherence* 6 (2012): 369.

[21] Mi, Zhibao, et al. "Repetitive transcranial magnetic stimulation (rTMS) for treatment-resistant major depression (TRMD) Veteran patients: study protocol for a randomized controlled trial." *Trials* 18.1 (2017): 409.

[22] Blue Cross Blue Shield of Montana: Behavioral Health Care Management Program, https://www.bcbsmt.com/ provider/clinical-resources/ behavioral-health-programs

[23] Blier P. Do antidepressants really work? J Psychiatry Neurosci. 2008;33:89–90.

tiveness, numerous and sometimes mysterious pharmacologic characteristics, serious side effects and under use.

Historically, clozapine was distinguished by one of its dangerous and sometimes lethal side effects, agranulocytosis, which almost caused its complete banishment from the psychiatric pharmacopoeia.[24] It was only rescued when its superior therapeutic effects compared with chlorpromazine in patients with refractory schizophrenia were demonstrated.[25] Since its controlled comeback, clozapine has consistently demonstrated advantages in a variety of clinical situations. Its enhanced therapeutic profile in patients with schizophrenia who respond poorly to other antipsychotic medications, both typical[26,27,28] and atypical,[29,30,31] have been reported in many studies and encompass many dimensions of the schizophrenia syndrome.[32,33] Positive symptoms are most consistently improved by clozapine, but there are also reports indicating that anxiety, mood and negative symptoms[34] as well as hostile behaviours[35] are better controlled with clozapine than with other neuroleptics, although the data are less consistent. Moreover, it has been reported that patients are more likely to remain compliant with clozapine than with other atypical antipsychotics.[36,37,38] Clozapine is also the only antipsychotic medication that has shown an anticraving effect for drugs of abuse,[39] a significant effect in reducing suicide rates in patients with schizophrenia[40] and an efficacy on refractory mood disorders.[41] Every clinician who has prescribed clozapine can recount a few experiences of seeing patients emerge from their chaotic psychotic experience. This is one of the most rewarding experiences that a psychiatrist can have in his or her professional life, and it is among the most important strikes we have made against one of the most devastating diseases affecting mankind.

---

[24] Marder SR, Van PT. Who should receive clozapine? Arch Gen Psychiatry. 1988;45:865–7.

[25] Kane J, Honigfeld G, Singer J, et al. Clozapine for the treatment-resistant schizophrenic. A double-blind comparison with chlorpromazine. Arch Gen Psychiatry. 1988;45:789–96.

[26] *Id.*

[27] Kane JM, Marder SR, Schooler NR, et al. Clozapine and haloperidol in moderately refractory schizophrenia: a 6-month randomized and double-blind comparison. Arch Gen Psychiatry. 2001;58:965–72.

[28] Hong CJ, Chen JY, Chiu HJ, et al. A double-blind comparative study of clozapine versus chlorpromazine on Chinese patients with treatment-refractory schizophrenia. Int Clin Psychopharmacol. 1997;12:123–30.

[29] Kumra S, Kranzler H, Gerbino-Rosen G, et al. Clozapine and "high-dose" olanzapine in refractory early-onset schizophrenia: a 12-week randomized and double-blind comparison. Biol Psychiatry. 2008;63:524–9.

[30] Azorin JM, Spiegel R, Remington G, et al. A double-blind comparative study of clozapine and risperidone in the management of severe chronic schizophrenia. Am J Psychiatry. 2001;158:1305–13.

[31] Lewis SW, Davies L, Jones PB, et al. Randomised controlled trials of conventional antipsychotic versus new atypical drugs, and new atypical drugs versus clozapine, in people with schizophrenia responding poorly to, or intolerant of, current drug treatment. Health Technol Assess. 2006;10:iii-xi.

[32] Elkis H. Treatment-resistant schizophrenia. Psychiatr Clin North Am. 2007;30:511–33.

[33] Tandon R, Belmaker RH, Gattaz WF, et al. World Psychiatric Association Pharmacopsychiatry Section statement on comparative effectiveness of antipsychotics in the treatment of schizophrenia. Schizophr Res. 2008;100:20–38.

[34] Breier AF, Malhotra AK, Su TP, et al. Clozapine and risperidone in chronic schizophrenia: effects on symptoms, parkinsonian side effects, and neuroendocrine response. Am J Psychiatry. 1999;156:294–8.

[35] Citrome L, Volavka J, Czobor P, et al. Effects of clozapine, olanzapine, risperidone, and haloperidol on hostility among patients with schizophrenia. Psychiatr Serv. 2001;52:1510–4.

[36] Cooper D, Moisan J, Gregoire JP. Adherence to atypical antipsychotic treatment among newly treated patients: a population-based study in schizophrenia. J Clin Psychiatry. 2007;68:818–25.

[37] Nasrallah HA. The roles of efficacy, safety, and tolerability in antipsychotic effectiveness: practical implications of the CATIE schizophrenia trial. J Clin Psychiatry. 2007;68 (Suppl 1): 5–11.

[38] Ascher-Svanum H, Zhu B, Faries DE, et al. Adherence and persistence to typical and atypical antipsychotics in the naturalistic treatment of patients with schizophrenia. Patient Prefer Adherence. 2008;2:67–77.

[39] Green AI, Noordsy DL, Brunette MF, et al. Substance abuse and schizophrenia: pharmacotherapeutic intervention. J Subst Abuse Treat. 2008;34:61–71.

[40] Meltzer HY, Alphs L, Green AI, et al. Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT) Arch Gen Psychiatry. 2003;60:82–91.

[41] Suppes T, Webb A, Paul B, et al. Clinical outcome in a randomized 1-year trial of clozapine versus treatment as usual for patients with treatment-resistant illness and a history of mania. Am J Psychiatry. 1999;156:1164–9.

> Expiration of the patent on clozapine in 2007 has lessened the burden of economic constraints against the use of clozapine. However, side effects remain a major issue affecting the choice to use the drug.

As noted above, schizophrenia is a major risk factor for suicide among veterans. The goal of this recommendation is to spur innovation by establishing a major cash reward, similar to the original $10 million dollar X Prize that led to the commercialization of space flight, to incentivize the development of a medical screening tool to determine who can be prescribed Clozapine without any risk of developing dangerous side effects. An effective screening tool would make it easier for veterans with schizophrenia to access this potentially life-saving therapy. The relatively low cost of Clozapine, in comparison to similar medications, would likely also save VA critical resources. The potential positive effects of a Clozapine side effect screening tool would also dramatically improve the cost of caring for individuals with schizophrenia, which is generally covered by the Centers for Medicare and Medicaid Services (CMS). The cost savings could be dramatic as the current costs of caring for schizophrenia are increasingly expensive, with estimated "annual direct and indirect costs of up to US$102 billion." [42]

F. Better Utilize Non-VA Providers

(1) Develop an Advanced Analytics Online Directory that is Continuously Expanded and Culled by veterans and managed by VACO staff

On Thursday, September 21 I helped assist a family who had a veteran in mental health crisis. The VA staff did an excellent job, and was able to receive the veteran into their emergency room, identified his need for inpatient treatment and transported him by ambulance to a private hospital to receive care. This was generally the correct result, but the hospital is an hour and a half away from the people that love this veteran on a day-to-day basis. They likely will be unable to get time off of work or find childcare in order to visit and support his care. The last update I received was that he was escalating a few days later on Saturday, September 23, and it was unlikely that anyone who cared about him was going to be able to get there to see him over the weekend.

The Montana VA chose not to use the Journey Home, a private nonprofit mental health crisis center, that is located in the same town as the emergency room the veteran first received care. There may have been a medical reason for him to be hospitalized in a different town. However, I have reviewed instances where the VA staff processing the veteran are simply not aware of the resources available in that veteran's community because the resources are either new, or for an unknown reason do not fit into the standard community resource manual.

Similarly, I recently helped assist a Vietnam veteran who had become suicidal. There were many real treatment issues involved, but there were also unrelenting life issues in that he could not afford meals and he was deeply lonely. Both of those issues could be partially addressed through the local Area Agency on Aging Senior Meals and Support programs. A fellow veteran brought the veteran in crisis there, and the services were greatly appreciated.

There are so many different local services, even in a sparsely populated state like Montana, that it is impossible for a single clinician, social worker, or peer support specialist to keep them straight. Thankfully, the technology for tracking and culling these services from a centralized location has gotten much easier.

For example, NAMI Montana was able to develop a resource guide for every county in Montana through the work of a single VISTA volunteer. We also developed a resource guide which included every inpatient mental health and substance abuse facility in the U.S. for the Family Support Foundation on Mental Illnesses. This resource guide is available online at treatmentscout.com, and was created by scouring open source information and combining publicly available resource guides.

While it sounds daunting, VA should develop a central resource guide for community services across the U.S., managed by VACO through a creative combination of an advanced analytics program and veterans working the phone lines.

---

[42] Wang Y, Iyengar V, Hu J, et al. Predicting Future High-Cost Schizophrenia Patients Using High-Dimensional Administrative Data. *Frontiers in Psychiatry*. 2017;8:114. doi:10.3389/fpsyt.2017.00114.

(2) Create a More Synergistic Relationship Between VA and the Community Health Centers (CHCs)

There are over 1,300 CHCs distributed across the country.[43] For purposes of this testimony, CHCs include federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). CHCs care for a large number of patients across the country. In 2015 alone, CHCs had almost 97 million patient visits.

As mentioned above, 70 percent of veterans nationally who die by suicide had not previously been connected to VA care.[44] It is likely that a portion of the veterans who do not receive care through VA, do receive care through CHCs. These CHCs provide comprehensive primary care services, but also provide access to mental health and substance abuse treatment. Their standard of care is monitored closely by the Health Resources and Service Administration (HRSA). They also have a billing structure which allows them provide services in underserved rural areas, which would help close the gap in providing necessary mental health services to rural veterans.

In an era where we are struggling to figure out how to ensure veterans always receive access to high-quality care, Congress should take a serious look at how to ensure VA and the CHC's are able to seamlessly work together across the U.S. Congress acting on this recommendation will specifically enhance our ability to get America's veterans the best, mostly timely care.

G. Increase VA's Collaboration with Outside Researchers

In May, VA and Coalition member Cohen Veterans Bioscience announced a public-private partnership alliance, called the Research Alliance for PTSD/TBI Innovation and Discovery Diagnostics (RAPID-Dx), "to enable different institutions to coordinate efforts and integrate data across dozens of labs and leverage synergistic capabilities for a 'big data' team-science approach to discover and support development of first-generation validated biomarkers and diagnostics for PTSD and TBI."[45] The partnership will to develop new tools "to consistently and accurately diagnose" PTSD and TBI, then assess if treatment is working. The VA described this partnership as, "affirming our commitment to a new type of radically collaborative science defined by data sharing and coordination of efforts toward our shared goal of finding clinically-useful diagnostics and treatments for these invisible wounds of war." Secretary Shulkin reiterated the view of the Working Group, noting that "we're able to accomplish so much more when we work strategically with our private and public sector partners." NAMI Montana and our national office agree with Secretary Shulkin—we will be able to serve our Nation's veterans and address their mental health needs in a better, more comprehensive way engaging all public and private sector stakeholders.

We encourage this Committee to task VA to maximize the effectiveness of this new partnership, as well as the work of similar initiatives. This includes the Multidisciplinary Association for Psychedelic Studies (MAPS). MAPS, in conjunction with the National Institutes of Health (NIH) is conducting a rigorous analysis of several Schedule One substances to determine whether they can be clinically effective when well-regulated and monitored under a clinician's care. Some of MAPS efforts may be opening the door to new pathways to effective treatment.[46]

Additionally, we respectfully ask this Committee to work with VA to provide researchers outside of VA access to the veteran-specific PTSD datasets and biological samples, and provide institution-wide support for multi-site PTSD clinical trials.

H. Establish a Continuity of Care Pipeline for Veterans directly from DOD to VA/Community Providers

When servicemembers leave the military, it can often be a time full of life transitions which can cause stress which can exacerbate mental health conditions. We

---

[43] "Community Health Center Delivery Sites and Patient Visits." Kaiser Family Foundation website, http://www.kff.org/other/state-indicator/community-health-center-sites-and-visits/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[44] Hope Yen, "VA data show veteran suicide highest in US West, rural areas," *Chicago Tribune*, September 17, 2017, http://www.chicagotribune.com/lifestyles/health/sns-bc-us_veterans-affairs-suicide–20170915-story.html

[45] Cohen Veterans Bioscience, Press Release CVB and the Veterans Health Administration Announce Landmark Partnership to Advance the Diagnosis and Treatment of Trauma-Related Brain Disorders (May 17, 2017), http://www.cohenveteransbioscience.org/2017/05/17/cohen-veterans-bioscience-and-the-veterans-healthadministration-announce-landmark-partnership-to-advance-the-diagnosis-and-treatment-of-trauma-related-braindisorders/

[46] *See e.g.*, Griffiths RR, Johnson MW, Carducci MA, et al. Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial. J Psychopharmacol (Oxford). 2016;30(12):1181–1197.

have strong reason to believe that the lack of this continuity of care "pipeline" between DOD and VA healthcare systems is resulting in many veterans slipping through the cracks. Unfortunate consequences can result in this case, as the ability to early identify and provide pre-emptive intervention care for mental health conditions is severely delayed, thus making the conditions far worse.

We would like to respectfully recommend this Committee work with the Senate Armed Services Committee to task VA to develop a plan with DOD to develop a Continuity of Care Pipeline to minimize the number of veterans that miss the opportunity to take advantage of VA's potentially lifesaving mental health care.

VI. CONCLUSION

Thank you again for the opportunity to testify in front of this honorable Committee. Your attention to this issue means a lot to me, our entire NAMI organization, veterans and their families. We look forward to working with you to save the lives of America's injured heroes.

Chairman ISAKSON. Thank you, Mr. Kuntz. We appreciate your being here today.

What I am going to do is, I am going to reserve my time since we have three Members that are here, and I know we have different meetings that are going to take place. I am going to go straight to our Members for their questions and will ask mine a little later when Senator Tester returns. He is doing a presentation at another hearing and will be here for his opening statement in just a little bit.

Let me start off with the senator from Arkansas, John Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you very much, Mr. Chairman, and thank you for holding such an important hearing, and again, also to Senator Tester.

I cannot think of anything that is more important to discuss. Certainly, we all agree that this is a crisis. In Arkansas, I think we are number 10 in suicide rate overall. Of that group, veterans represent about 8 percent of the population, but represent about 20 percent of the suicides. We are a State that is like so much of the rest of the country; in fact, the rest of the country, period, that is experiencing significant problems.

Dr. Bryan, you mentioned that recent reports have highlighted the inadequacies of our Nation's mental health professional training. In fact, I was looking at the chart—50 percent of psychologists, 25 percent of social workers, 2 to 6 percent of marriage counselors, 28 percent of psychiatrists. Only those have really received what we would call even the old-fashioned training, perhaps, not to mention the work that you and others are doing in such a good way. Those are pretty staggering.

How do we go about—unless we have a metric out there, how do we go about solving that problem?

Mr. BRYAN. I will admit that this is——

Senator BOOZMAN. And also, let me—as you are thinking about that—and the rest of you all can jump in too—how do we—you know, once we have the new research, once we perhaps get a metric, how do we get that, you know, not talked about but actually instituted in a timely manner.

Mr. BRYAN. Correct. Both very good questions.

The first one, I think is a much bigger question, and I will admit it. This is a huge issue that would probably require a concerted ef-

fort in redesigning or potentially really reengineering our education and training system in professional practice of mental health. We would need to find ways to incentivize graduate training programs and medical schools to ensure that not only are they providing any amount of training, but that training is scientifically supported. This can be accomplished in other ways, perhaps looking at grants and other Federal incentives and initiatives to encourage certain types of curriculum as well as training opportunities, but also, I think partnering with and working alongside with various accreditation bodies to look at how do we determine whether or not an educational system is meeting minimum standards for the practice of mental health across these disciplines. If we kind of work with those organizations, I think we would be able to see some very dramatic shifts in curriculum.

For your second question regarding dissemination and implementation, I think one of the challenges that many of us have as scientists is that scientists tend not to be very good at communicating their ideas to nonscientists, and so many of us in the dissemination field have really talked about how do we find opportunities to have researchers and scientists work with communications experts on how to convey this information not only to the general public, but also to other professionals, those who we want to target to be using these strategies.

But, we also need to target the consumer, so the consumer is educated and understands which treatments work best, so that when they go to a health care provider they can ask the right questions to determine if this is an individual who is likely to be able to help me.

Senator BOOZMAN. Right.

Yes, sir. Go ahead.

Mr. KUNTZ. Yes, sir. You know, one of the things that we found to be very important is getting the research to the States, creating a pipeline to have those conversations.

We had to startup a research center in Montana to make that happen, and because of the way that the VA structures their centralized research, we probably will never have VA research in Montana. But, if that pipeline is adjusted, that gets those conversations started, which gets people trained.

The other thing that I would recommend is for the VA to make its treatment algorithms for veterans more widely available. I think that the transition to the Cerner medical records is going to make that more possible, but, you know, get those treatment algorithms out to the field so people in non-VA facilities can use them.

Thank you.

Senator BOOZMAN. Very good.

Is overmedication a problem?

Mr. BRYAN. I would say my response is overmedication is broad.

What we would see—for instance, a student of mine just finished their dissertation. We are about to publish the results, finding that there is about a larger than expected proportion of veterans who receive benzodiazepines, despite being diagnosed with PTSD. Benzodiazepines are not indicated for PTSD and can actually interfere with effective treatment for PTSD.

Oftentimes, physicians and other prescribers rely on these because first-line treatments have not worked, and so they are hoping to provide some kind of symptom relief.

The unfortunate aspect of this, as my student found, was that in those cases, those veterans with PTSD who received benzodiazepines, they are almost three times more likely to die by suicide, so there is another risk associated with contraindicated medications where—I do not know if they are overprescribed, but I am not necessarily certain that in all cases, veterans and their prescribers are aware of all of the risks and are able to weigh them with the benefits of those medications.

Senator BOOZMAN. Right.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator.

Senator Blumenthal, who I would point out was one of the real leaders in the Clay Hunt Suicide Prevention bill and did great work on that in the last Congress.

Richard.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you. Thanks, Mr. Chairman, and thanks for your leadership on this important issue.

I was, indeed, the lead Democratic cosponsor on the Clay Hunt bill along with Senator John McCain on the Republican side and believe that it was a start, only a first step in this effort. Much more needs to be done.

Obviously, there are steps that have been taken by the VA in furthering this effort, and I know we will hear from Dr. Shulkin later, but the more I learn about this problem, the more complex and challenging I think it is.

Dr. Bryan, one of the very important statistics in your testimony is that the suicide rate among veterans who do not use VA services increased by 39 percent between 2001 and 2014, whereas the suicide rate among VA users increased by only 9 percent.

Put aside the exact numbers. What I am hearing again and again and again is that the suicide rates are increasing among veterans who lack access, either because of geographic or other difficulties in reaching these services or because they have received less than honorable discharges. This has become a passion for me because there is a whole group of veterans who suffered from PTSD, often undiagnosed, were separated less than honorably, and have been cast out and barred from using those services and often feel stigmatized and disengaged, not only from the VA but from society in general.

I have met with many of them, and I have worked with the Department of Defense on the review process, which has been changed as a result of leadership within the Department of Defense, commendably, but many of those veterans who were discharged less than honorably do not know about it, do not know about the changes in policy, do not know about the possibility of access to these services. So, it is a vicious cycle, a lethal cycle, which can lead to suicide.

I guess my question to all of you, not only about the less than honorably discharged veterans, but women veterans who also perhaps do not readily access these services, and their suicide rates are increasing. Those segments of the veteran community whose suicide rates are increasing need to be reached, and my question to each of you is, Do you see that phenomenon as real? Do you recognize it, and can you elaborate on it? What are your recommendations for addressing it?

Dr. DAIGH. Sir, I agree with you. I think the adequate treatment of substance abuse disorder and access to therapy and the adequate treatment of depression, as Mr. Kuntz indicated, to include pharmacologic treatment and maybe ECT or other treatments that are available, is critical.

If you cannot get people to a competent provider, it is a very difficult problem. So, I agree with your statement.

Mr. BRYAN. I have two thoughts in response, the first of which is I think what the statistics highlight is that the rates are going up, even among VA users, but it is a much slower rate. So, the VA is doing something good that is not happening for those who do not receive the services.

A common question is, well, how do we get more veterans into the VA, and I think that is an important question. The other question, though, I think we need to ask is, Why are there not other adequate services available to veterans in their communities?

I think this really came to a head for me several years ago. I do not know if you read the *New York Times* article about the Second Battalion, Seventh Marine Regiment (Marine 2/7), who has had a very high suicide rate, and a lot of them did not have access to the VA. There is a lot of discussion about that, and I said, well, the implication of this is some veterans have access to really nothing, or they have access to community providers who have little to no experience working with servicemembers or veterans. They do not know how to treat PTSD. They have never seen Traumatic Brain Injury before, and as the statistics I show you here, they have no experience with suicide risk.

I think part of the solution will be how do we get more veterans into the VA because as the RAND report, recently released, highlighted, the quality of care in the VA for mental health exceeds that in the private sector.

But, for those who do not access VA services, whether because they are not eligible or because they choose not to—we have to keep that in mind. Some veterans choose not do. We need to make sure quality services are available to them.

What we have done in Salt Lake City kind of as a model of this is—our center is on the University of Utah campus, right across the street from the Salt Lake VA, and what we say is we are not a competitor to the VA. We are the augment; the VA sometimes sends their patients to us for treatment. There are some veterans in the community who cannot go to the VA or are unwilling, so they come to us. We can sometimes connect them with the VA for other services and benefits that maybe they did not know.

I think we need to look at models like that on how different community agencies and the VA can further strengthen working together to better meet the needs of all veterans.

Senator BLUMENTHAL. Thank you.

Mr. KUNTZ. Senator Blumenthal, thank you for bringing up the less-than-honorable issue. That was something that came up in our family before my stepbrother's death, and it is a really big issue.

I will point out that one of the ways that it was solved in Helena, Montana, or improved was by adding a Vet Center to our community, and at the time, the VA had fought it because they said that, "You already have a hospital. Everybody that will go there, you know, that would go to the Vet Centers already go to the hospital," and that turned out not to be true.

I think that part of it is when you are depressed or when you have PTSD, the first thing that you cannot stomach is bureaucracy, and you just quit. You are faced with bureaucracy, you face this red tape, and you give up. The Vet Centers have less bureaucracy. The federally qualified health centers, FQHCs, have less bureaucracy—in order to get in and start treatment. I think that is part of what is not really shown in those statistics is the folks that give up because they look at the bureaucratic red tape and say, "I cannot mentally take it."

Senator BLUMENTHAL. I just want to thank all of you for your testimony today. Obviously, we have just scratched the surface of this topic. I hope that we can get the latest numbers on vet suicide rates, on the differences between VA users and non-users.

I have sponsored legislation with my colleague, Senator Blunt, to—it is called the Veteran PEER Act, legislation that would establish peer specialists in patient-aligned care teams within VA medical centers to do this kind of outreach. The peer-to-peer relationship among vets, I think, is an effective way to enable more access.

But, the VA has been doing better, and I commend Dr. Shulkin and his team, and we will—as I mentioned, we will be hearing from him. But on all counts, the Nation needs to do better. Thank you.

Chairman ISAKSON. Thank you, Senator Blumenthal.

For the benefit of the members here, we are going to take questions by order of appearance, alternating by party, and our next three questioners will be Senator Heller, Senator Manchin, and Senator Sullivan, in that order.

Senator HELLER. Mr. Chairman?

Chairman ISAKSON. Yes.

Senator HELLER. Thank you.

Chairman ISAKSON. You betcha.

HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Thank you for this hearing. I want to thank those that are witnesses for being with us today, and I want to especially thank Senator Tester because I know this is an issue that is important to him and an issue that is important to Montana. It is unfortunate that Montana leads us in the statistic, but the issue is that Nevada is right behind them.

A question that I continue to ask myself is, what makes Montana and Nevada unique? Mr. Kuntz, I will start with you as to why we see the stress in the areas of Montana and Nevada, maybe a little more unique than the rest of the country.

Mr. KUNTZ. Senator Heller, that is a great question, and I will tell you that if I had the perfect answer for that, I would probably be making a lot more money.

But, I would tell you that we do have higher access to lethal means in our State. For the most part, when you are suicidal, the closer you are to lethal means, then the higher your risk of dying by suicide.

We also have a lot of veterans per capita in our communities, and I think that that is an important factor.

One of the things that is a little bit different about our suicide tends—and I do not know if it is the same for Nevada—is we have more older veterans that are killing themselves, and I think that there is national trends saying that it is younger. But, if you look at Montana, that age 30 to 65, white males, is when we are losing them, and maybe it is just that we have a lot of people in that population group.

I think that it is also an issue of lack of care. We have no psychiatric residency program in our State, and I know a lot of Nevada rural communities struggle too. So, I think it is a number of different factors, and we have got to tackle them one at a time.

Senator HELLER. I really do appreciate your comments.

We had Secretary Shulkin in the State just a month or so ago, and he expressed his efforts to tackle this particular problem. We have hospitals, both north end and the south end of the State. We have a number of clinics that have been opened recently because of the efforts and the work of the Secretary and the VA, and it is appreciated.

Let me ask you, Mr. Bryan. They have a resiliency program in Israel that they—and maybe we have already discussed this—where they try to get this on the front end instead of the back end, where they actually train their soldiers, both male and female, of trying to avoid some of the stressful situations they may find themselves in and train them for them. Are we doing the same thing here in our country?

Mr. BRYAN. I would say, in general, yes, in the sense that if you look at military training, in general, a lot of it is designed to foster resiliency, how to endure difficult, adverse situations—perform under pressure, manage stress, et cetera.

Where we have not had much success over the past decade or so is when we try to develop new resiliency programs that take more of a classroom format, wherein we bring in outside experts who then teach or train, sometimes trainers within the units or resiliency experts within the units, who are then supposed to go and teach these concepts and skills to others within the unit. There have been a number of barriers to that, but unfortunately, some of the research that has been done on some of the larger resiliency programs, such as Comprehensive Soldier Fitness, have yielded no benefit.

We have seen some promise, however, in other resiliency methods. The one that has garnered the best, greatest promise so far is a program developed by the Army called Battlement that was shown to prevent or reduce PTSD symptoms, a small degree. It was not large, but it was a small and a noticeable degree amongst those who had the greatest and most intense levels of combat exposure

while deployed, which if you think about it in many ways, it makes sense. Where we found the effect were the ones who probably needed it the most and the ones who had the highest level of trauma exposure while deployed.

So, we have a couple of threads of evidence suggesting that certain approaches might help to reduce or prevent, at least reduce the severity of PTSD. However, we have not been able to large scale implement and further study those different strategies.

Senator HELLER. Is there any family training, not just the veteran themselves but actual family training so that they can identify some of these issues prior and prepare to help that veteran?

Mr. BRYAN. Right. There are a number of programs that have been created. There is none that sort of rises above the top.

Where a lot of the family training programs—and this actually is very common. The peer issue that you mentioned before, a lot of the programs tend to take more of a "Here is a bunch of signs and symptoms of this health condition" and now refer someone to a mental health professional, but what we lack is what do the family members do.

If a veteran is struggling with PTSD and does not want to go to treatment or there is a 2-week wait, what are you supposed to do in the meantime? We do not currently have any programs training that.

Now, newer research, for instance, the crisis response plan that I mentioned before, this is something we have been teaching to family members. We have been teaching to peer specialists. We have been teaching the non-health care providers in the community who are closest to the veteran in need to not only recognize when they might need help but also what to do about it and doing things that have been scientifically shown to prevent suicidal behavior and reduce PTSD.

Senator HELLER. Mr. Bryan, thank you, and I want to thank all of our panelists.

Mr. Chairman, thank you.

I want to thank the Secretary, who is in the audience with us today, for his commitment and coming out to the State of Nevada and expressing his concerns on these particular issues because it does make a difference, and we need to figure this out and make that kind of difference.

Mr. Chairman, thank you very much for the time.

Chairman ISAKSON. Thank you, Senator Heller. We appreciate it.

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, and thank you, Ranking Member Tester, for having this hearing. I think it is very important—I got to turn my mic on first—for all of you to be here.

My first question will be to Mr. Kuntz. As you mentioned in your testimony, community health centers are a critical part of providing health care in rural areas. Your State and my State are pretty rural, and in West Virginia, for instance, community health centers treat almost 400,000 patients. That is almost 25 percent of our population, and out of that, we have 166,000 veterans in our State. I am sure many of them got treatments there rather than

traveling a long distance to the VA if they lived out in the rural areas of West Virginia.

I would just like to hear, you are speaking on the importance of the community health centers and as mental health providers in your research. Are they capable? Do they have the personnel, they have the expertise to do that, so we can get—I am trying to get the treatment as quickly as possible without trying to build a whole other infrastructure to do it, if this vehicle is available for us, community health centers.

Mr. KUNTZ. Senator Manchin, thank you for your question.

It is an amazing point. I would tell you that we have our licensing board in the State of Montana, and we have Licensed Clinical Social Workers (LCSWs) that work at the FQHCs. We have LCSWs that work at the VA. Psychologists too. This is the same level of staff. The training may be a little bit different, but the FQHCs and the rural health centers are adding mental health professionals all the time. They are absolutely at the same level of professionalism——

Senator MANCHIN. Are you saying the quality of care for our veterans can be as adequate there as they will at the VA centers?

Mr. KUNTZ. Yes, sir.

The only thing that they are not that good at is long-term care. I think that that short-term turnaround coverage may be six sessions of counseling until they are transferred to the VA, but if you are in a time crunch, that is exactly a place where I send people. If you are struggling to get into the VA, go to the FQHC.

Senator MANCHIN. OK. Good.

Mr. Bryan, in your testimony, you highlighted a lack of adequate training on suicide prevention methods among the mental health professionals, not just among VA providers but nationwide, and we know our Nation's veterans are using non-VA care, as we just talked about.

My question would be, if this Committee moves forward on efforts to rework the non-VA care, how can we better invest and incentivize mental health training? How do we get more people with that expertise and on suicide prevention?

Mr. BRYAN. I think it will require a multipronged approach, and I think the easiest or sort of most straightforward approach is to invest in training workshops. However, I will say that will likely have limited impact. If there is one thing I have learned over the past decade, training thousands of mental health professionals, is going to 2 days of workshops, getting continuing education, and a deck of PowerPoint slides, oftentimes is not enough for them to actually use the therapy in an effective way.

One of the things we have learned actually from a lot of the VA's efforts in educating is you have to provide ongoing support. You train people. You supervise them. You meet with them on a regular basis. You help them. You teach them how to overcome common barriers, and so I think as we look at training, we are going to have to look at this from more of a long-term support.

I think the second aspect of this is we will have to look at our educational system.

Another lesson I have learned over the decade of doing this training professionals at all levels is that if you teach a student how to

do good medicine, they spend the next 30 to 40 years of their life doing good medicine. If you teach a student to use unsupported, non-scientifically based interventions, they start doing that for 10 or 20 years, and it becomes very difficult to get them to change back.

When I really think of this question, it is not only training the current labor force, but we are also going to have to look at how do we change how we train and teach the future labor force.

Senator MANCHIN. OK.

I have one more question, Mr. Chairman, if I may.

Dr. Daigh, in your testimony, you brought up the concern about confidentiality requirements for sharing a veteran's treatment information to coordinate and improve a veteran's mental health between the veteran's provider and extended family. I am glad you pointed to that issue because, as it stands, more than a half a million VA patients are abusing opiates, and VA patients overdosed on prescription pain medication have more than doubled the national average. And it is a horrible problem in my State of West Virginia, as most States are dealing with this.

While the VA has made really significant improvements, I still believe the areas—that these are critical areas we must work on.

In March, I introduced the Vet Connect Act of 2017, which would streamline the health records sharing between VA and community health providers, since we are basically giving more services and outside the VA. The bill requires the Veterans Health Administration to comply with HIPAA but ensures that community providers can make informed decisions based on the veteran's holistic medical history.

My question would be, Can you please elaborate on your findings as to why it is so important for the providers, health care providers, to have access to this behavioral health treatment information for their patients and how the current law is undermining the quality of coordinated care and hurting our veterans? What do we need to do to change?

Dr. DAIGH. I do not know if I can answer all of that. I think that——

Senator MANCHIN. Give it a shot.

Dr. DAIGH [continuing]. In the personal relationship that exists between veteran and the team at VA that is providing care to the veteran, they often know who the significant individuals are in that veteran's life, who are not necessarily related family members. I think that coming up with mechanisms—and VA does currently use advanced directives, but could use them more widely and more thoughtfully and consider additional situations in which they could be used, so that when people get in crisis, VA providers can reach out and talk to significant individuals to try to bring that person back in.

To the second point of sharing medical records across systems, I think that the data exchanges have to work in order for the VA medical record to communicate with all those other medical record systems. Among the vital points going forward, that is an extremely vital point.

I am not advocating that there be some change to the privacy rules. I am advocating that we be more creative in getting permis-

sion so that at the time a person is ill, a larger community can be brought into the discussion.

Senator MANCHIN. Well, we are going to need your help on that because we have had trouble getting past that.

I will give you one example. We have a bill called Jessie's Law, a little girl 30 years of age who was addicted, and she overdosed a couple times, and then she died in the hospital. She died because when she went into the hospital, she explained that she was a recovering addict, and she had asked repeatedly. She says, "Please notify my records. Make sure my records are identified, that they know that I am a recovering addict." Well, there was no such—the records were buried. It was not like if you have—allergic to cortisone or any of the other types of things that are really stamped and marked. The dispensing doctor did not see it, and they gave her 30 OxyContin. She was dead by one o'clock in the morning.

We are having a hard time getting through the HIPAA because of the patient privacy, and just common sense has to prevail and especially with our veterans on the front line now. You might be the ones that will help us transition this thing and get this piece of legislation and gives you the chance to share that, patients within the professional ranks that you can better serve them, but you need to speak out on that one.

Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Manchin.

The Senator from Montana is back, and we are going to let you go ahead and do your opening statement and questions at the same time unless—are you ready for your questions now, Senator Tillis?

Senator TESTER. Go ahead, Senator. Go ahead.

Chairman ISAKSON. Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Well, first, I want to thank Senator Tester because we have worked together over the past year or two, getting with the Department. We had a good meeting with Dr. Shulkin in our office, and I appreciate your continued, very valuable contribution to us, keeping track of the transformation efforts within the VA. I am sorry that I was not here earlier to hear the testimony.

We will start back on the medical record. Back in North Carolina, I sat on the Electronic Health Record Board when we were trying to integrate health records among medical providers within the State, and since I am here and I am on the Senate Armed Services Committee, we were successful with getting a provision in the NDAA that makes absolutely certain—and I believe that the Department is glad that we did, the VA—makes absolutely certain that we do not miss a step as we integrate the two electronic medical record platforms that are going to be common platforms.

There is still a lot more work to do. With over 100 or 120 different instances of medical records in the VA, we have got to first make sure there is a good flow from DOD to the VA. Then we have got to make sure that we get that right. Then we go to the next step, which is all the other providers that could be involved in providing a veteran care.

Senator Manchin, I am glad that you brought that up. I think it is critically important. There are ways to do it, and we need to push the envelope. We can address the privacy rules, but we want to make absolutely certain that the comprehensive view of the veteran in terms of their health history is known to anybody who may provide them care at any level.

I am kind of curious about the work that we need. I have got the State—the heartbreaking statistics for the State of North Carolina, but frankly, they are, in some cases, better than the national average and other cases, which led me to wonder to what extent do we see a correlation between the incidences of suicides in other States and the lack of VA resources available to them or other resources.

In other words, in a State like North Carolina where we have such a large military footprint, you have a natural group of people that have a therapeutic value just by being around other veterans, and then we have brick-and-mortar facilities. Have we looked at that to see if there is any correlation between footprint and outcomes to your knowledge?

Dr. DAIGH. No, sir. The gentleman who compiles the data may be able to answer that question, but I do not have an answer for that.

Senator TILLIS. I think it is important because it could be instructive as we go through and we take a look at how we are prioritizing the footprint, and every one of our States is very different. That is why some of the performance of the VA differs. It is based on support networks, VSOs, a variety of other factors. I think that should be instructive as we look at how we deploy resources to increasing our presence.

I do not know. I saw Senator Blumenthal. I think he was probably heading out of the hearing as I was moving in, but I was curious if he brought up the issue that he and I share a concern with, which has to do with possibly bad paper and not tracking the—what more should we do to go back and take a look at discharges other than honorable, that if we had had a better understanding of what may have occurred during their service that could put them at a higher risk and actually could have resulted in paper that they should not have been discharged with.

Mr. BRYAN. Yes. He did raise that issue, and this is, I think, an important issue not only for suicide, but also for a host of other social issues that are, I think, of high relevance.

We have seen higher rates of homelessness, higher rates of criminal activity in that subgroup as well, other social problems, so I think if we address it here with suicide prevention, we actually probably would have a much larger social impact in other areas as well.

Senator TILLIS. Are you all aware of anything that we should view as best practices for going—while we deal with the policy issues of how do we go back. There are two pieces to this. Prospectively, going forward, how do we make sure that at the point in time when we are making a discharge decision that we are taking in factors, particularly the invisible wounds of war that could have—could have affected that person's behavior and resulted in the other than honorable.

How do you go back? The statistics here show that a lot of the suicides that we are seeing are not in the current wars that we are fighting, but they are Vietnam War and prior to that. Has there been much work done or any bright spots that you see that we are going back and going in that veterans population and trying to help them, try to clear up their record or at least make sure they are getting the care they need to avoid the possible suicide?

Mr. KUNTZ. Senator, probably the best one that I have seen in the Vet Centers because if you have been in combat, they do not care what your paperwork looks like. There is a place where people can go. I think that the other policy statement is these mental health conditions lead to conduct that eventually can get you discharges. If you have been to combat, why is there a less-than-honorable status? I mean, I do not know if we can scientifically say this did not cause your behavior or did not have some kind of effect. So, in my perspective, the tie goes to the runner.

Senator TILLIS. Yeah. I will take that at face value, and it may be something that we should talk about—and I chair the Personnel Subcommittee in Senate Armed Services—but look at it in a way that there can clearly be—even in the U.S. military, there are people who do things that I think are appropriate for a dishonorable discharge. It is a matter of how you get that right and how you do based on the circumstances that a soldier was exposed to, to where that may be the tiebreaker, is the nature of the environment they were exposed to and what you could reasonably expect as a medical practitioner, as someone who would look at that and say, "Look, this is probably where the tie needs to go to the soldier."

Mr. BRYAN. Well, one other point that I will add to that is when you look at some of these decisions, there are two separate processes by which a servicemember is separated from military service. There is the medical process, and then there is the administrative process. They do not parallel each other. They do not necessarily interface with each other, and there are—I can speak for myself as a former military psychologist. Sometimes there is confusion about who has precedent, because both issues are going on, which one goes first, which one goes second, and so it can create a lot of confusion and a lot of frustration for everyone involved—the commanders, the health care providers, and the servicemember and the veteran.

Perhaps something going forward is how do we create a process wherein these two separate parallel tracks maybe work together a little bit more explicitly, there are no policies in place wherein there is crosstalk among these two stovepipes. That right now is not happening, so it is a little easier to make these types of decisions, which I think would help to reduce a lot of these conflicts and questions.

Senator TILLIS. Thank you all, and thank you, Mr. Chair, and thank you, Senator Tester.

Chairman ISAKSON. Senator Tester.

HON. JON TESTER, RANKING MEMBER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman.

I was not even going to talk about this, but since you guys—since Senator Tillis brought it up, I would just tell you that the easy thing for the military to do is pitch somebody out if they have got behavior problems. The more difficult thing to do is talk to people, make an analysis whether combat changed them, which I really think is incumbent upon the military to do that. This is not the DOD committee, but it is VA, and it is important.

OK. This is for either Mr. Bryan or Dr. Daigh. You do not have to both answers, but one or the other. Could you give me an idea on what percentage of veterans who have attempted suicide were previously diagnosed with mental health issues?

Mr. BRYAN. When you say attempted suicide, they died by suicide or they made a nonfatal attempt at suicide?

Senator TESTER. Attempt. They made an attempt.

Mr. BRYAN. I do know the statistics are available. I want to say the VA report—please take this with a grain of salt—said somewhere around 70 percent, give or take.

Senator TESTER. Seventy percent had already been diagnosed with a mental illness?

Mr. BRYAN. Right. Yes.

Senator TESTER. OK. Have we seen a correlation between combat exposure and suicides?

Mr. BRYAN. We actually published a paper on this a couple years ago, and the answer is a little more complex to answer.

So, is the relationship between deployment in general——

Senator TESTER. Yes.

Mr. BRYAN [continuing]. And suicide? No.

Senator TESTER. That is fine.

Mr. BRYAN. Is there a correlation between exposure to certain types of combat-related traumas?

Senator TESTER. Yep.

Mr. BRYAN. Yes.

Senator TESTER. OK.

Mr. BRYAN. It is killing and exposure to death. There was a small correlation.

Senator TESTER. OK.

There has been some research that has indicated that living at higher altitudes could impact suicide, depression. Is that—are you familiar with those studies, and are they real?

Mr. BRYAN. Yes. Actually, a colleague of mine at the University of Utah, Perry Renshaw, is really kind of the leading scientist in that area.

Senator TESTER. They are real?

Mr. BRYAN. Absolutely.

Yeah. What seems to happen is at higher altitude, we have different oxygenation of——

Senator TESTER. Yeah.

Mr. BRYAN [continuing]. Metabolites in the bloodstream, so it affects how our brain processes neurotransmitters and how our brain, in essence, works.

Senator TESTER. Interesting.

Mr. BRYAN. Yep.

Senator TESTER. This is, I think, more for you, Matt. Veterans have been concerned about when you seek mental health care,

there is a stigma attached. It could have effects on their career, perception by family, friends, right down the line. Do you think we are taking the appropriate steps to take care of the stigma that is associated with mental health issues, or have we done—have we made any progress in the area of de-stigmatizing mental illness?

Mr. KUNTZ. Senator Tester, I think we have made some progress as a society.

The one thing I guess I just do not understand is why we do not really brag about how some of our best Americans had mental health conditions, had Post Traumatic Stress Disorder. Why do we not—I mean, when you are talking about Abraham Lincoln, why are we not saying that our Nation was blessed because that guy had bipolar disorder or depression?

Senator TESTER. Yeah.

Mr. KUNTZ. I mean, I think that some of our greatest leaders—like we are bringing a sergeant major from Delta Force to Congress in November, and, I mean, people like that need to stand up and say, "In some ways, my condition helped me, but on those days where I struggle, you better be there to help me, too."

Senator TESTER. Right on.

So, you talked about older veteran suicide. Can you give me—and this kind of goes back to the question I just asked Mr. Kuntz. Can you give me an idea whether the newer generation of veterans are seeking mental health care more readily than the older generation, or is there no difference?

Dr. DAIGH. I do not have the data on that.

Senator TESTER. You do not?

Mr. BRYAN. My sense—I do not know the data offhand. My sense is that there is a decreased likelihood of younger generations of veterans who access services at the VA.

Senator TESTER. Oh, really? So, it has actually gotten worse?

Mr. BRYAN. That is what I understand. I could be wrong, but that was my understanding from some of my VA colleagues. Maybe someone else has better data or understanding of the data than me.

Senator TESTER. All right.

One of the things that I think is interesting, we were contacted by a veteran from Sidney, Montana—that is in the far eastern part of Montana, very rural—who noted that the VA is unable or unwilling to include family members in the intervention process if a veteran is in crisis. I do not know if this is true or not, but if it is true, I think we are making a big mistake.

I would love to hear all of your opinions very briefly, because you have only got about a minute left, 30 seconds, on what the VA can do better to engage families.

Let us start with you, Dr. Daigh.

Dr. DAIGH. I think that use of advanced directives or some other mechanism that allows providers to talk about otherwise prohibited information to families widely when there is a crisis would help that intervention process.

Senator TESTER. OK. Dr. Bryan?

Mr. BRYAN. I think there are two key strategies that we could work with family members about. The first is a basic crisis management, how to talk to someone in crisis and how to help them

when they are struggling to identify solutions to their current problem.

Senator TESTER. Actually working with the families to train them so they could recognize what to do?

Mr. BRYAN. Correct. Correct.

Senator TESTER. OK.

Mr. BRYAN. This is something we have been doing at Salt Lake City, training family members on what to do.

The second related piece of that, teaching family members and bringing them—involved in the firearms safety aspect, how do we work with families to increase safety within the household, even maybe during times of non-crisis, because if we have a safer household to begin with during a time of crisis, everyone in the household is safer overall.

Senator TESTER. Hold it just for a second, Matt.

Do you have any statistics on how many suicides by veterans are committed by guns versus other ways?

Mr. BRYAN. Yeah. The vast majority, close to 70 to 75 percent are through firearms.

Senator TESTER. OK.

Matt?

Mr. KUNTZ. Senator Tester, I think telling the families how to communicate with the VA, because you can get around HIPAA. I mean, "You need to send us a letter. You need to send it to this portal. You can call us. We may not be able to tell you about the veteran, but if your veteran is in trouble, this is how you communicate to us. This is the way that you do it and a way that we will respond." We tell our families, "You do written letters to professionals. They start thinking about malpractice, and pretty quick, they will get moving." But, you have to train those families.

The same thing—we have a Family-to-Family course which helps train them in how to interact with the treatment system.

Senator TESTER. Well, thank you all for your testimony. I have got—I mean, we could spend all day long on this issue, truthfully, and we could spend all week and maybe the next month.

I want to thank you for what you guys are doing. Each one of you in your own right are doing some really good work. I think you are the key, to be able to partner with folks like you, to really move this issue in a way where we have better outreach, we have better education, and we have better results.

Thank you.

Chairman ISAKSON. Thank you, Senator Tester.

I have a couple of quick questions, and we will go to Senator Cassidy if he has a question, and then we will go to the second panel.

Real quickly to this panel, Mr. Kuntz, you made reference to biological susceptibility. Is that a test? Is there a biological susceptibility test you can give someone, a blood test or something that have markers or indicators that there may be a suicide?

Mr. KUNTZ. Sir, I absolutely wish that there were. There is not a test now, but it is important to point out that biological susceptibility is something that is also dependent on other—you know, it factors into every other health care condition. There is not nec-

essarily a biological susceptibility test for skin cancer either, but some people are more prone.

That is one of the things that we have asked the Committee, is to ask the VA for more biological indicators by the fall of 2020, and I think that even if it is not a specific this test for that, there are things like computerized executive functioning, where we know if that executive functioning is getting worse, there is something going on in that brain. It is not necessarily PTSD or depression, but there are tests that need to be brought forward, and I am hoping that they can be rolled in by the fall of 2020.

Chairman ISAKSON. The reason I asked the question is, when you listen to the testimony of all of you, there are two things that pop out: one is, we have not had enough good training in the VA for dealing with suicide, and we need to work on that. I know Dr. Shulkin is going to do that, and prioritized suicide prevention is a main focus of his leadership.

But, the other thing is that people do not ask the right questions, do not report the right—and their timing—our timing is never very good. Response timing on suicide prevention ought to be immediate and not an appointment 2 weeks later down the road.

That is why I am so proud that all of our staff on the majority and the minority side have taken the SAVE course, now understand how important it is to look for the signs of suicide, to ask the question, "Are you considering suicide?" and not beat around the bush about it, to validate the veteran's experience and to encourage treatment and expedite getting help.

I think if we embrace the SAVE program in the VA and work to do it, we will save a lot of lives by simply having the awareness in the direction of knowing what to do, and knowing what to do is 90 percent of solving the problem; and 100 percent of solving the problem is identifying it. So, if we are better aware of the things we need to look for, the better off we will be. We will not need a biological test. Everybody wishes there was a biological test, but you are right. Most diseases, there is not, per se, a biological test, but there are indicators whether it is skin cancer or whatever it might be.

Senator Cassidy, did you have a question?

HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Yes.

I apologize, gentlemen, if these questions have already been asked. I apologize in advance.

Dr. Daigh, you mentioned that in your studies that it is unclear how do you establish intent. So, let me ask, if somebody dies from a drug overdose, say John Belushi, is that considered a suicide, or is that considered a drug overdose?

Dr. DAIGH. In the course of our work, sir, we would rely on what the medical examiner said in their determination of all the relevant facts at the time the death occurred to state whether they thought it was an accidental death or an intentional death.

Senator CASSIDY. Accidental in the sense that they are addicted to drugs, they took too much, they stopped breathing. That would not necessarily be a suicide. That, indeed, might be considered accidental overdose?

Dr. DAIGH. We would record it that way, yes, sir. We would have that interpretation. We would always wonder if we were right.

Senator CASSIDY. Got that.

Mr. Bryan, you mentioned this, but any of you all can answer these questions. Again, I am just trying to understand.

Clearly, you cite the statistic, I believe, the 30 percent increased rate of suicide among veterans, but I am not sure. I think that is compared to the general population, not to an age-, gender-based cohort, and going beyond that, I am not sure it is related to socio-economic class and/or disease burden. Intuitively, people with greater disease burden are more likely to commit suicide.

As we understand these statistics, epidemiologically, are they matched against a match cohort, or is it against the general population? And, if they are not matched against a matched cohort, what are the excess rates relative to one which is matched?

Mr. BRYAN. Correct. The statistics that I cited was from the VA's report from last year. Those are age- and gender-adjusted for the reasons that you note. Age and gender are——

Senator CASSIDY. What about SEC?

Mr. BRYAN. I was not involved in the analysis. I do not know what other variables it may have adjusted for.

Senator CASSIDY. OK. But age and gender——

Mr. BRYAN. Age and gender are the most common adjustments that we make when looking at veteran and military suicide statistics and comparing it to the U.S. general population.

Senator CASSIDY. For my general knowledge—I do not know—is suicide more common among certain—clearly, suicide would be more common among people who have addictions. That is intuitive, right? They are addicted for a reason, but are there other kind of breakups? If you were going to match them against in the general—in the general population as a whole, are there certain things, yes, in this social strata, it is more common, or in this disease burden, it is more common? I am asking this for my knowledge.

Mr. BRYAN. Right. Yes. If we look, for instance, like in the VA report, they broke things down into different age groups. They looked at different diagnostic characteristics, what type of mental illness does a person have, diagnosis for—they looked at opioid, opioid abuse as well, and what we are—men versus women. What we tend to see is that, on a whole, veterans have a higher rate of suicide, regardless of the categories.

Senator CASSIDY. But I am asking in the general population.

Mr. Kuntz, are you——

Mr. KUNTZ. Senator Cassidy, I can really speak well to Montana, but I think since we are the highest suicide rate in the country, there may be something to learn there.

We created a Montana Suicide Review Team that went through all the death certificates in the State for exactly the reasons that you are talking about. We cannot solve it unless we know it.

Interestingly enough, the one demographic that really jumped out was white males between 30 and 60. Like that was, you know, not—and yes——

Senator CASSIDY. Let me stop you, Mr. Kuntz, because there is a research out of Princeton, which says in the general population,

white males, to a lesser extent white females, in that demographic are dying. And, it does relate to lower socioeconomic class.

Now, your State, I think has a higher rate of poverty than New Jersey.

Mr. KUNTZ. Yes, sir.

Senator CASSIDY. So, have you corrected that for kind of economic status or not?

Mr. KUNTZ. Sir, from looking at the economic status, it will also say that most of our suicides are from people that are economically struggling; in particular, people who have not a lot of education, like they are less—likely the higher you go up the education totem pole, the less likely you are to commit suicide in our State.

Although I will say that there are some other factors that weave into this because, if you have depression, anxiety——

Senator CASSIDY. I totally get it.

Mr. KUNTZ [continuing]. You know, popping people off the work, popping people off of the education or——

Senator CASSIDY. Rich people shoot themselves too. I hate to say it.

Mr. KUNTZ. Yes, sir.

Senator CASSIDY. Yet, it does sound—then I am sure Dr. Shulkin will testify as to whether or not these VA statistics are—you know, are these veterans atypically lower socioeconomic class, et cetera. How closely do they match this Princeton data? If you all know that, I have 10 more seconds, and if not, I will wait for Dr. Shulkin.

Thank you all. I yield back.

Chairman ISAKSON. Thank you very much, Doctor.

Senator Tester.

Senator TESTER. Yeah. I think, Mr. Chairman, I am done with this panel. While they are setting up for the next panel, I would just like to make a quick statement, if I could.

Chairman ISAKSON. We will do that. I want to thank the panelists for being here today. Your testimony has been eye-opening and helpful, and we will continue to focus on this, as Dr. Shulkin needs to focus under the VA. We thank you for your attendance today, and we will now switch the table around for our next panel.

Senator TESTER. If I might, Mr. Chairman, while they are doing that, I would just like to give a quick statement.

Chairman ISAKSON. The Ranking Member is recognized.

Senator TESTER. Well, thank you, Mr. Chairman.

I would just say, look, this discussion is very, very important today. It continues to be unacceptable that we have the number of suicides in our veteran population that we have, but make no mistake about it. It is also a national epidemic, not specific to veterans, yet we are here to talk about veterans.

In fact, it is the 10th leading cause of death in the United States. Since the Chairman dropped the gavel at the beginning of this hearing, six people have committed suicide in this country.

Look, VA data suggests that approximately 20 veterans commit suicide every day. On average—and this is an important statistic for us to know—only six were enrolled in VA health care. So, what does that mean? We have got to do a better job of outreach, and once we do that job of outreach, we got to make sure that those

folks have the health care professionals on the ground within the VA to get the help they need.

Why is that important for this Committee? If we are going to get health care professionals on the ground in urban and rural areas—and I think they are needed in both—it is going to cost some money. We have got to have more residency slots. We have got to be more aggressive on this. I think it is really an important issue moving forward. I think this last panel has showed it.

We need to fill those vacancies within the VA. We need to make sure we fully leverage the assets, like our Vet Centers, and we can talk about this. I think it is important we talk about it and get the facts. But as Matt Kuntz knows—and I do not know if Matt left or not. He was on the first panel, but I will tell you this guy knows, not only talks the talk, he walks the walk. We need to follow his lead and make sure that we follow up this Committee hearing with action that actually does right by our veterans in this country, which by the way, if we do that, I think it helps the civilian population too.

Thank you very much, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Tester. It was an excellent panel, and I appreciate your leadership on this entire issue about suicide. We know it is number 1 in your State, both with the general populous as well as veterans, and we want to do everything we can to make sure we are addressing it within the Veterans Administration.

We know that Dr. Shulkin is focused on preventing—suicide prevention is one of the key things he wants to focus on, and in the absence of making an introduction, I want to say thank you to Dr. Shulkin for a second.

We worked very hard in the first 9 months of this year, the Ranking Member and I and the entire Committee, to bring legislation to the floor that was sought by many of us and, in some cases, sought by the Secretary to improve the VA. We have changed the paradigm of the VA. We have changed the headlines of the VA, and we are very proud of that.

One of the reasons we have done it is the Committee has been united, Democrat and Republican alike, to getting the job done, and we have done that, but also, because the VA under Dr. Shulkin's leadership, is seizing the advantage we have given.

I just want to acknowledge that this week or last week—maybe this week, but certainly by last week—was the first use of the accountability legislation in the termination of a senior member of the staff at the Veterans Administration for lack of performance, incompetency, et cetera, et cetera, et cetera. That would not have been possible had that legislation not passed, nor would it have been possible unless we had a Secretary that was willing to take that initiative and to go on.

I want to, on behalf of the Ranking Member and myself and everybody on the Committee, thank you for taking advantage of the tools you have asked for and we have given you in the Veterans Administration. There are a lot more tools in the bag that you are going to need to use. We are going to be there to support you; we are going to help you with your initiative on suicide as well.

I just wanted to acknowledge publicly and thank you for your initiative on accountability last week in the VA.

Without further ado, Dr. David Shulkin, the Cabinet member for the Veterans Administration, and Dr. Carroll to assist him, if necessary. I think that is the way it is supposed to be.

STATEMENT OF HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DAVID CARROLL, Ph.D., EXECUTIVE DIRECTOR, OFFICE OF MENTAL HEALTH AND SUICIDE PREVENTION

Secretary SHULKIN. Great, great.

Thank you, Mr. Chairman, and good morning. Senator Cassidy, Senator Murray, nice to see you. Senator Manchin gets the Best Attendance Award. Thank you for staying for the whole thing. [Laughter.]

I want to thank you, Mr. Chairman, for several things. First of all, I think I could not agree more with your comments. I am very proud of this Committee. I think it is the best Committee in the Senate. It works together in a bipartisan way and working to really get things done, and I am proud to be working with you on that.

I also thank you for having the first panel first because they got all the hard questions, and I got to hear all the answers. That was terrific.

But, as you know, we are here today, and this is an important hearing because our goal is to eliminate suicide. We want to do that through risk identification. We want to do it through effective treatments, education, outreach, research, and strategic partnerships.

Senator Tester mentioned right before he left that our research shows that 20 veterans a day are dying through suicide. He did something by saying that there were six Americans who died during the course of our hearing. I think about that every day: how many veterans are dying, for us not being more effective at the way that we are addressing this problem.

We know veterans are at greater risk for suicide than Americans. This is an American public health crisis, but for the veteran population even more so, and we do know, as has been said several times already this morning, that 14 of those 20 are not receiving care within the VA system.

We know from research that VA care saves lives, and we know that treatment works. So, this is a matter of trying to get more people treated. What we are trying to do is, more aggressively than ever before, to outreach to veterans that are not getting access to care. But, we cannot help those that we do not see. This is where we are extending our help into the community to work with community partners.

We are doing more to reach veterans than ever before. As Secretary, I have authorized that we do start providing emergency mental health services to those that were other than honorably discharged, and that is important, but we can do more in that extent with your help.

We have asked every medical center this month to sign a suicide declaration pledge. I am pleased that you signed it this morning, Mr. Chairman, along with the Ranking Member. When I was out

in Nevada, Senator Heller also signed it with his community members. So, we are doing that across the country. That is a pledge of specific action steps that we want leadership to take to be able to help reduce suicide.

We have developed the largest integrated suicide prevention network in the country, over 1,100 professionals who are dedicated to suicide prevention, including suicide prevention coordinators and other mental health professionals. Our goal that I have announced is to hire 1,000 additional mental health professionals so we can even do more and to grow that network.

Our Veterans Crisis Line, which we established in 2007, has now answered more than 3 million calls and dispatched 84,000 emergency ambulances to help people who were in urgent need of help. That is incredible. We have had 504,000 referrals to suicide prevention coordinators, so we are helping a lot of people through that.

The Veterans Crisis Line number—and I encourage everybody to keep this in their phone because you never know when you are going to get that 2 a.m. call, and you do not want to be looking for this—is 1–800–273–8255, 800–273–8255.

We have recently appointed, 7 weeks ago, Dr. Matt Miller to head up our Veterans Crisis Line. This is the first time we have had a clinical psychologist in charge of the Veterans Crisis Line, because this is clinical work, and this is not just a call center.

We have expanded telemental health. We have 11 telemental health regional hubs throughout the country, and in 2006 alone, we had 427,000 telemental health encounters. That is more than ever before.

We have taken from our research enterprises a big data analytics program that we call REACH VET that now predicts who may be at the greatest risk for suicide, up to 80 times the risk of suicide of a regular person, over the next year. Now we call them—and this has been done around the country—to outreach and see what we can do to proactively help, so not waiting until there is a suicide attempt.

On September 15 of this month, we released State suicide data. Many of you have been referencing that data, but we think that is going to help people design more effective interventions.

We have continued to develop public-private partnerships because VA cannot do it alone. This morning, I was talking to the Cohen Veterans Network, as one of those partnerships, but many of our VSOs and other groups are here in the room today, are those partners that we are working with.

We continue to invest in two VA center of excellence research initiatives to help us understand how to do interventions better and to take a population health approach toward reducing suicide.

This month, as you have said, is Suicide Prevention Month. That is our #BeThere campaign, where we are reaching out to make people aware and try to decrease the stigma of mental illness. With that today, I have brought with us our new public service announcement. I just want you to listen to it for a second. Hopefully, you will recognize who is helping us with this.

[Audio presentation.]

> AUDIO. "In the fabric of America, they are the toughest threads, our bravest, and most selfless. They raise their

hands, stepped forward, and served for each other, for you, and me.

"One of the first things they learned was the code that every servicemember lives by: Leave No One Behind. Now all of us need to live by it too, because some veterans are being left behind. Twenty of them take their own lives every day. Why? It is not simple. It never is.

"What matters is that we are there for them, just like they were there for us. The handshake, the phone call, the simple gesture make a big difference to a veteran in crisis.

"Learn how to be there for a veteran at bethereforveterans.com. Honor the code. Be there. Leave no one behind."

Secretary SHULKIN. We are grateful to Tom Hanks for lending his credibility to help us get this message out, and you will begin to see this national PSA with a video starting in about 30 days.

Despite all this progress that we are making, we still have so much more work to do. That is why, as you said, Mr. Chairman, this is my number 1 priority. This is what we are focusing on to make a difference, but we do need your help. It would not be a hearing if we did not ask for your help. There are three things that I think that we could use your help on.

First, we have to figure out a way to recruit more mental health professionals, and frankly not just for the VA but for the country at large to be able to train more. I have identified we need 1,000 more, and we are not making the progress that I need to make in recruiting them.

Second, we want you to be part of helping us spread the word in the #BeThere campaign. Thank you again for signing the declaration, but you are, as well-respected members in the Senate, very helpful in spreading that word with us.

Third, we need more research in this. I think many of you have identified there are no blood tests, the biomarkers. We need to be able to do this better. We need better research in genomics to be able to make a difference, and VA has that capability with your additional support.

Thank you for holding this hearing today, and I would be glad to take any questions along with Dr. Carroll.

[The prepared statement of Secretary Shulkin follows:]

PREPARED STATEMENT OF HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

GOOD MORNING, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND DISTINGUISHED MEMBERS OF THE COMMITTEE. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) suicide prevention programs, including the implementation of the Clay Hunt Suicide Prevention for American Veterans (SAV) Act (Public Law 114–2). I am accompanied today by Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention.

INTRODUCTION

Recent research suggests that 20 Veterans die by suicide each day, putting Veterans at even greater risk than the general public. VA is committed to ensuring the safety of our Veterans, especially when they are in crisis. Losing one Veteran to suicide shatters their family, loved ones, and caregivers. Veterans who are at risk or reach out for help must receive assistance when and where they need it in terms that they value. Our commitment is to do everything possible to prevent suicide

among the Veterans we serve and to reach all Veterans through partnerships and collaboration.

September is Suicide Prevention Month. VA is closely working with the Department of Defense (DOD) and other stakeholders, including families who have lost loved ones to suicide, to do everything we can to be there for Veterans to prevent suicide. We have held a month of facility Suicide Prevention Declaration signings. Veterans Service Organizations (VSO) participated in the declaration signing at the Suicide Prevention Advisory Group meeting. We are also partnering with the Substance Abuse and Mental Health Services Administration to establish Mayor Challenge programs in seven communities and local outreach and partnership activities in 20 more. VA's Readjustment Counseling Service, Canteen Service, Pharmacy, Chaplains, and many other programs are all playing a role in supporting Suicide Prevention Month and our on-going initiative so we connect with Veterans in as many different ways as possible.

SUICIDE PREVENTION OVERVIEW

VA has developed the largest integrated suicide prevention program in the country. We have over 1,100 dedicated and passionate employees, including Suicide Prevention Coordinators, Mental Health providers, Veterans Crisis Line staff, epidemiologists, and researchers, who spend each and every day working on suicide prevention efforts and care for our Veterans. Screening and assessment processes have been set up throughout the system to assist in the identification of patients at risk for suicide. VA also has developed a chart "flagging" system to ensure continuity of care and provide awareness among providers about Veterans with known high risk of suicide. Patients who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow ups, safety planning, weekly follow-up visits, and care plans that directly address their suicidality.

We also have two centers devoted to research, education, and clinical practice in the area of suicide prevention. VA's Veterans Integrated Service Network (VISN) 2 Center of Excellence in Canandaigua, New York, develops and tests clinical and public health intervention strategies for suicide prevention. VA's VISN 19 Mental Illness Research Education and Clinical Center in Denver, Colorado, focuses on: (1) clinical conditions and neurobiological underpinnings that can lead to increased suicide risk; (2) the implementation of interventions aimed at decreasing negative outcomes; and (3) training future leaders in the area of VA suicide prevention.

Every Veteran suicide is a tragic outcome, regardless of the numbers or rates; one Veteran suicide is too many. We continue to spread the word throughout VA that "Suicide Prevention Is Everyone's Business." The ultimate goal is to eliminate suicide among Veterans via strategic community partnerships, identification of risk, training, treatment engagement, effective treatment, lethal means education, research, and data science. Although we understand why some Veterans may be at increased risk, we continue to investigate and take proactive steps to understand all risk factors for all Veterans. VA's strategy for suicide prevention requires ready access to high-quality mental health services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention as a public health issue for all Veterans.

Suicide prevention is VA's highest clinical priority. As part of VA's commitment to make resources, services, and technology available to reduce Veteran suicide, VA initiated Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET) in November 2016, and fully implemented it by February 2017. REACH VET uses a new predictive model to analyze existing data from Veterans' health records to identify those who are at a statistically elevated risk for suicide, hospitalization, illnesses, and other adverse outcomes. Once a Veteran is identified, his or her mental health or primary care provider reviews the Veteran's treatment plan and current condition(s) to determine if any enhanced care options are indicated. The provider will then reach out to Veterans to check on their well-being and inform them that they have been identified as a patient who may benefit from enhanced care. This allows the Veteran to participate in a collaborative discussion about his or her health care, including specific clinical interventions to help reduce suicidal risk.

DOD and VA have a new joint effort to institute a public health approach to suicide prevention, intervention, and postvention using a range of medical and non-medical resources through data and surveillance, messaging and outreach, evidence-based practices, workforce development, and Federal and non-government organization partnerships. We know that 14 of the 20 Veterans who die by suicide on average each day did not receive care within VA in the past two years. We need to find a way to provide care or assistance to all of these individuals. Therefore, VA is ex-

panding access to emergent mental health care for former Servicemembers with other than honorable (OTH) administrative discharges. This initiative specifically focuses on expanding access to assist former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behaviors. It is estimated that there are a little more than 500,000 former Servicemembers with OTH administrative discharges. As part of the initiative, former Servicemembers with OTH administrative discharges who present to VA seeking mental health care in emergency circumstances for a condition the former Servicemember asserts is related to military service would be eligible for evaluation and treatment for their mental health condition.

VA has authority to furnish care for service-connected conditions for former Servicemembers with OTH administrative discharges if those individuals are not subject to a statutory bar to benefits. Individuals with OTH discharges may access the system for emergency mental health services by visiting a VA emergency room, outpatient clinic, or Vet Center or by calling the Veterans Crisis Line. Services may include assessment, medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy. We may also provide services via telehealth.

At VA, we have the opportunity and the responsibility, to anticipate the needs of returning Veterans. As they reintegrate into their communities, we must ensure that all Veterans have access to quality mental health care. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increased its staff for mental health services. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from over 900,000 in fiscal year (FY) 2006 to more than 1.65 million in FY 2016.

We anticipate the need for VA to provide this level of mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA has taken aggressive action to recruit, hire, and retain mental health professionals to improve Veterans' access to mental health care. As part of our ongoing comprehensive review of mental health operations, VA has considered a number of factors to determine additional staffing levels distributed across the system, including: Veteran population in the service area; the mental health needs of Veterans in that population; and the range and complexity of mental health services provided in the service area.

Since there are no industry standards defining appropriate mental health staffing ratios, VA is setting the standard, as we have for other dimensions of mental health care. VA has developed a prototype staffing model for general mental health and is expanding the model to include specialty mental health. VA will buildupon the successes of the primary care staffing model and apply these principles to mental health practices. VA has developed and implemented an aggressive recruitment and marketing effort to fill specialty mental health care occupations. Key initiatives include targeted advertising and outreach, aggressive recruitment of qualified trainees/residents to leverage against mission critical mental health vacancies, and providing consultative services to VISN and VA stakeholders.

Earlier this year VA announced plans to hire 1,000 additional mental health employees. VA expects to meet the goal of hiring 1,000 new mental health FTE by December and expects to continue hiring to meet the recommended levels beyond that date. This initiative began in January 2017. As of September 1, VA has hired 649 new mental health providers, including 173 psychiatrists, 198 psychologists, 118 social workers specifically in mental health, 87 mental health registered nurses, 39 counselors, and 34 in various other occupations.

VA is committed to working with public and private partners across the country to support full hiring to ensure that no matter where a Veteran lives, he or she can access quality, timely mental health care. VA is working with its partners to expand the ways it engages with Veterans through innovation, social media, and new technologies. VA is also working within its facilities and with DOD, Service Organizations, and other partners to advance and promote lethal means safety.

CLAY HUNT SAV ACT IMPLEMENTATION

Since its enactment in 2015, VA has been aggressively implementing the Clay Hunt SAV Act, as amended, participating in a third party evaluation of mental health programs, developing a publicly available resource tool, and fostering an abundance of public and private partnerships, all in support of VA's goal to eliminate Veteran suicide.

VA has contracted with an independent evaluator to conduct an evaluation of the VA mental health and suicide prevention programs to determine the effectiveness, cost effectiveness and Veteran satisfaction with VA mental health and suicide pre-

vention programs. An interim report was dispatched to Congress last year and a second interim report is due at the end of this month. The first annual report with findings from the independent evaluation will be delivered to Congress in December 2018. We plan to use the results of this evaluation to improve the mental health care and services that VA provides to Veterans. In addition, VA has VA Resource Locator tools that include information regarding Post Traumatic Stress Disorder (PTSD), substance use disorder, and Vet Center programs, as well as contact and resource information. This tool is accessible at www.vets.gov and on www.MaketheConnection.net. VA is also making strides in implementing the pilot program to repay psychiatrist student loans as a recruitment incentive, as required by section 4 of the Clay Hunt SAV Act. VA published regulations for this pilot program in the first quarter of 2017, 81 FR 66815. VA is currently finalizing the advertisement, application policy, and procedures. Recruitment will target medical residents in their final year in the next cycle of residency applications in July, 2018. The Clay Hunt SAV Act prohibited additional appropriations for its implementation, so VA is working to identify sources of funding for this initiative.

VA has set up community peer support networks in five VISNs where there are large numbers of Servicemembers transitioning to Veteran status. Since January 2016, networks have been developed in Virginia, Arkansas, Texas, Arizona, and California. Outreach teams of Peer Specialists and their supervisors have formed coalitions with VSOs, employers, educational institutions, community mental health providers, military installations, and existing VA and DOD transition teams to connect Veterans in the community with mental health assistance when necessary. This has included providing community partners with training on Veteran and military culture, peer support skills, and interventions, as well as invitations to annual mental health summits.

VA is working with and/or building new partnerships with non-Federal mental health organizations around suicide prevention. Areas for collaboration include patient and provider marketing of educational materials and research. VA has partnered with Psych Armor, a non-profit devoted to free, online training for non-VA providers to better serve Veterans. Psych Armor uses VA expertise to help inform its course content, which is geared toward health care providers, employers, caregivers and families, volunteers, and educators. These types of partnerships are a powerful strategy to increase outreach to vulnerable Veterans. Under the Expanded Period of Eligibility provided by the Clay Hunt Act, 1,192 combat Veterans discharged between January 1, 2009, and January 1, 2011, who did not enroll in the VA health care during their initial 5-year period of eligibility have enrolled in VA care under this additional enrollment opportunity.

MENTAL HEALTH PROGRAMS

VA is committed to providing timely access to high-quality; recovery-oriented, evidence-based mental health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers into their communities.

While focusing on suicide prevention, we know that preventing suicide for the population we serve does not begin with an intervention as someone is about to take an action that could end his or her life. Just as we work to prevent fatal heart attacks, we must similarly focus on prevention, which includes addressing many factors that contribute to someone feeling suicidal. We are aware that access to mental health care is one significant part of preventing suicide. VA is determined to address systemic problems with access to care in general and to mental health care in particular. VA has recommitted to a culture that puts the Veteran first. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increased staff in mental health services. Between 2005 and 2016, the number of Veterans who received mental health care from VA grew by more than 80 percent. This rate of increase is more than three times that seen in the overall number of VA users. This reflects VA's concerted efforts to engage Veterans who are new to our system and stimulate better access to mental health services for Veterans within our system. In addition, this reflects VA's efforts to eliminate barriers to receiving mental health care, including reducing the stigma associated with receiving mental health care.

Making it easier for Veterans to receive care from mental health providers also has allowed more Veterans to receive care. VA is leveraging telemental health care by establishing eleven regional telemental health hubs across the VA health care system. Hubs are located in Seattle, WA; Long Beach, CA; Salt Lake City, UT; Harlingen, TX; Charleston, SC; Sioux Falls, SD; Battle Creek, MI; Pittsburgh, PA; Brooklyn, NY; West Haven, CT; and Honolulu, HI. VA telemental health provided more than 427,000 encounters to over 133,500 Veterans in 2016. Telemental health

reaches Veterans where and when they are best served. VA is a leader across the United States and internationally in these efforts. VA's www.Makethe Connection.net, Suicide Prevention campaigns, and the PTSD mobile app (which has been downloaded over 280,000 times) contribute to increasing mental health access and utilization. VA has also created a suite of award-winning tools that can be utilized as self-help resources or as an adjunct to active mental health services.

Additionally, in 2007, VA began national implementation of integrated mental health services in primary care clinics. Primary Care-Mental Health Integration (PC-MHI) services include co-located collaborative functions and evidence-based care management, as well as a telephone-based modality of care. By co-locating mental health providers within primary care clinics, VA is able to introduce Veterans on the same day to their primary care team and a mental health provider in the clinic, thereby reducing wait times and no show rates for mental health services. Additionally, integration of mental health providers within primary care has been shown to improve the identification of mental health disorders and increase the rates of treatment. Several studies of the program have also shown that treatment within PC-MHI increases the likelihood of attending future mental health appointments and engaging in specialty mental health treatment. Finally, the integration of primary care and mental health has shown consistent improvement of quality of care and outcomes, including patient satisfaction. The PC-MHI program continues to expand, and through May 2017, VA has provided over 7.2 million PC-MHI clinic encounters, serving over 1.6 million individuals since October 1, 2007.

VETERANS CRISIS LINE (VCL)

VA recognizes the importance of VCL as a life-saving resource for our Nation's Veterans who find themselves at risk of suicide. Of all the Veterans we serve, we most want those in crisis to know that dedicated, expert VA staff, many of whom are Veterans themselves, will be there when they are needed. The primary mission of VCL is to provide 24/7, world class, suicide prevention and crisis intervention services to Veterans, Servicemembers, and their family members. However, any person concerned for a Veteran's or Servicemember's safety or crisis status may call VCL.

VCL is the strongest it has been since its inception in 2007. VCL staff has forwarded over 504,000 referrals to local Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with their local VA providers. Initially housed in 2007 at the Canandaigua VA Medical Center (VAMC) in New York, it began with 14 responders and two health care technicians answering four phone lines. Since 2007, VCL has answered over 3 million calls and dispatched emergency services to callers in crisis more than 84,000 times. Consistent with our mission, we have implemented a series of initiatives to provide the best customer service for every caller, making notable advances to improve access and the quality of crisis care available to our Veterans, such as:

- Launching "Veterans Chat" in 2009, an online, one-to-one chat service for Veterans who prefer reaching out for assistance using the Internet. Since its inception, we have answered nearly 359,000 requests for chat.
- Expanding modalities to our Veteran population by adding text services in November 2011, resulting in nearly 78,000 requests for text services.
- Opening a second VCL site in Atlanta in October 2016, with over 250 crisis responders and support staff.
- Hiring a permanent VCL director in July 2017, psychologist, Dr. Matthew Miller.

Prior to the opening of our new Atlanta call center in October 2016, VCL had a call rollover rate to back-up call centers of more than 30 percent. Currently, the average rate is 1.24 percent, with calls being answered by the VCL within an average of 8 seconds. Overall, VCL performance is above the National Emergency Number Association service level standard of answering greater than 95 percent of calls in less than 20 seconds; specifically, the VCL's average service level exceeds 98 percent. VCL continues to exceed these metrics, despite overall call volume continuing to rise. Overall call volume has increased 12 percent since April 2017, and increased 15 percent over the course of the 2 weeks marked by notable adverse weather events earlier this month.

Today, the combined VCL facilities employ more than 500 professionals, and VA is hiring more to handle the growing volume of calls. VA will also be opening a third VCL site in Topeka, Kansas, which will give VCL the additional capacity needed as we expand the 'automatic transfer' function, Press 7, to all of its community-based outpatient clinics (CBOC) and Vet Centers. Despite all of these accomplishments and plans, there still is more that we can do.

The No Veterans Crisis Line Call Should Go Unanswered Act (Public Law 114–247) directed VA to develop a quality assurance document to use in carrying out VCL. It also required VA to develop a plan to ensure that each telephone call, text message, and other communication received by VCL, including at a backup call center, is answered in a timely manner by a person. This is consistent with the guidance established by the American Association of Suicidology. In addition to adhering to the requirements of the law, VCL has enhanced the workforce with qualified responders to eliminate routine rollover of calls to the contracted backup center. We also implemented a quality management system, to monitor the effectiveness of the services provided by VCL. This will also enable us to identify opportunities for continued improvement. As required by law, VA submitted a report containing this document and the required plan to the House and Senate Veterans' Affairs Committees on May 23, 2017. The Veterans Crisis line can be reached by dialing 1–800–273–8255, Press 1.

PEER SUPPORT AND VET CENTERS (READJUSTMENT COUNSELING SERVICE)

Peer support is integral to VA mental health care. The introduction of Peer Specialists to the mental health workforce provides unique opportunities for engaging Veterans in care. VA has nearly 1,100 peers providing services at VAMCs and CBOCs. Peer support programming has been implemented at every VAMC and very large CBOCs since 2013. Peers provide services in mental health programs and some primary care clinics. Certified peer specialists are Veterans who have recovered from or are recovering from a mental health condition and who have been certified by a non-profit engaged in peer specialist training or by a State as having satisfied relevant State requirements for a peer specialist position. These peer specialists are employed by VA to provide support and advocacy for Veterans coming to VA for treatment of mental health conditions, including PTSD. Crisis intervention and suicide prevention are skills that peer specialists apply from the moment they first meet Veterans coming in for treatment and throughout their treatment cycles. Working with Veterans who have recovered from mental health conditions, including many who have also survived suicidal ideation or attempts themselves, demonstrates to other Veterans that there is hope for recovery and a quality life after treatment.

VA's Office of Readjustment Counseling Service (RCS) operates VA Vet Centers (www.vetcenter.va.gov), which are welcoming community-based counseling centers situated apart from larger VA medical facilities and placed in convenient, easily accessible locations. Based on the Veteran peer model, clinical staff at these Centers provide confidential professional mental health services and psychosocial counseling services as needed to help assist Veterans and active duty Servicemembers (ADSM) (including members of the National Guard and Reserve components) who served in a combat-theater or area of hostilities achieve a successful readjustment to civilian life. Readjustment counseling services and other services (e.g., consultation, counseling, training, and mental health services) are available to their family members if essential to the effective treatment and readjustment of the Veteran or ADSM. Readjustment counseling services include, but are not limited to, individual counseling, group counseling, marital and family counseling for military-related readjustment issues. Use of non-professional Veteran peer counselors at the Vet Centers also helps contribute to the RCS mission. Readjustment counseling services are provided through 300 Vet Centers, 80 Mobile Vet Centers, and the Vet Center Call Center. In FY 2016, Vet Centers provided over 258,000 Veterans, ADSMs, and their families with 1,797,000 visits.

In addition, Vet Center staff facilitates community outreach and the brokering of services with community agencies that link Veterans and ADSMs with other VA and non-VA services that can help with their successful readjustment to civilian life. One of the Vet Center core values is reducing barriers to access to readjustment counseling services. To this end, all Vet Centers offer services during non-traditional times such as early mornings, evenings, and weekends. Barriers to access based on distance (i.e., communities distant from the 300 "brick and mortar" Vet Centers) are ameliorated by having Vet Center staff regularly deliver readjustment counseling services in Vet Center Community Access Points (CAP). Generally speaking, CAPs are established when community partners, pursuant to a no-cost arrangement, permit Vet Center counselors to provide readjustment counseling services on their premises on a regular recurring schedule (ranging from service provision once a month to several times a week). CAPs allow Vet Center clinicians to provide services at a level that is in line with the fluid readjustment demands and needs of that community. Currently, Vet Center staff operates over 820 CAPs. In FY 2016, Vet

Center CAPs provided 236, 435 readjustment counseling visits, a 6% increase over FY 2015.

RCS leadership is also working in close collaboration with Veterans Health Administration's Office of Mental Health and Suicide Prevention to implement improved collaboration to better improve coordination and referral between Vet Centers and VA medical facilities. A memorandum of understanding was signed in August 2017 to formalize this relationship and outline improved communication processes, training, collaboration, and access to important suicide predictive data to help decrease suicide within the Veteran population. Vet Center counselors are trained, as part of assessment, to identify Veterans or ADSMs who are at high risk of harm or suicide. They refer these clients to their treating mental health providers (or for emergency services, if appropriate). And if a Veteran client is getting his/her care through VA, Vet Center staff refers the shared Veteran client to the local VAMC and the Vet Center counselor also contacts the facility's Suicide Prevention Coordinator to ensure that enhanced care delivery procedures for suicide prevention are in effect.

CONCLUSION

Mr. Chairman, all of us at VA are saddened by the crisis of suicide among Veterans. We remain focused on providing the highest quality care our Veterans have earned and deserve and that our Nation trusts us to provide. Our work to effectively treat Veterans who desire or need mental health care continues to be a top priority. We emphasize that we remain committed to preventing Veteran suicide, and aware that prevention requires our system-wide support and intervention in preventing precursors of suicide. We appreciate the support of Congress and look forward to responding to any questions you may have.

Chairman ISAKSON. Thank you very much, Dr. Shulkin.

The Ranking Member asked that Senator Manchin be recognized first, and so to honor that, Senator Manchin?

Senator MANCHIN. Mr. Chairman, I cannot thank you enough. I am so sorry. I have a hard 11:30 meeting with about 100 children here, but I wanted to ask a couple of questions.

Secretary SHULKIN. Sure.

Senator MANCHIN. Dr. Shulkin, I know that you are aware, and there are more and more stories in the news about veteran suicides. The most alarming one is they are doing it in parking lots. They are doing it coming to the VA facilities and doing that. We just had one in Clarksburg.

Secretary SHULKIN. Yeah.

Senator MANCHIN. I do not know what you can do to train your security in this, in that. I just do not know how to do it, but I know there is some timing involved here. Everything goes in lockdown if it is on the property, but it is becoming more of an occurrence than we ever thought it could be. I do not know if you all have taken steps, if it has been at a high enough level to where you know it is a problem around the country.

Secretary SHULKIN. Yeah. Oh, believe me, we are extremely aware of this. It is so painful to hear each of these stories.

You are right that what we are seeing is that people are coming onto VA property, and we are doing a number of things. Part of these declarations that every one of our facility leadership are signing are 10 action steps. One of them is to train, just like this Committee, every one of our staff members in suicide prevention and risk identification and what to do, and we are establishing much off of what we learned in our homeless program that you do this through a no-wrong-door approach.

So, a veteran who is at risk and somebody identifies them should know where and what to do and have a responsibility to follow through.

Senator MANCHIN. Can I ask this question, if I may, real quick?
Secretary SHULKIN. Yes. Yep.
Senator MANCHIN. What I am concerned about——
Secretary SHULKIN. Yeah.
Senator MANCHIN [continuing]. And it is alarming, you know, this in people—it is not well publicized, as you know. It is becoming more and more, and when it happens in a small rural State such as West Virginia in a parking lot at a VA that a lot of—we have an awful lot of veterans in our State. I am concerned about maybe this being taken inside the hospital to where it is more than just that person doing harm to themselves because they need help.
Secretary SHULKIN. Mm-hmm.
Senator MANCHIN. I do not know how you secure that. Are we securing the hospitals? Can we secure the—because we all have to come through. To come onto VA property, we have to have a stop. There is a checkpoint.
Secretary SHULKIN. Right.
Senator MANCHIN. I do not know, but I would hope you would consider that.
Secretary SHULKIN. Right.
Senator MANCHIN. But I want to go to another question-—
Secretary SHULKIN. Yes.
Senator MANCHIN [continuing]. Very quick, if I can.
Secretary SHULKIN. Sure.
Senator MANCHIN. I am just saying please at the highest element you can. I am concerned.
You talked about 1,000 additional mental health professionals. OK. I am talking about a rural West Virginia, a rural Montana, this and that.
We had one vacancy for a psychiatrist in Clarksburg that was posted in January 2017. We had another vacancy for a psychiatrist to oversee the addiction program in Martinsburg. That has been posted since October 2016. And another vacancy for our psychiatrist in Martinsburg just posted within the last 5 or 6 months, and there is vacancies for mental health counselors at both Beckley and Princeton. So are you having a harder time in rural—can you tell me, of the 690—649 people that have been hired, what is the ratio between rural and urban? Because it is probably a lot easier to get somebody——
Secretary SHULKIN. Yep.
Senator MANCHIN [continuing]. In an urban area than a rural, so we are going to have to put more effort in that.
Secretary SHULKIN. Yeah. Well, I think you have it right.
Martinsburg is actually, believe it or not, a success story.
Senator MANCHIN. Yeah.
Secretary SHULKIN. We have—about a year and one-half ago, I was really concerned about their staffing levels. They have done a great job of bringing people on, but in general, it is harder to recruit in rural areas. There is no doubt.
Our urban areas, where there are more trainees and younger people are staying, that is where we are establishing our 11 telemental health hubs to be able to help support the rural areas.
But, you know, this is where we want to see expanded graduate medical education programs in those rural areas.

Senator MANCHIN. Do you have a loan forgiveness program?

Secretary SHULKIN. We do. That is part of the Clay Hunt Act. We use up all of our dollars that you allow us to use. We would like to use more because it is a very effective program, and in the Clay Hunt program, you have asked us to do that more. But, you did not appropriate money for us, so we are trying to find the additional dollars that will be in July 2018.

Senator MANCHIN. I have more questions, but I will go ahead and give them later. I want to thank you all so much for the job you are doing. Thank you.

Secretary SHULKIN. Yes.

Chairman ISAKSON. I think I have got this right. We are going to go to Senator Moran, then to Senator Murray, then to Senator Rounds, then to Senator Tester, and I will finish up.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you very much.

Secretary, thank you for joining us this morning on a hugely significant and unfortunately so timely topic.

First of all, I want to highlight the hearing that our Appropriations Subcommittee had in April on this topic, but I want to remind you, Mr. Secretary—and I understand that Senator Murray has a question for you about VA follow-through on a commitment that was made at that hearing. It was committed by the VA that we would get monthly reports in regard to your efforts, the Department's efforts, to comply with the Inspector General's recommendations and failures at the VA in regard to suicide. We have not received those reports on a monthly basis.

I will defer to Senator Murray, but I would join her in her request that what was promised would actually be followed through on.

Let me then talk about another topic that Senator Tester and I have worked on. We have been trying for a long time—and in fact, in 2010, now 7 years ago, gave the VA the authority to hire marriage and family therapists and licensed professional mandatory counselors. The results of that authority have not resulted in any significant hiring of either one of those professionals. I would guess that Senator Tester and I are interested in this reason for the scarcity of professionals generally but especially, as you were indicating, in rural communities, and so we have sought and have provided congressional authority for the VA to hire. You indicate you are in the process of hiring 1,000 additional professionals, but I would tell you that after 7 years, those two categories only account for 2 percent of the mental health workforce at the Department of Veterans Affairs.

Senator Tester, I, and others have a letter to you in this regard that was sent to you just a few days ago, but in this hiring, would you again commit to filling these positions with those professionals, something that has not happened? If so, how many of those are going to be—what would your prediction be would fit a Marriage and Family Therapist (MFT) or a Licensed Professional Mental Health Counselor (LPMHC), and would you provide me with those numbers as you fill those positions? I assume that there will be a

priority given in regard to places that are hard to recruit professionals.

I also know that you have hiring authorities that are difficult. I do not know what your expedited hiring authorities are. What are they? Do you currently—what do you have at your disposal, and do they apply to mental health professionals? What needs to happen to fix this problem?

We have noticed so many times that the things that are having to be posted do not result in any kind of quick response for hiring at the VA.

We discussed this topic with Dr. Stephanie Davis who testified. She is at the eastern part of our Kansas VISN. She testified before our Appropriations Subcommittee in April, jobs are posted at USAjobs.com, where applications can linger for 4 or 5 months. People find other jobs in the meantime, and it becomes even more impossible to recruit and retain. We know that positions sit vacant for months or even years while providers go through the process of the Federal hiring mechanism. What can you do to get that process expedited?

Finally, Mr. Secretary, I wanted to tell you that I was just within—earlier this month at the Phoenix VA, where I saw one of the pilot programs under the Clay Hunt Act. They are called Be Connected. I was impressed. What this is about is having those who have similar circumstances, who have served our country, who are veterans themselves who have had PTSD and other problems, as the counselors for those who are calling the number. I would be interested in knowing what the VA is doing to support Be Connected, and are there others plans—are there plans to expand that program elsewhere?

Secretary SHULKIN. A lot of questions, so I am going to go really quickly, and anything I do not do an adequate job on, I will follow up.

First of all, on the issue that you talked about us not providing timely follow-up—and if Senator Murray is going to comment on that too—look, that is unacceptable. If we say we are going to commit to something, my expectation is that we commit to it. So I appreciate you letting me know about it. I can assure you my staff will be knowing about that, but we will do better. That is just not the way that I want the Department run. So, we will make sure that you get that.

On the marriage and mental health counselors, I look forward to the letter. I am aware that we continually hear about VA's strictness on our accreditation issue. This is particularly a training issue, since there are two accreditation programs. We are committed to bringing on marriage and family therapists.

If Dr. Carroll has any specific information on numbers, I would defer to him in a second.

On the issue of hiring, look, it is the single most challenging thing that I know of in VA. It should not be that hard to get people on board.

In the Accountability Act that the Chairman referred to that we passed together not too long ago, you gave direct hiring authority to medical center directors. That is really helpful to us. It allows us to skip over a lot of the red tape. I want that authority for all

of our critical health professionals. I would urge us to work together on that. It is just too hard to get people hired into the VA.

Senator MORAN. Do you have the authority under the Accountability Act to do what you need to do?

Secretary SHULKIN. Only under medical center directors.

Senator MORAN. OK.

Secretary SHULKIN. If we could work on expanding that, I would love to target it for mental health, you know, but we have other health needs as well. I would love to work with you on that.

On the Be Connected program, peer support is something that we are really committed to. We think this works, particularly for veterans who understand what they have gone through. Thank you for your visit. Thank you for mentioning that, IT is something that we are going full force on.

Senator MORAN. Do you have other plans for that program elsewhere?

Secretary SHULKIN. Yes. We already have about 1,100 peer support counselors, and much of our Vet Center model is actually based on that model. We know it works, and Vet Center growth has been continuing to go up each year.

Senator MORAN. Thank you.

Chairman ISAKSON. I know Dr. Shulkin wants to be sure we point out, since the resident State of Senator Moran is Kansas, that the third mental health hotline center——

Secretary SHULKIN. Yes.

Chairman ISAKSON [continuing]. Is being set up in Topeka, KS, if I am not mistaken.

Secretary SHULKIN. You are absolutely correct.

Senator MORAN. We are delighted to have you.

Chairman ISAKSON. Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, thank you so much for having this hearing. It really is such an important topic. I was able to listen to much of the first panel from my office between meetings. It really was good, and I appreciate it.

Secretary Shulkin, thank you for being here. Thank you for your testimony, and thank you for saying in your testimony this is the number 1 priority, because it is.

Secretary SHULKIN. Mm-hmm.

Senator MURRAY. But, I do remain deeply troubled by the IG's findings from May 2017 that VA is not complying with a number of policies, including 18 percent of facilities not meeting the requirement for five outreach activities each month, 11 percent of high-risk patients' medical records did not have a suicide prevent safety plan, and for 20 percent of inpatients and 10 percent of outpatients, no documentation the patient was provided a copy of the safety plan. There were several shortcomings in the use of patient record flags, coordination of care for patients at a high risk of suicide, and critical improvements to follow up for high-risk patients after discharge. Sixteen percent of non-clinical employees did not receive suicide prevention training, and more than 45 percent of clinicians did not complete suicide risk management training in their first 90 days.

When it comes to suicide prevent policy, to me anything less than 100 percent is not acceptable. When will all the IG's recommendations be fully implemented?

Secretary SHULKIN. Well, first of all, this is exactly why the IG is valuable, pointing this out. I have no other mechanism to get data that comprehensive. We have committed to addressing the IG concerns.

The reason why we have made suicide prevention the number 1 priority and made all of our leadership this month sign off on the declaration is to fix those issues. We have committed to training.

Over this year—look, 100 percent is the right goal, but I cannot tell you exactly what date we are going to reach that. We are going to be working really hard to get as close to that as possible as quickly as possible.

Senator MURRAY. Well, as Senator Moran alluded to at the veterans suicide hearing at the VA Approps Committee back in April——

Secretary SHULKIN. Mm-hmm.

Senator MURRAY [continuing]. I asked for monthly updates until all of the problems of the crisis line are resolved. VA has not done that, and that is really unacceptable. So, I want a commitment from you today——

Secretary SHULKIN. Mm-hmm.

Senator MURRAY [continuing]. To all of us that we will get those updates starting right now.

Secretary SHULKIN. I think you have that commitment. Yes.

Senator MURRAY. OK. Well, we will intend to see that happen.

Let me ask about women veterans. This is something I have asked about many times. I am really disturbed by the increase in suicide rate among our women veterans. Between 2001 and 2014, the rate of suicide for women veterans who do not use VA care increased by 98 percent.

Now, I have heard from women veterans many times about how they do not think of themselves as veterans, and I hear far too often from women who do not feel welcome at our VA facilities, just do not feel like that is their place. It is a significant problem, actually, that the RAND Corporation testified in April as well, but this increase in suicide is the most important reason yet that I believe VA has to redouble its efforts to reach out to women and get them into care. So, I wanted to ask you, what are we doing to address that?

Secretary SHULKIN. Well, you gave a really important statistic, which is that those that over the last 15 years, between 2001 and 2014, those women that did not receive care in the VA, that the rate of suicide went up by an extraordinary number. You said 98 percent.

Those that did use the VA, we actually saw a decrease, a decrease in suicide rates over that 15-year period of 2.6 percent. We know that particularly in this population, but it is for all veterans, getting care and access to care makes a difference and saves lives.

The issue about making the VA more welcoming to women is a critical issue. It is a cultural issue, and we have worked hard to create women centers and to change the culture and environment.

I speak about this, so does our Center for Women Veterans, all the time.

But, of course, we are absolutely, as this is our number 1 priority, committed to doing much more and to be more aggressive and to put more resources into this.

Senator MURRAY. OK. Well, this is something we have to keep working on because if a women does not consider herself as a veteran, she does not think about going to the VA.

Secretary SHULKIN. Right.

Senator MURRAY. If she is not welcome at the VA or does not feel that the veteran facility is welcoming to her, she will not go. If she has other issues—child care, work—it is doubly hard. This is not an easy problem to solve, but we really have to put hearts, minds, resources, and as a country really recognize women veterans.

Secretary SHULKIN. I agree.

Senator MURRAY. I feel very strongly about that.

I just have a couple seconds left. I wanted to, if I can, just to ask about the VA's REACH VET initiative, to use predictive models to identify veterans who may be at risk of suicide before it happens. I wanted just if you could quickly tell us how that model works, but also 14 of the 20 veterans who die each day by suicide do not come to the VA for care. Again, I want to ask, how does that work for folks who are not coming to the VA?

Secretary SHULKIN. All right. Very quickly, REACH VET is a big data analytic research project that when I was Under Secretary, I said, "It is time to stop researching it and start putting it into practice," validating Senator Tester's point about every day we delay, there is going to be more deaths.

We have moved it into the clinical setting. Our suicide prevention coordinators get lists of veterans' names that are in the highest, 0.1 percent risk of suicide, 80 times higher risk than a person who is not on the list, and they proactively are calling out every day saying, "How are you doing? How can we potentially help you in anything that you need help with?" and connecting with them.

I meet with those people. Dr. Carroll has more contact, of course. It is making a difference, though I do not have statistics.

Senator MURRAY. Are you working with local groups and providers and non-VA agencies to use the program?

Secretary SHULKIN. No. We do not have that data. REACH VET data, because of its limitation, uses VA user data off of our electronic medical records. We have no way of identifying the 14 in the community. That is a big issue for us.

Senator MURRAY. Yeah.

Secretary SHULKIN. I think expanding VA access in mental health will save lives. That is why I made the decision on other than honorable discharges to do that.

We have a big hole here. One of the big holes is with the Department of Defense. What we are working with now with them—and they are being very cooperative—is essentially an auto enrollment program, so nobody leaves active service without knowing where they can get their mental health care. I think that is going to be a big deal in eliminating a gap right now that we have.

Senator MURRAY. OK. Thanks very much. Appreciate it.

Chairman ISAKSON. Senator Cassidy.

Senator CASSIDY. Dr. Shulkin, again, let me just echo others' praises for the changes you have made in your reign so far, so, anyway, thank you for that.

I had mentioned earlier with the earlier panel, there is a professor of economics out of Princeton, Anne Case, who is—I will quote the article, "rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century." What I am trying to figure out is what we are looking at as a specific veterans' phenomena or it is just reflective of the cohort within the VA but is also throughout. Are you with me?

Secretary SHULKIN. Yes, I am.

Senator CASSIDY. They find among this population that the increase for whites was largely accounted for by increasing death rates from drug and alcohol poisoning, suicide, chronic liver disease, and cirrhosis, although all education groups saw increases in mortality from suicide and poisoning. I could go on.

I guess what I am trying to figure out is how much of this is unique for the VA relative to this study as opposed to it is just kind of what we are seeing in society?

Secretary SHULKIN. Right. Well, first of all, your questions before were excellent. We do not adjust by socioeconomic status because the way that we collect the data off the National Data—Death Index and from the CDC data and VA data does not have a socioeconomic status.

Senator CASSIDY. Now, let me ask, though, because as a physician, when I used to practice——

Secretary SHULKIN. Yes.

Senator CASSIDY [continuing]. I would find that usually folks who are a little bit more well-to-do did not go to the VA for their health care.

Secretary SHULKIN. Yeah. Well, our eligibility does not allow it unless they are service-connected.

Senator CASSIDY. But even though the service-connected who actually had, you know, more money, may have preferred a different facility for whatever reason.

Secretary SHULKIN. Mm-hmm.

Senator CASSIDY. Do you know the mean socioeconomic class of your typical VA attendee versus the general population?

Secretary SHULKIN. Yes, yes. We are definitely more a safety-net organization, in general.

Senator CASSIDY. So, by proxy, we can assume——

Secretary SHULKIN. Yes.

Senator CASSIDY [continuing]. That you have a higher death rate among those being seen, that that would probably reflect your overall population?

Secretary SHULKIN. Yeah, yeah. You know, my background is not hepatology; it is health services research. So, I am going to give you my best guess, you know, educated guess.

There is a socioeconomic status component that I think you are identifying, but the veteran population is more than that. You would not see as large a difference. I think it is both in here. I think——

Senator CASSIDY. Now, we tease that out——

Secretary SHULKIN. Yeah.

Senator CASSIDY [continuing]. Because, again, if it is merely reflective of the larger population, that is tragic.

Secretary SHULKIN. Mm-hmm.

Senator CASSIDY. But, VA represents the hope.

Secretary SHULKIN. Right.

Senator CASSIDY. If it is not, being a veteran in the VA system is an additional risk factor, then that is something to be identified and corrected.

Secretary SHULKIN. We will give that to our health services research team to see if we can do that.

We published 75 articles on suicide and suicide prevention last year, and we have a good team on this that I think could maybe tease some of that out.

Senator CASSIDY. Now, let me ask—my staff has just given me, but I have not yet comprehended it, a spreadsheet that has been distributed, the Mental Health Domain Composite Summary, Fiscal Year 2017, Quarter 3. I have status for Louisiana. I cannot say I comprehend them yet, but I know you have done that analysis.

Secretary SHULKIN. Mm-hmm.

Senator CASSIDY. Is there a difference in suicide rates associated with different facilities? Again, hopefully correcting for that each population is the same, but I am assuming it is roughly a homogenous population.

Secretary SHULKIN. I have seen the analysis by State, not by facility.

Dr. Carroll, have you seen that?

Mr. CARROLL. No. The analysis is by State, and the veteran population is not homogenous from one State to the other, nor is the general population. There are State differences in the population, both at large and for veterans.

Senator CASSIDY. I accept that. But probably, broadly, Louisiana has a higher African-American population, and some States have a higher Hispanic. So, there is going to be that broad demographic.

But, Dr. Casey pointed out that it is among non-Hispanic whites that we are really seeing a bump in the general population.

Dr. Carroll, have you done any kind of very rough—as I was told in the previous panel, yes, we have it for age and gender. I could see throwing race in there because that is usually pretty apparent. Do we have any sort of, kind of rough estimate on that?

Mr. CARROLL. Those analyses are ongoing, so we are looking at ethnicity and race as part of the ongoing evaluation of the data.

Senator CASSIDY. Now, let me ask as well, because you are sending out this data—but thank you very much—looking at specific facilities. I am presuming that most vets, not all, but most vets have a facility of choice.

Secretary SHULKIN. Yes.

Senator CASSIDY. Does your analysis—is your analysis going to include the rate of—corrected for all these other factors, how each specific facility is doing? Senator Murray pointed out that we are not getting 100 percent of these being passed out, but I suspect that that would vary from facility to facility as well.

Secretary SHULKIN. Yeah, yeah. I think the type of statistics that Senator Murray was talking about, about compliance with screen-

ing, absolutely is done not only at the facility level, but by the specific provider.

Senator CASSIDY. Oh, yes. That would be good.

Secretary SHULKIN. Yeah, yeah. Because you have electronic medical record data on that.

The broader statistics, which include the National Death Index and other things, may be harder to do by facility, but chances are we could——

Senator CASSIDY. But you could at least do it by State and by catchment area——

Secretary SHULKIN. Absolutely, yes.

Senator CASSIDY [continuing]. Because I think we need to know is this a VA issue or does it just reflect broader society.

Secretary SHULKIN. Yeah.

Senator CASSIDY. If it is a VA issue, we need to give you tools. As a broader society, we need to correct, do something more broadly. Does that make sense?

Secretary SHULKIN. Right. You do have—you do know about the difference between veterans who are getting care in the VA and not in the VA.

Senator CASSIDY. I saw that.

Secretary SHULKIN. Yeah.

Senator CASSIDY. Clearly, you would want to correct for that.

Secretary SHULKIN. Yeah.

Senator CASSIDY. You mentioned your safety net, and we suspect that—my suspicion is in some places, you are serving as a safety net, and in some places, there is inadequacy——

Secretary SHULKIN. Yeah.

Senator CASSIDY [continuing]. In which case we have to identify that and address it.

Secretary SHULKIN. Right.

Senator CASSIDY. If you need tools, we have to give them to you.

Secretary SHULKIN. Mm-hmm.

Senator CASSIDY. Thank you all very much. I yield back.

Secretary SHULKIN. Thank you.

Chairman ISAKSON. Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, and thanks to the Ranking Member, too, for yielding me the time.

I want to follow up on Senator Murray and Senator Cassidy, too, who talked about the suicide report, and I first thank you for being here. Thanks to Dr. Carroll, too.

I do not really understand. In my State, 244 veterans took their own lives in 2014. I want to talk about them and the thousands around the country. I am not really clear on why you would release that State-by-State report on a Friday afternoon at five o'clock. That is not really my question. I do not understand why you would do that.

But, talk to me about how you share this data State by State, how you share it with veterans, with medical centers, with CBOCs, with community providers, with academia, and to address what you called the national public health issue.

Secretary SHULKIN. Yeah. We have—this analysis, which was released on September 15, a Friday, at five o'clock, is really the first time that we have released that type of specific data. We are actively trying to get that out and to share it with the groups that you have mentioned.

There was no attempt to downplay this issue. If there was, it was a bad strategy because what we are seeing all around the country is that data getting out there and being picked up by the press, being discussed in forums. It is exactly what we want to have happen. We are actively disseminating it, because if you do not know your data, like you know 244—and to the point of Senator Cassidy, I want every medical center director knowing what their number is, how many veterans they lost last year, last month, last day. You cannot design as effective intervention as this.

Senator BROWN. That means not just a patient from that medical center. It means that——

Secretary SHULKIN. It is population.

Senator BROWN [continuing]. Never got into the VA system in Franklin County or whatever.

Secretary SHULKIN. Yeah. The catchment areas, the populations.

Senator BROWN. OK, OK.

Secretary SHULKIN. Yeah.

Senator BROWN. Talk through how the new PSA implores the country to leave no vet behind. It is my understanding that 14 out of the 20 vets who take their lives each day do not use VA care. Talk to us, if you would, about the REACH VET initiative, what metrics you have in place to see how it is working, what your—what the process to get those 14 who then will not take their lives if they get VA care.

Secretary SHULKIN. The REACH VET program is not for the—is not for those that are not using VA. It is for those that are using VA that we know are at high risk.

We are beginning to start tackling the 14 that are not using VA through other strategies. Letting other-than-honorable discharges have emergency mental health is a strategy that will bring some of those 14 into the VA.

For others that are not eligible or choose not to go to VA, we are working with community partners, we are working with veteran service organizations, and working with the churches and the synagogues to make sure that they understand that they have a responsibility in this.

The PSA message, essentially, is suicide prevention is everybody's business, and we need family members, friends, coworkers to be able to identify people at risk to get them help, whether it is at VA or outside VA.

Senator BROWN. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Dr. Shulkin, for your work on this issue, and you heard a number of my questions earlier today, as you were here——

Secretary SHULKIN. I did.

Senator BLUMENTHAL [continuing]. About that difference between the veterans who have used the VA and the veterans who

have not done so. I know you have been asked a number of questions about that issue so far.

I want to focus on the less-than-honorable discharge group. Do you have any thoughts about how——

Secretary SHULKIN. Yeah.

Senator BLUMENTHAL [continuing]. That cohort can be better accessed and how they can be encouraged to come forward?

Secretary SHULKIN. Yeah.

Senator BLUMENTHAL. Because I think that the knowledge about them is also lacking.

Secretary SHULKIN. Yeah. Well, quite frankly, I did what I could. It was one of the first things I did as Secretary, which is just to use the authorities that I had to offer emergency mental health services, because I thought it was wrong that we were not providing access, we are letting them out there. They are at higher risk for suicide, as homeless veterans I believe are at higher risk.

But, I did as much as I can. Now, I actually need your help. We are going to need legislative changes to allow us to offer other-than-honorable discharges to be able to access our full array of mental health and physical services. All that I was able to do was to offer 90 days of emergency treatment, and then I am trying to find them other places to get care working in the community.

We are going to do everything we can, but it is not the ideal approach. We could use your help in this, Senator.

Senator BLUMENTHAL. Well, I would like to work with you.

Secretary SHULKIN. Yeah.

Senator BLUMENTHAL. I have other questions, so I would——

Secretary SHULKIN. Sure.

Senator BLUMENTHAL [continuing]. Hope we can pursue this issue as to all of the veterans who right now are, through no fault of their own, perhaps, not part of the VA system.

Secretary SHULKIN. Yeah.

Senator BLUMENTHAL. I know you have been asked about the Clay Hunt Suicide Prevention Act.

Secretary SHULKIN. Mm-hmm.

Senator BLUMENTHAL. I would also like to follow up on that, particularly as to the funding that is necessary.

Secretary SHULKIN. Mm-hmm.

Senator BLUMENTHAL. The President has signed a number of measures dealing with veterans issues. Those pieces of legislation have been long in the works, and we have devoted a lot of time and attention to them. And I hope that his apparent commitment to those issues will translate into funding, which is really the test.

It is fine to wield a pen on measures that were started well before his presidency. Now is the test of his commitment, and I think that applies to issues like the Veterans Crisis Line, the Clay Hunt veteran suicide prevention measure, and I would like to again ask you about women veterans and what expanded or enhanced efforts you contemplate involving women veterans.

Secretary SHULKIN. Mm-hmm. Well, first of all, thank you for highlighting, I think, all these issues that are important.

The President's budget, the requested budget, actually has increased funding for both mental health care and women's health care issues, both critically important. I think that he does share

that commitment that you have to seeing us do better in these areas.

Senator BLUMENTHAL. Is that amount of money, in your view, sufficient?

Secretary SHULKIN. I was very pleased with the President's budget. I think that many of the issues that we are dealing with were not financial issues solely, but in areas that we have to do better in, I am not only seeking additional funds, as we saw in the President's budget, but I am actually moving current budget funds into higher-priority areas. I do think that we have sufficient resources this next year, should the President's budget get approved.

Senator BLUMENTHAL. I would be remiss if I did not ask you about the West Haven veterans facility. You and I have talked about it. It was built in the 1950s. It is out of date structurally. It needs more than just rehabilitation. It really needs rebuilding, and I wonder where it stands on the list——

Secretary SHULKIN. Yeah.

Senator BLUMENTHAL [continuing]. Of priorities and whether the President's budget is sufficient to cover the capital improvement there and elsewhere.

Secretary SHULKIN. Yeah. As you know, you and I stood outside that building, and I think your assessment is generous.

I trained at the West Haven VA, and I do not think it has changed too much since I was there.

We are still undercapitalized in the VA. We have a very old infrastructure, but I think realistically, we cannot expect to take decades of essentially underfunding and fix it all at once. So we are putting more funds—we have requested more funds into the modernization of VA. I have announced that I want to dispose of 1,100 facilities that are not being utilized well by veterans to put back into facilities that are busy, like the West Haven VA.

I do not have a specific number of where the projects are, but certainly, I am going to support fixing the West Haven VA and other facilities that are not modernized. Part of that is we are going to have to redo our matrix on how we make capital decisions, because right now I will tell you, the number 1 weighted factor and where the money goes is to seismic improvements.

And while that is really important—and I am not going to say that that is not critical—you are not on a fault line, and it puts facilities like West Haven at a disadvantage. So we are going to be looking at that.

Senator BLUMENTHAL. Well, I hope I can be generous in pushing West Haven to a higher level on the list. As you noted, I was being generous. It has really changed little, if at all. There are some cosmetic——

Secretary SHULKIN. Right.

Senator BLUMENTHAL [continuing]. Improvements, but you well know the level of dissatisfaction that——

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. Exists about it, and I would add that it is dissatisfaction with the structure——

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. And the capital facility, not with the staff.

Secretary SHULKIN. I agree.

Senator BLUMENTHAL. I want to just give a shout-out to the very dedicated men and women who work for the VA in Connecticut, and I have no authority to speak on behalf of veterans in Connecticut, but generally, I find a high level of approval and satisfaction. So they deserve our thanks, and they work under conditions that should be better for them and for our veterans.

Secretary SHULKIN. Yeah. No, I am sure they will appreciate both of those sentiments. Yes.

Senator BLUMENTHAL. I would like to invite you to come visit again and be at that facility with me again. And I want to thank you for——

Secretary SHULKIN. I do have a visit scheduled. I will let you know——

Senator BLUMENTHAL. OK.

Secretary SHULKIN [continuing]. When that is, so we can get there together.

Senator BLUMENTHAL. Wonderful.

I thank you, by the way, in the meantime for the work that is being done on the Wi-Fi Internet connections, which is very important there and at VA facilities around the country.

Secretary SHULKIN. Exactly.

Senator BLUMENTHAL. So, thank you.

Secretary SHULKIN. Thank you.

Chairman ISAKSON. I want to add to your answer a second ago, and if I am wrong, I want you to tell me. That as you go through your 1,100-location evaluation of underutilized facilities, to rearrange your capital to invest in places that need more help, you are going to consider rural locations, rural States, population density, and things of that matter, so that North Dakota and Montana and States of the like population do not lose out on a statistic in terms of the availability of CBOCs and clinic association?

Secretary SHULKIN. What I announced is that—first of all, I share the sentiment that we do not want policy that discriminates against locations because they are rural or because they are not on seismic fault lines.

But, what I announced previously was that in the State home money distribution that the rural areas were never getting—from the bottom of the list. I committed to re-looking at those criteria because the State home grant monies really were going only to very small numbers of States, essentially.

I do want to make sure that we are modernizing the facilities in an equal way across the country.

Chairman ISAKSON. I want the Ranking Member to make sure we knew we were looking after his interests as well.

Secretary SHULKIN. Yeah.

Chairman ISAKSON. Senator Tillis.

Senator TILLIS. Thank you. That is why you are such a good Chair, Mr. Chair.

I was going to end with the capital projects, but let me go to that because I think this is critically important. You have said that you believe—I believe the President has a real commitment to veterans in accelerating some things and frankly did not move as quickly as I would have liked for them to have in the past couple of years,

but I have the same view in my role at Senate Armed Services. We are always going to have fewer resources than you want.

Secretary SHULKIN. Right.

Senator TILLIS. And shame on any Member of Congress who advocates for moving something up ahead of line where the data does not say it is the best way to provide care to the communities that need it.

I am in North Carolina. I am in a 50 percent urban, 50 percent rural State, with over a million veterans—10 percent of my population. But, if you told me Montana is where the resources need to go to serve that population, that is where I want them to go.

Along with that, when you are taking a look at optimizing capital projects, shame on any member who tries to come up with a statutory protection for something that you do not think is in the interest of supporting the veterans.

I every once in a while will call up a VA facility the night before I just happen to be in town and want to stop in and see them. I say, "This is not a surprise visit. I just want to talk to you all."

I stopped in one a year or so ago who said that they have made a proposal to actually consolidate two operations that were only about 40 minutes apart. It made total sense. They thought they could provide better care to the veterans by consolidating these resources and getting more leverage out of them.

But, we had a Member of Congress stop that because it happened to affect 75 jobs in their district. That is not the way we should be thinking if we are going to get out of the way and let you support veterans in a more appropriate manner.

So, we need to make sure that—I need to make sure that I have your commitment that at any time you see us doing something that is at odds with what in your best professional judgment is getting the resources to the communities that need it most and making optimal the resources that we are giving you, I want to know who that is because I think they should be held accountable.

Now on the electronic medical record. I want to go back to the questions I asked the first panel. Actually, I want to thank you for being here because I was rushing in and I mistakenly thought you were on the first panel. But, it does not surprise me that you and your team were here to hear that testimony, and I thank you for that commitment.

I like the decision that you made for the baseline system because I think it is an accelerating between DOD an VA, but similar to the question I asked you the question when you were here last, we know that we have got over 120 instances that have to be consolidated within VA. But even more importantly, we have non-VA care providers out there. We have choice providers out there.

I believe that as you get further into the implementation plan that we discussed in my office that you are going to identify that you need other layers in the technology stack to make sure that we know how prescriptions are being dispensed, whether there is any dangerous interactions, other indicators that you can use to make that a more productive experience for the provider and for the patient.

Have you gotten to a point now where you are thinking through how you—as you are looking at your implementation priorities and

your broader transformation plan, the remainder of the stick—or we used to call it "glue-ware"—the other, either custom efforts or hopefully buy and configure tools you are going to need to kind of flesh out that technology sector?

Secretary SHULKIN. Yeah. We have gotten to essentially the principles that you have talked about, saying a system that is going to work into the future is going to have to have the components that, frankly, you have done a good job of outlining.

We have not gotten to defining which specific tools they are yet and how we are going to meet those needs, as we have talked about the days of VA being a software developer are over——

Senator TILLIS. Good.

Secretary SHULKIN [continuing]. And we are going to be looking at off-the-shelf current technologies. But, there is going to be a lot more definition on that.

I think yesterday we released to Congress, to you, the 30-day notice of an award of a contract. We are keeping on the timeline that we talked about. We are marching forward. We have the principles. I have some updates to share with you on the strategic IT plan, because I think we are making a lot of progress with that.

We are going to announce that we will—in this IT conversion with obviously your support, we will be sunsetting 80 percent of the projects that were currently under development. So this will be not only, I think, the right thing for clinical care, but it will also be the right thing for taxpayers.

Senator TILLIS. That is great to hear.

Secretary SHULKIN. Yeah.

Senator TILLIS. I am going to hold to my time because I guess I am the last, the last Member to speak, but we do have a number of questions for the record on suicide prevention issue. We are—I took note in the first panel, and I have asked my staff to get with the Senate Armed Services staff because I would like to have a Committee hearing at the Subcommittee level to talk about Traumatic Brain Injury, PTSD, and things that we are doing to do a better job of detecting and treating. I would like to add a second panel that then talks about the veterans who may actually—first off, how do we track those who get an honorable discharge and make sure that we are trying to anticipate or provide interventions for ones who may be at risk of suicide? Then, for the ones who have other than honorable discharge, what are we doing to make their experience when they were in the military instructive to any decision about what category of discharge they get? Finally, we have to come back to the VA and get your advice on——

Secretary SHULKIN. Yeah.

Senator TILLIS [continuing]. How we do that for those who have already received that paper and they need care.

Secretary SHULKIN. OK.

Senator TILLIS. Thank you for pushing the envelope.

Secretary SHULKIN. Yeah.

Senator TILLIS. I heard you loud and clear. It is time for Congress to give you more tools so that you can provide more veterans with care.

Secretary SHULKIN. Thank you.

Senator TILLIS. Thank you.

Thank you, Mr. Chair.

Chairman ISAKSON. Senator Tillis, are you on the way out the door, or do you have 5 more minutes?

Senator TILLIS. All right.

Chairman ISAKSON. I want to ask you a favor, if you will gavel the meeting out. I am going to have to leave. Senator Tester will have some questions he wants to ask and I do not want to cut him off.

Senator TILLIS. Yes, sir.

Chairman ISAKSON. I have got one I want to be sure is for the record.

Your great move of Cerner, to adopt the same software that is being used by DOD health care, is a huge step forward, and you have been commended for that. Does that merger also allow you access to the same information that DOD has regarding the Warrior Transition Units?

Secretary SHULKIN. Yes.

Chairman ISAKSON. Because our warriors, when they leave the battlefield or leave deployment in battlefield areas, they are asked questions on a computer. They answer by computer. It does not have a stigma to it. They are answering a computer question, and there are questions that give indicators of where there may be somebody at risk for suicide. You will now—because you have interoperability software 1 day soon——

Secretary SHULKIN. Yeah.

Chairman ISAKSON [continuing]. Will also have interoperability access to that type of information. Is that correct?

Secretary SHULKIN. Yeah. There are certainly some exceptions with DOD. One of the things I just learned recently—I do not know if you know this—the Coast Guard does not have—it was not in their contract. So, we are going to have to figure out a way to be interoperable with them or get them into this. There are some small exceptions, and we are working through those.

Our relationship with DOD is extremely cooperative on this project, and I think we are helping them in their implementation. They are certainly helping us. But, those types of data sources are extremely valuable to us.

Chairman ISAKSON. You are to be commended for that move, and we are very proud of it.

I am going to turn it over to the Ranking Member for his questions and then ask Senator Tillis to adjourn the meeting.

Secretary SHULKIN. Thank you.

Chairman ISAKSON. I appreciate your patience, Mr. Secretary.

Secretary SHULKIN. Thank you, Mr. Chairman.

Senator TESTER. Thank you, Mr. Chairman. I want to thank you fellows for being here, as well as the first panel.

I just want to touch on BRAC really quick because I think there is some opportunity to get rid of some facilities that are not being used, but you would agree that manpower and recruitment of manpower is a continuing challenge, would you not?

Secretary SHULKIN. Absolutely.

Senator TESTER. OK. I would just tell you, as we look for ways to save money in common-sense ways, what I am really concerned about is—and I know that you are not a part of this, and if you

are, let me know—that they will come in and potentially—if we do it in Congress or if you do it administratively—do a BRAC and say, "You know what?"—and I will just pick a town, Glasgow, MT. They have got a CBOC. They have not had a doc for years. You walk in and say, "Well, gee, the vets are not using this," and close it down. The same thing could be said for Senator Rounds' South Dakota. if something like that were to happen, I guarantee you, there would be a bipartisan explosion on this Committee, which would not be a good thing.

I just bring that to your attention. I am all for making sure that you are getting rid of properties you do not use anymore and have outlived their usefulness and utilizing those dollars. I think it makes—that is a good government thing, and I applaud those efforts. But, when we get into the really—because I am going to tell you, I know there are some people that want to do a full-blown BRAC, and I am going to tell you that some of the metrics out there are not going to speak too well, not because these are not good facilities, but because they have not been staffed.

Secretary SHULKIN. Right.

Senator TESTER. I just want to bring that up.

In your testimony, you cited that suicide prevention was a top priority.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. You also mentioned that VA has integrated mental health services into the primary care at Vet centers and at CBOCs. Tell me what that means in Montana.

Secretary SHULKIN. Well, what it means is that VA by far is leading the strategy across the country where if you are in your primary care office, you do not have to say, "I have been given a number to go and to call for a mental health appointment," and then go down the street to the mental health department. You get that behavioral health care as part of your primary care office experience. The——

Senator TESTER. And how are you——

Secretary SHULKIN. Yeah.

Senator TESTER. How are you going to—I agree it is——

Secretary SHULKIN. This is about de-stigmatizing.

Senator TESTER. I know, but how are you going to do it when you have got to have somebody there that knows the issue, right?

Secretary SHULKIN. You have to have the—you have to have the mental health professionals with our primary care people.

Senator TESTER. OK.

Secretary SHULKIN. Collocated.

Senator TESTER. And in a small-population State like Montana, we are about 20 short right now.

Secretary SHULKIN. Yeah.

Senator TESTER. I mean, the best-laid plans without the people, infrastructure, so it is going——

Secretary SHULKIN. Well, it gets back to what you were saying. We have a manpower issue. It is not—and it is geographically distinct, particularly in areas that do not have a lot of medical schools and other places that train professionals.

Senator TESTER. Right. Senator Moran, even though I was not here for his questions, talked about other opportunities that are

out there that could get us—besides psychiatrists and psychologists—some other——

Secretary SHULKIN. Yeah.

Senator TESTER [continuing]. Folks out there that could help. Is that proceeding, and is it proceeding well? Are we making some inroads? Because I am going to tell you that we have talked about a lot of metrics today, about what population is committing suicide and what altitude and all this stuff. We have got to get our arms around the whole baby before we can even get to a point where we are talking about——

Secretary SHULKIN. Well, look, no other health system that I am aware of has suicide prevention coordinators. That is a VA strategy that I think is super effective.

Senator TESTER. Yep.

Secretary SHULKIN. We are using peer support specialists in a way that no other health system is using, and of course, we are trying to hire traditional mental health professionals, licensed social workers, psychologists, and psychiatrists.

Dr. Carroll, do you have any comment on the marriage therapist and family therapist?

Mr. CARROLL. I think we are encouraging, as strongly as we can, facilities to hire them.

Senator TESTER. OK.

Mr. CARROLL. That is part of their—within their purview.

The other thing that we are doing, to your question about primary care, mental health integration, is using telemental health, using our telemental health system to provide providers into places where they may not be able to hire a mandatory professional.

Senator TESTER. Can you tell me, CBOCs overall, do they all have telehealth capabilities?

Secretary SHULKIN. Not all of them. We list them on our website, first of all, which ones do, but certainly, the rural ones will be much more likely to have it than you would have in New York City where——

Senator TESTER. Really?

Secretary SHULKIN. But, one of the cool things—I do not know if you have ever seen it—that just amazes me is you go into a primary care office in a CBOC or a medical center, and right there is a digital display. That if the primary care doctor wants to dial in an psychologist or psychiatrist, they can do it right from their office, while the patient is there. I do not see that in many places in the private sector. That is that integration you were talking about.

Senator TESTER. Yeah. That is good.

I want to go back to manpower for just second.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. Earlier in the year, you testified that you were going to try to get 1,000 additional mental health providers this year.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. Your testimony today says that you have hired over 600 new mental health providers. I am not going to ask what the difference between additional and new are, but has there been

a net increase in the number of VA mental health clinicians in that——

Secretary SHULKIN. Well, you just asked it, then; and the answer is no. The 623 is just keeping us even. We are not succeeding at that 1,000 net new professionals. I need help in doing that.

Senator TESTER. Doctor?

Secretary SHULKIN. Yes.

Senator TESTER. What do we need to do?

Secretary SHULKIN. What we need to do is to, A, give us more direct hiring authority, just like you did in the Accountability Act for my medical center directors. Make it easier for me to hire.

We talked about the fact that our recruitment and retention dollars were actually cut in half. That was shortsighted, quite frankly. We need the tools that the private sector has to be able to recruit the very best health care professionals. If we are serious about tackling this, let us—do not tie one of my hands behind my back.

Senator TESTER. Well, I just want to be clear.

Secretary SHULKIN. Yeah.

Senator TESTER. Did we cut your recruitment and retention dollars?

Secretary SHULKIN. To pay for the CARA legislation, yes, sir. Yes.

Senator TESTER. Boy, we ought to be taken out and beaten. Keep going.

Secretary SHULKIN. I need, a competitive process so I can hire quicker and——

Senator TESTER. Yeah. Recruitment dollars?

Secretary SHULKIN. Recruitment dollars and the flexibility to be able to help expand training. Those are the three areas that would really make a difference.

Look, there is a national shortage here, so, you know, I think we all worry about not just what is happening in VA, but everywhere. These are all important strategies, particularly the training one.

Senator TESTER. Yeah.

I will just make one side comment, and you know this better than I do. You are right. It is a national problem, but with veterans——

Secretary SHULKIN. Mm-hmm.

Senator TESTER [continuing]. We made a promise to them.

Secretary SHULKIN. Yes.

Senator TESTER. So, we cannot have a bunch of excuses. We have got to have more solutions than excuses.

Secretary SHULKIN. Right, right.

Senator TESTER. I appreciate you guys being here. Thank you.

Secretary SHULKIN. Thank you.

Senator TILLIS [presiding]. Just on the last point—we are about to adjourn. I am not going to ask other questions, although I will have them for the record. But, I remember this discussion with then Secretary McDonald. I think there was a series of news stories that some of our Members got tempted into amplifying that had to do with training and retention programs that you thought were critically important, and I think what we need to do is understand if you are going to make this an attractive place for profes-

sionals to come to, then you better have professional development and a retention program similar to the private sector.

When I see some of the dollars that you were spending on training, I am sure I could find something that was not a good idea. I saw the number that the VA was spending on a per-employee basis, and it was pennies on the dollar compared to what I would have spent as a partner at Pricewaterhouse.

Secretary SHULKIN. Right.

Senator TILLIS. You are never going to get to that ratio, but we need to make sure we are not talking out of both sides of our mouth; on the one hand, saying we need to give you recruiting and retention resources, and then we want to micromanage how you go about spending it.

I have never been the head of a major health system before. You have, and now you are the head of one of the biggest in the world.

Secretary SHULKIN. Mm-hmm.

Senator TILLIS. I trust you to make a decision about how you have therapists and doctors and technicians and other people that you want to attract and have a value proposition so you are getting your fair share of the best resources out there in the private sector.

That is another one where when we hear us say one thing and do another thing here, please give me your commitment that you will say, "That is not a good idea."

Secretary SHULKIN. Thank you.

Senator TILLIS. We are going to adjourn the Committee hearing, and we are going to leave the record open for 1 week for questions for the record.

I thank the first panel for being here. It is always a pleasure to see the leadership from the VA.

This meeting is adjourned.

Secretary SHULKIN. Thank you.

[Whereupon, at 12:20 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO JOHN D. DAIGH, JR. M.D., CPA, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Can you share with the Committee your thoughts on how the expansion of telemental health through the VA can assist in suicide prevention and your assessment of the VA's use of telemedicine for this purpose?

Response. Veterans with depression, Post Traumatic Stress Disorder, substance use disorder, and a variety of other mental health conditions are at high risk of suicide. Most mental health care is provided by primary care providers who lack expertise in the determination that an individual has the characteristics (age, sex, clinical diagnosis, access to firearms, etc.) that may put them at high risk of suicide. The telehealth system can give primary care providers access to expert advice on both the management of a veteran's mental health disorders, as well as identifying which veterans may be at increased risk of suicide and determining what steps should be taken to address this risk. The OIG has not evaluated the telemedicine program with respect to the provision of specialty care that is not available locally.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO CRAIG BRYAN, NATIONAL CENTER FOR VETERANS STUDIES, THE UNIVERSITY OF UTAH

TELEHEALTH

Introduction: VA's testimony notes that telemental health provided more than 427,000 encounters to over 133,500 Veterans in 2016. Telemental health reaches veterans where and when they are best served however legal barriers for VA providers remain which is why I sponsored a bill with Sen. Ernst to allow allowing VA health officials to practice telemedicine across state lines if they are qualified and practice within the scope of their authorized Federal duties.

Question 1. Can you share with the Committee your thoughts on how the expansion of telemental health through the VA can assist in suicide prevention and your assessment of the VA's use of telemedicine for this purpose?

Response. The VA is a national leader in the use of telemental health, which is a critical tool for making access to mental health services accessible to veterans who live in geographically remote areas. A growing body of research indicates that the outcomes associated with telemental health are comparable to the outcomes obtained from visiting with healthcare providers face-to-face. The impact of telemental health is therefore largely limited by the same limiting factors that characterize mental healthcare in general: insufficient use of empirically-supported treatments. As noted in my testimony, enhancing access to care without addressing quality of care just makes it easier for veterans to receive services that don't work. We must therefore ensure that telemental health service providers are trained to provide the latest and most advanced treatments available.

There is one especially noteworthy problem with how telemental health services are often employed: they regularly exclude suicidal veterans. The typical rationale for this is that high-risk veterans are better served via in-person services. We therefore withhold telemental health services from those veterans who most need them due to concerns about safety. The irony and tragedy of this mindset is that the highest risk veterans often do not access VA services, but instead of finding ways to make it easier for them to receive services, we preserve the very barriers that contribute to their high risk state. This is an area of potential improvement for the VA.

FEMALE VETERANS AND SEXUAL TRAUMA

Introduction: I've had discussions with female veterans in my state of Hawaii, and there is a sense that VA is not doing enough to assist female combat veterans suffering from PTSD or TBI.

Question 2. What is your assessment of VHA's overall approach to help our female veterans facing mental health issues, especially those who have experienced sexual assault or trauma? What recommendations do you have to better equip VA to provide the appropriate gender-specific mental health care for sexual trauma victims?

Response. Many VA's have established women's health centers and clinics to meet this need, and have established specialty programs for female veterans struggling with the consequences of sexual trauma. The most important barrier to quality care for female veterans is the limited use of scientifically-supported treatments for PTSD secondary to sexual trauma. Only two treatments are recommended for the treatment of sexually-based PTSD: prolonged exposure therapy and cognitive processing therapy. Both of these treatments were developed to treat PTSD among female sexual assault survivors and were later modified and adapted for combat and military trauma. Unfortunately, these treatments are not always available to female veterans. On top of this issue, many mental health professionals carry the perspective that military sexual trauma cannot be effectively treated. As a result, an unsettling number of mental health professionals—the very individuals who are supposed to be trained to effectively treat PTSD and sexual trauma—convey a sense of hopelessness to female veterans, telling them that there is nothing that can be done to help improve their lives.

This contradicts a large body of research and the experience of many of us who have been treating female veterans for years. Sexually-based PTSD can be effectively treated, but too few mental health professionals know how to do these treatments. We need to ensure that mental health professionals know about these treatments while they are still in graduate and medical school, which will lead to a much better-prepared pool of mental health professionals from which the VA can hire.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO MATTHEW KUNTZ, EXECUTIVE DIRECTOR, NATIONAL ALLIANCE ON MENTAL ILLNESS FOR MONTANA

TELEHEALTH

Introduction: VA's testimony notes that telemental health provided more than 427,000 encounters to over 133,500 Veterans in 2016. Telemental health reaches veterans where and when they are best served however legal barriers for VA providers remain which is why I sponsored a bill with Sen. Ernst to allow allowing VA health officials to practice telemedicine across state lines if they are qualified and practice within the scope of their authorized Federal duties.

Question 1. Can you share with the Committee your thoughts on how the expansion of telemental health through the VA can assist in suicide prevention and your assessment of the VA's use of telemedicine for this purpose?

Response. Senator Hirono, mahalo for the question. You are correct that Telemental health is critical to care in frontier states within the Continental United States, like Montana, and geographically separated states like Hawaii and Alaska. NAMI Montana and others work very hard to make our states hospitable to new clinicians, but there is a critical need to have qualified clinicians be able to easily serve our veterans from other locations.

The VA has been a pioneer in Telemental health services in Montana, particularly in our tribal communities, and I fully agree with you and Senator Ernst that legal barriers around this solution for effective treatment in provider-scarce communities need to be taken down.

FEMALE VETERANS AND SEXUAL TRAUMA

Introduction: I've had discussions with female veterans in my state of Hawaii, and there is a sense that VA is not doing enough to assist female combat veterans suffering from PTSD or TBI.

Question 2. What is your assessment of VHA's overall approach to help our female veterans facing mental health issues, especially those who have experienced sexual assault or trauma? What recommendations do you have to better equip VA to provide the appropriate gender-specific mental health care for sexual trauma victims?

Response. While I cannot speak for this on a national level, there may be some insights from the Montana experience that would be helpful. I have seen the VHA in Montana take great strides in the past few years in their response to female veterans who have experienced sexual trauma. Kelly Downing Keil, the Military Sexual Trauma Coordinator in our community, is exceptional. She has definitely raised the awareness of this issue and providers personal high quality care for women veterans.

However, I still feel that more resources are necessary to provide effective care for women veterans who have been impacted by sexual trauma. Some of those resources should certainly be located in the geographic location of the veteran, but I think that it also would be helpful to have more national expertise such as telemental health and inpatient care that supported this specialty need for veterans.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Shulkin, in encouraging veterans to seek mental health care, are we making appropriate progress in addressing the stigma attached to mental health care? What additional steps does VA need to take?

Response. VA is taking a multi-faceted approach to address the stigma associated with mental health and seeking mental health care, including a Nation-wide outreach campaign, technological innovations to reduce barriers to seeking care and providing care in alternative settings. We are making progress on this issue, but need to continue these efforts as robustly as possible in order to continue these advancements. Truly addressing mental health stigma requires changing the conversation and changing culture across the U.S.

National Awareness and Outreach: Make the Connection (www.maketheconnection.net) is VA's national public awareness and outreach campaign that highlights Veterans' true and inspiring stories of mental health recovery and connects Veterans and their family members with mental health resources in their communities. Make the Connection provides personal stories of hope and recovery from hundreds of Veterans as well as resources and information that help Veterans who are experiencing mental health challenges discover ways to improve their lives.

Make the Connection is specifically designed to address the stigma associated with mental health and seeking mental health care. Since its launch, Make the Connection has seen tremendous engagement among Veterans and their family members and supporters. Via the MakeTheConnection.net website, the campaign's outreach efforts, and social media properties including Facebook and YouTube pages, the campaign has garnered:

- Over 13.1 million website visits
- 400,000 resource locator uses (to find local VA and other community-based sources of support)
- 27.7 million video views
- 39,476 YouTube subscribers
- 2.9 million "likes" on the campaign's Facebook page, making it one of the largest U.S. Government Facebook communities
- Over 56 million Facebook engagements ("likes," comments, and/or shares)
- Over 377,000 airings of the 11 public service announcements (PSA) for over 2.2 billion impressions and equaling more than $36 million in equivalent paid media value.
- During the month of May, highly successful Mental Health Awareness Month campaign to increase awareness of VA mental resources and the Make the Connection campaign.

Technological Innovations to Reduce Barriers to Care: VA has created a suite of award-winning tools that can serve as self-help resources or as adjuncts to mental health services. These tools are available as web-based courses and smart phone mobile applications. Veterans and their loves ones can anonymously access these resources at any time and from any location. In 2014, VA launched an online Veteran Training portal for web-based self-help resources (www.veterantraining.va.gov) to provide "one-stop shopping" for Veterans and their families. The courses include an educational and life-coaching program that teaches problem-solving skills to help Veterans better handle life's challenges (www.veterantraining.va.gov/moving forward), a course to help parents learn how to address both everyday parenting challenges and family issues unique to military families (www.veterantraining.va.gov/parenting) and a course on anger and irritability management skills that offers a wide range of practical skills and tools to manage anger and develop self-control over thoughts and actions (www.veterantraining.va.gov/aims/).

VA has also deployed a suite of award-winning mobile apps to support Veterans and their families with 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 stopping smoking, and those used with a mental health provider to support Veterans' use of skills learned in psychotherapy. Enabling Veterans to engage in self-help before their problems reach a level of needing professional assistance can be empowering to Veterans and their families and allow them to access information and resources privately to learn about support and treatment. VA's mobile apps address common mental health and related problems such as Post Traumatic Stress Disorder, depression, insomnia, smoking, problem solving, anger management and parenting.

Providing care in alternative settings: To further reduce stigma Veterans may feel in seeking mental health care, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions in non-traditional settings, when appropriate. Mental health services are incorporated into VA's primary care to Patient Aligned Care Teams (PACT), an interdisciplinary model to organize a site for holistic care of the Veteran in a single primary health care location.

All of these efforts are aimed at empowering and engaging Veterans to seek mental health services when needed.

Question 2. When it comes to the provision of mental health care, how does the VA measure progress?

Response. VA has a broad, multi-level data-based management system that it uses to monitor, evaluate, and improve provision of mental health care. The top layer of this system consists of a "Mental Health Balanced Scorecard" (AKA MH Domain of SAIL), a composite measure that combines information about three key domains into a single overall assessment of mental health care access and quality. The Mental Health Balanced Scorecard addresses three core components of mental health care delivery: (1) Population Coverage—assessing whether patients with indications for mental health treatment are able to successfully access evidence-based services for their condition across the spectrum of mental health treatments, (2) Continuity of Care—assessing whether patients who start treatment get full courses

of proactive, coordinated care delivered safely and effectively, and (3) Experience of Care—assessing whether patients and providers feel they can access or provide the treatments they believe are needed, and receive high quality care. In brief, it measures whether a patient can receive the services most appropriate for their disorder, delivered in a safe and effective manner, in a manner that is satisfactory to both patients and mental health professions. The scores on this measure are posted publicly at https://www.va.gov/QUALITYOFCARE/measureup/Strategic_Analytics_for_Improvement_and_Learning_SAIL.asp. VA sets goals for improvement and resets scores to 0 at the start of the year, and then tracks improvement over the year from that baseline. Improvement in mental health care delivery is supported through a detailed program of data-based management tools and expert technical assistance. Managers can drill down the Mental Health Balanced Scorecard to identify specific areas of weakness, and tools and expert support are available to isolate gaps and problems and recommend and implement improvements. VA has improved on this global indicator of mental health access and quality every year since it was instituted in 2014.

The Mental Health Balanced Scorecard assumes that Veterans will benefit if VA provides mental health services consistent with research literature on effective treatments. VA is also monitoring Veterans symptoms, functioning and improvements in the early stages of treatment engagement through the Veterans Outcomes Assessment (VOA) program. The VOA conducts telephone assessments with a sample of patients as they start a new episode of mental health care in VA and then 3 months later. This program provides information on Veterans needs as they start in treatment, and provides feedback on how patients are progressing in early treatment. VA uses this data to understand what programming is most effective for rapidly stabilizing Veterans with mental health needs and to plan longer-term programming to ensure services are available to help Veterans address mental health and behavioral challenges where recovery requires prolonged effort and support.

Question 3. VA's goal is to end suicide among veterans regardless of whether they seek treatment at VA. With that in mind, what innovative steps is VA taking to reach veterans not already connected to VA?

Response. Suicide prevention is VA's number one clinical priority. In consultation with Veterans, Service Organizations, subject matter experts, national and community partners, and field leaders, VA has developed a comprehensive strategy—the #BeThere for Veterans Suicide Prevention Initiative.

The strategy has five key domains—Improve Transition, Know All Veterans, Partner Across Communities, Lethal Means Safety, and Improve Access to Care.

Improve Transition

- VA's collaboration is stronger than ever with DOD. We are facilitating enrollment in VA care for eligible transitioning Servicemembers and formalizing our partnership to enhance sharing of best clinical practices, data, and outreach efforts.

Know All Veterans

- On September 15, VA released a breakdown of Veteran suicide data by state. It includes Veteran suicide counts and rates for each state and the District of Columbia. These data will help us better address suicide risk factors for all Veterans.
- Using Predictive Analytics to Identify Those at Risk and Intervene Early

Partner Across Communities

- VA is leveraging strategic partnerships with community, Federal partners, and the entire Department of Veterans Affairs to reach Veterans not in VA care.
- VA has partnered with the PsychArmor Institute to create a web-based suicide prevention training that will be free and available to the public.
- VA is partnering with Johnson & Johnson to create an integrated marketing campaign that will include a national public service announcement.
- In October VA will launch a national initiative with Substance Abuse and Mental Health Services Administration (SAMHSA) to engage Mayors in a Suicide Prevention Challenge and employers in suicide prevention training.
- VA is developing partnerships including the Semper Fi Fund, Cohen Veterans Network, Department of Homeland Security, and Veterans & First Responders Healthcare; those will all promote the reach of information and resources to assist Veterans who are not in VA care.
- Leveraging VA Vet Centers and Readjustment Counselors

Lethal Means Safety

- Lethal means safety is a key component in preventing suicide and accidental overdose. VA has distributed over 3 million gun locks since 2010 and more than 100,000 naloxone kits since November 2014.

• VA is sponsoring a Gun Safety Matters Challenge in partnership with VA Center for Innovation (VACI) and National Aeronautics and Space Administration (NASA) to seek Veteran-centric ideas and solutions for safer gun storage.
• Suicide Prevention training is now mandatory each year for all VHA employees and will soon be mandatory for VBA and NCA employees. The goal is for every single VA employee to be trained to recognize someone who may be in crisis and who may be at risk for suicide and to know how to help that person get appropriate care right away.

Improve Access to Care

• Nationwide, our system of over 400 VA Suicide Prevention Coordinators participated in 14,135 outreach events that touched over 1.5 million people who play a role in Preventing Veteran suicide.
• A Community Toolkit was distributed through the Veteran Experience Office—https://www.va.gov/nace/docs/myVAoutreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf
• VA is leveraging telemental health care by establishing four regional telemental health hubs across the VA health care system. VA telemental health innovations provided more than 427,000 encounters to over 133,500 Veterans in 2016. VA is a leader across the United States and internationally in these efforts.
• VA's MakettheConnection.net, Suicide Prevention campaigns, and mobile apps (e.g. Posttraumatic Stress Disorder (PTSD) Coach has been downloaded over 280,000 times) contribute to increasing mental health access and utilization. VA has also created a suite of award-winning tools that can be utilized as self-help resources or as an adjunct to active mental health services (www.veterantraining.va.gov).
• For Veterans unable (e.g., rural Veterans) to engage in traditional mental health treatment, web-based, self-guided interventions for health conditions associated with suicide risk, offer a potentially effective means of overcoming treatment barriers and preventing "downstream" suicides. The Rocky Mountain MIRECC is piloting a two-year project on this.
• VA is expanding access to emergent mental health care for former Servicemembers with other than honorable (OTH) administrative discharges.
• Free Mobile Apps to Help Veterans and Their Families.

Veterans Crisis Line (VCL)

• VCL is available to all Veterans and Servicemembers 24 hours a day/365 days a year, including holidays.
• Facilitates connecting Veterans to national and local resources, as well as VA services.
• Since its launch in 2007 through August 2017, the Veterans Crisis Line has answered over 3.1 million calls and initiated the dispatch of emergency services to callers in imminent crisis nearly 87,000 times.
• Since launching chat in 2009 and text services in November 2011, the VCL has answered nearly 362,000 and nearly 79,000 requests for chat and text services respectively.
• Year to date data:
  – Average Rollover Rate: 1.25%
  – Average Speed of Answer: 8 seconds
  – Veterans Crisis Line is expanding to a third site in Topeka, with training classes expected to begin November 2017 and a go live date of January 2018.

Question 4. Understanding the shortage of mental health professionals isn't specific to the VA, particularly in rural areas, what can VA do to fundamentally address chronic workforce shortages?

Response. VA is authorized by Title 38 Section 7302 to provide clinical education and training programs for developing health professionals. VA conducts the largest education and training effort for health professionals in the United States. VA's physician education program is conducted in collaboration with 135 of 144 allopathic medical schools and 30 of 33 osteopathic medical schools. In addition, over forty other clinical health professions education programs are represented by affiliations with over 1,800 unique colleges and universities. Among these institutions are Minority Serving Institutions such as Hispanic Serving Institutions and Historically Black Colleges and Universities.

VA health professions education programs have a major impact on the healthcare workforce in VA. For example, roughly 70% of current VA optometrists and psychologists and 60% of physicians participated in VA training programs prior to employment. VA's involvement in health professions education has thus been shown to be an effective mechanism to support VA's patient care mission.

Given that over 120,000 health professions trainees receive clinical training in VA each year, it is vital that VHA look to the trainee pipeline to fundamentally address chronic workforce shortages. For example, the Veterans Access Choice and Accountability Act legislation in 2014 established an additional 1500 new Graduate Medical Education positions for VA. Over 750 of these positions are filled, with 2/3 of the positions allocated to Primary Care and Mental Health. The Office of Academic Affiliations, in partnership with the Office of Mental Health and Suicide Prevention, has also been engaged in a 6-year, phased expansion of mental health training positions in VA. Since 2012, an additional 750 mental health trainee positions have been authorized and funded.

For the agency's most hard-to-fill clinical vacancies, VHA currently utilizes multiple strategies and tools to address workforce shortages. The National Healthcare Recruitment Service's (NHRS) National Recruitment Program (NRP) provides VA with an in-house team of 18 skilled and experienced professional physician recruiters called National Healthcare Recruitment Consultants. NHRS has recently added a National Nurse Recruitment & Retention division, with two full-time experienced nurse recruiters to develop plans for critical nursing vacancies. VHA has developed a national-level clinical and healthcare executive recruiting contract (blanket purchase agreement) that can be used both nationally and locally to aid in filling hard-to-fill vacancies. When recruiting providers for rural opportunities, NHRS develops marketing ads that highlight unique features associated with smaller communities and key amenities within reasonable proximity, directs sourcing efforts to providers with direct ties to the targeted rural locations (by birth, training, previous employment, education, etc.) or an expressed preference for rural community practice, and partners with national/regional associations dedicated to rural health (i.e. National Rural Recruitment & Retention Network/3RNet- a nonprofit organization that connects health professionals searching for jobs in rural or underserved areas with healthcare organizations.). NHRS also advises the maximum utilization and leveraging of recruitment incentives, benefits, and compensation packages to secure the long-term needs of well-qualified candidates such as relocation, sign-on bonus, continuing medical education, etc.

Additionally, VHA utilizes both education loan repayment and scholarship programs to recruit and retain healthcare providers in difficult to fill positions. The Education Debt Reduction Program (EDRP) is offered to repay education loans for healthcare professionals in VA's most critical positions that have been determined to be difficult for recruitment and retention. Over the last five fiscal years, FY 2013–2017, VHA has awarded 423 EDRP awards to participants in rural stations. The number of awards to rural stations continues increase each year; in FY 2013, 30 new awards were made to participants in rural stations, while 97 new awards were made in FY 2017. From FY 2013 to FY 2017, VHA has awarded 543 new scholarships to employees located at rural facilities. VA has implemented regional telehealth resource centers in urban areas of the country, where recruiting specialty providers is easier, to serve Veterans in rural areas where recruiting is more difficult.

As noted in OIG Determination of VHA Occupational Staffing Shortages, Report #17–00936–385, staffing models are being created to assist healthcare systems to identify where these shortages exist. VHA has initiated a comprehensive review of all defined VHA staffing models to further enhance workforce planning and projection tools and conducted a regrettable loss analysis in 2017 which included loss rates at rural healthcare sites for mission critical occupations (MCO). VHA is currently conducting additional analysis of loss rates in rural areas and working with subject matter experts to determine strategies to address recruiting and retaining staff in these areas. Furthermore, while not a critical occupation need in the recent OIG report, Human Resources is ranked third on VHA's 2017 MCO list after physicians and registered nurses. One-quarter of facilities noted that shortages in this occupation create staffing barriers for other occupations and H.R. total loss rates for FY 2016 were 11.2%, higher than any other mission critical occupations in VHA. Identifying priorities to improve recruitment and retention for this occupation will assist VHA with the ability to onboard potential employees in an effective and efficient manner to meet VHA's medical center and Veteran patient needs.

Question 5. To what extent does VA work with other Federal agencies on collaborative efforts to train and recruit medical personnel, or to incorporate best practices to address medical workforce shortages?

Response. VHA collaborates extensively with other Federal partners on health professional workforce issues, and continues to seek and develop collaborative efforts. For example, the National Academic Affiliations Council, a federally Chartered Advisory Committee, has membership from VA, Health Resources and Service Administration (HRSA), and Department of Defense (DOD). This forum allows for

planning and brainstorming of collaborative activities. VHA also has a Memorandum of Understanding signed with HRSA that allows extensive collaboration. With the Department of Defense, VA has historically encouraged health professions trainee exchanges between DOD and VA facilities and is also actively engaged in an exploration of using the Uniformed Services of the Health Sciences University for VA-obligated medical students. A Memorandum of Understanding has been signed with Health and Human Services (Public Health Services) in order to directly assign Public Health Officers to VA facilities. Last, VA's Office of Academic Affiliations is working directly with Indian Health Services on building their academic affiliations.

Question 6. Understanding there is no standardized treatment when it comes to mental health, does VA have an appropriate diversity of mental health professionals—whether its counselors, family therapists, psychologists or whomever—to meet the individualized mental or behavioral health needs of veterans?

Response. VA is committed to promoting a diverse, well-qualified mental health work force, which includes representation from all mental health disciplines. As of 9/21/17, excluding VHACO staff, VHA employed 21,863 mental health professionals that are specifically clinical and/or have documented outpatient mental health direct care encounters. Mental Health professionals include psychiatrists, Advance Practice Registered Nurses, Physician Assistants, Clinical Nurse Specialists, pharmacists, psychologists, social workers, Licensed Professional Mental Health Counselors, Marriage and Family Therapists, Addiction Therapists, Peer Support Specialists, and Registered Nurses. Additionally, many Mental Health programs utilize occupational therapists, recreational therapists, art therapists, among other professionals within their inpatient, residential, and outpatient services.

Currently, approximately 46% of the mental health workforce is comprised of psychologists (25.5%) and social workers (20.5%). Registered Nurses and psychiatrists each comprise of approximately 15% of the VHA mental health workforce. There are currently over 1,100 Peer Support Specialists (5%) in the mental health workforce. Since 2010, VA facilities have been authorized to hire Licensed Professional Mental Health Counselors (LPMNC) and Marriage and Family Therapists (MFTs) as specialty providers in mental health, and these professionals currently make up approximately 1% of the workforce.

Different sites have different needs, so VHA does not have a formula to determine the most desirable mix of provider types. Instead, we allow local leadership to fulfill their needs within the resources available to them locally. To this end, VHA has focused efforts to encourage professional diversity at the local level in the following ways:

- Within the mental health professions, a number of services can be provided by multiple professions, and sites are encouraged to extend hiring considerations to focus on the needed skillset rather than a specific profession. For example, psychologists, social workers, Licensed Professional Mental Health Counselors, and Marriage and Family Therapists may all have training and advanced skills in providing couples therapy. With this, facilities are encouraged to expand the hiring consideration to all these professions rather than focusing the hiring effort on a single specialty.
- To promote professional diversity at the facility level, VHA established as policy that all mental health professions must be considered when hiring mental health leadership positions. This has served to diversify mental health leadership in VHA which not only promotes professional and leadership development, but this diversity strengthens the clinical programs.
- Educational training has been a vital component in increasing diversity and succession planning. For 70 years, VA has provided clinical training to build a pipeline of highly qualified mental health professionals who consider serving Veterans at VA as a career. The VA Office of Academic Affiliations (OAA) annually supports the training of more than 7,500 mental health professionals, and about 70 percent of VA psychiatrists and psychologists received at least some of their clinical training at a VA facility. Nationally, nearly one in five VA psychologists completes their doctoral internships in VA facilities. VA is recognized for preparing mental health professionals who work in both VA and other U.S. health care settings, expanding specialized expertise in providing care to Veterans and their families beyond our walls.
- The VA Office of Academic Affiliations has expanded mental health training opportunities through a 5-year program called the Mental Health Education Expansion (MHEE).
- The MHEE increases the number of slots in existing training programs and establishes new training opportunities, particularly in highly rural areas where it is often difficult to recruit mental health professionals without a training program. When the MHEE was launched, not all regions of the country had psychology train-

ing, but in academic year 2017—18, VA psychology internship training programs were available in all states, the District of Columbia, and Puerto Rico.

• The 5-year MHEE has added 750 mental training slots across the country. The MHEE has encouraged multidisciplinary training encompassing mental health professions such as psychiatrists, psychologists, nurses, nurse practitioners, physician assistants, social workers, licensed professional mental health counselors, marriage and family therapists, and advanced mental health specialists such as pharmacists, chaplains, and other clinicians.

• VHA has supported local LPMHC and MFT hiring efforts by creating new clinical training opportunities. To start this process, a special Request for Proposals to the facilities was released in April 2015, which led to 18 positions being awarded for LPMHC training programs at seven VA medical centers. Fewer applications were received for MFT internships on this first call for proposals. Three MFT intern positions were awarded to one VA medical center to begin in academic year 2016–17. To support these newly funded programs, the profession-specific monthly calls have continued to assist facility training directors in establishing and maintaining their internship programs. To further expand LPMHC and MFT internship training opportunities, the next phase of the MHEE (which began in Q4FY2016) solicited LPMHC and MFT training expansion along with expansion of four other MH professionals including chaplains, pharmacists, psychologists, and social workers. For all professions, experienced mentors are available from other VA facilities that have existing funded internship programs to coach applicant sites through the proposal process.

• In the 2016—17 academic year, the Office of Academic Affiliations and National Physician Assistant (PA) Services established the new Mental Health PA Residency program. This unique training will prepare PAs, who are normally trained to work in primary care, to join other professionals in providing mental health care as prescribing providers.

• VA is committed to working with public and private partners across the country to support full hiring and to make sure Veterans can access high-quality, timely mental health care, no matter where they live. For example, multiple professional organizations, such as the American Psychiatric Association and American Psychological Association, deliver announcements to their members about VA's rewarding career opportunities in mental health care.

• VA is committed to attracting and retaining the most qualified providers. To better recruit and retain psychiatrists amid a national shortage and stiff competition from Federal partners, academic programs, and state and private systems, VA has increased the pay level for psychiatrists and increased flexibility for medical center leaders to match pay to local circumstances.

• VA has expanded its psychiatry fellowship programs because psychiatrists who train within VA are more likely to make their careers there.

• New educational loan debt reduction opportunities created as part of the Clay Hunt Suicide Prevention Act will improve VA's ability to attract promising new psychiatrists in their final year of training.

Question 7. During the Committee's hearing in 2015 regarding mental health care, there was discussion of the high no-show rate for veterans at their mental health care appointments. Please provide updated statistics on no-show rates and what actions VA has been taking to minimize the no-show rate at VA and non-VA appointments?

Response. The no-show rate in mental health is substantially higher than no-show rates in other clinics, likely as a consequence of the additional logistical and clinical barriers to treatment adherence posed by mental health conditions (e.g. anxiety, depression, legal issues, homelessness, cognitive and organizational problems). General efforts to improve no-show rates across VHA clinical programs have produced some incremental improvements in mental health no-show rates. Specifically, in FY 2015Q1, the national mental health no-show rate (MOP12) was 19.26% with 43 health care systems over 20%. In FY 2017Q3, the national mental health no-show rate was 18.89% with 29 health care systems over 20%.

VA's National Initiative to Reduce Missed Opportunities (NIRMO) included 10 strategies to reduce no-show rates or improve clinic utilization in spite of no-shows. These include using a Recall Reminder System to help patients schedule appointments closer to the planned date of the visit, negotiating all visit times with the patient to ensure that they are scheduled at a time the patient can realistically come, coordinating appointments with other visits to the health care system and arranging transportation, using an open access model and scheduling appointments in the near the appointment date, using novel health care delivery models such as telehealth to reduce travel-related barriers to care, reducing wait times in waiting rooms, and improving patient-clinician relationships and interactions so that pa-

tients are more motivated to come for care. One particularly effective method includes making live reminder calls to patients at high risk of no-show. To support this effort, VA developed a predictive model to identify patients likely to not show up for an appointment. Clinics use this list to prioritize phone calls with the patients most likely to no-show to provide reminders and trouble-shoot possible causes for non-attendance.

Mental Health has taken some specific efforts to address no-shows beyond the overall VHA initiative. Mental Health provided national business operations trainings to teach clinic managers NIRMO strategies, and mental health technical assistance specialists assigned to each VISN provide hands-on support for facilities in implementing these practices. The Office of Mental Health and Suicide Prevention has quarterly calls with MH leadership within each VISN where missed opportunities rates are reviewed. Sites with exceptional rates are asked to share their practices with other sites, and teams problem-solve and suggest improvements for sites with high no-show rates.

To address the special challenges with treatment attendance among mental health patients, VA just developed a mental health specific no-show predictive model that incorporates clinical information about mental health conditions, treatments, and status. This should improve our ability to anticipate and prevent no shows. Tools using this model be rolled out in VA clinics in the coming months to improve upon the original general NIRMO predictive modeling-based interventions.

Question 8. Women's suicide numbers are beyond understanding. Does VA see a link between the higher rate of suicide among women veterans and the lower rate of VA utilization among this population? How is VA expanding outreach to women veterans to address this?

Response. Veteran suicide is VA's top clinical priority, and VA is committed to eliminating suicide among all Veterans, whether or not they are enrolled in VA care. It is of great concern that female Veterans die by suicide at a rate 2.5 times that of civilians, although this statistic is much lower than the previously estimated 7 times higher. Since 2001, there has been a relative decrease in suicide rates among female Veterans who use VHA care, and relative increase in suicide among female Veterans who do not use VHA care. Suicide is a complex phenomenon and there are likely many factors related to these trends in rates over time. VA remains committed to providing a full continuum of mental health services to women Veterans, including outpatient and residential programs that accommodate and support women Veterans with safety, privacy, and respect.

VA is committed to expanding outreach to women Veterans, in order to ensure that all Veterans receive the care and support they've earned. Our network of 400+ Suicide Prevention Coordinators partner with community organizations at the local level in order to expand VA's reach and meet the specific local needs of each community's women Veterans. In addition, partnerships with public and private organizations at the national level are aimed at expanding our reach to women Veterans. For example, the Department of Veterans Affairs (VA) is partnering with Department of Defense (DOD) to improve the military to civilian transition by expanding pre and post separation services and expediting VA enrollment. By doing this, VA will reach more at risk women Veterans who otherwise may have not come to VA for services.

Question 9. Has VA examined whether Vet Centers have the capacity and capability to help veterans who didn't deploy to a combat theater? Would there be a way to use any excess capacity to help them?

Response. Readjustment Counseling Service (RCS), through Vet Centers, already provide services to specific individuals (active Duty Servicemember, Veteran, National Guard, and Reserve) who have not deployed to a combat theater. These individuals' experiences include service in designated area of hostilities, experiencing a military sexual trauma, providing direct assistance to the casualties of war from outside the war zone (doctors, nurses, mortuary affairs, etc.), and unmanned aerial crews (drones). RCS was created by Congress to serve a specific and unique function designed to assist individuals to transition from combat service or other potentially traumatic situations, such as experiencing a military sexual trauma. There is concern of significant mission creep in providing services to others than the individuals and situations listed above and this recommendation is not consistent with the purposeful design of RCS. In addition, RCS has future capacity concerns in providing services to additional cohorts given our current eligible Veteran, Servicemember, and family growth trends.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

A recent study by Anne Case and her husband, Angus Deaton, found that there is a negative trend in the life expectancy of white Americans aged 45 to 54. This trend can be attributed to an increase in deaths of despair, including suicide, chronic liver diseases, cirrhosis, and drug or alcohol poisoning. I am curious if this trend for certain subgroups of society matches the trends experienced in the same subgroups of the veteran population. Unfortunately, the suicide data provided in the recent report issued by the VA accounts only for differences in rates by location, age, and sex. It does not take into consideration other important demographics, including education, economics, or race.

Question 10. In light of the above, it begs the question: is the increased suicide rate among Veterans greater than or similar to Veterans in the same catchment area who are not receiving care in the VA system and to non-Veterans in the same catchment area matched in other demographics? Once this is answered, it allows comparisons of how different VA facilities perform relative to one another and within their catchment area addressing deaths of despair.

Response. VA does not have the data necessary to respond to this question. VA and the Centers for Disease Control and Prevention are exploring ways to build capacities to enable such analyses.

Question 11. The question and request is if the VA will perform an analysis as per the above? This is beyond the academic and allows comparisons that can aid in improving systems of care and pin pointing geographic and programmatic areas of excellence. In regards to a data set to compare the VA population to, Case and Deaton reference the following: "CDC Wonder Compressed and Detailed Mortality files as well as from individual death records from 1989 to 2013. For population by ethnicity and educational status, we extracted data from American Community Surveys and, before 2000, from Current Population Surveys."

Although I do not know this, perhaps Drs. Case and Deaton would assist in the analysis. I think this would aid Congress tremendously in working with the VA to improve the lives of Veterans.

Response. VA does not have the data necessary to respond to this question. VA and the Centers for Disease Control and Prevention are exploring ways to build capacities to enable such analyses.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 12. In a letter earlier this year, Senator Tester and I expressed concern over the implementation of the Department's new policy to extend emergency mental health coverage to veterans with other-than-honorable discharges, particularly because over-promising and under-delivering on something as critical as mental health is dangerous. My questions on this issue are threefold:

a. Now that you have had time to implement this policy, do you have any data on the number of veterans who have received care under this interpretation of the already existing authority?

Response. As of October 21, 2017, more than 2,000 former Servicemembers who have Other than Honorable administrative discharges have sought care from VA. VA is working on an IT solution that will improve its ability to track the care furnished to these former Servicemembers.

b. In your letter to me, you stated that if a veteran shows up who does not have a service-connected injury, VA will take another look at their records for injuries and their character of discharge. If you cannot rule favorably, you are going to bill a veteran for any treatment provided by the VA. How long is it taking you to look at these veterans records? And, how many have been billed for their treatment?

Response. The procedures for character of discharge determinations and disability ratings are set forth in the M21–1 Manual. When a VHA facility requests a character of discharge determination from VBA, VBA requests that the claimant submit an application and then adjudicates the claim. If VBA determines the claimant's character of discharge is disqualifying for VA purposes, it will also adjudicate the claim to determine whether the claimant has a service-connected disability for which VHA will furnish health care, notwithstanding the otherwise disqualifying character of discharge. Once VBA renders a decision, a copy of the character of discharge and rating decision is provided to VHA and notification is provided to the claimant.

Under this initiative, the Secretary has requested that these eligibility determinations be given priority processing during the 90-day period of emergency mental health care treatment. VBA has centralized review of these requests to two regional offices, Winston-Salem and Nashville. Based on the pending workload, these offices complete these cases within 90 days.

As of November 20, 2017, VBA has identified 14 requests for character of service determinations received through this initiative. Eight of these cases have been processed. Seven were found eligible for health care and one was found Dishonorable for VA Purposes (DVA). VHA is looking into whether the former Servicemember determined to be DVA has been billed for care furnished under this initiative.

c. Also in your letter, you said that VA Medical Center directors were provided with the number of Other than Honorable veterans in their catchment area. Can we get a copy of that document?

Response. The number of Servicemembers whose discharge character was exclusively "other than honorable" was estimated from the administrative database that is developed in the office of Data Governance and Analytics under the VA Office of Enterprise Integration. This administrative database contains demographic and military service information from the Department of Defense and from the VA for those who have ever received VA services or benefits.

Question 13. The State data released to our staff regarding veteran suicide is from 2014. While I appreciate this data, I would like something more recent. Is there more data that is more recent and when can Congress anticipate another update?

Response. VA used the most current data available at the time. VA now has and is currently analyzing National Death Index data through 2015, but extensive analytic work is needed before we will have an update to release.

Question 14. On the West Virginia veterans suicide data in deaths by method section, 27.5% of veteran suicides in my state are categorized as "other, poisoning, suffocation" but that category is not represented at all in the overall West Virginia suicides chart. Do you know what is included in the "other" category and if not, can you get back to me on an explanation of that data?

Response. The specific categories presented are defined as follows:

- Firearm: ICD–10 codes X72 to X74
- Poisoning: ICD–10 codes X60 to X69
- Suffocation (including strangulation): X70
- Other: all intentional self-harm codes not captured in the above categories (X71, X75-X84, Y87.0), including cut/pierce, drowning, fall, fire/flame, other land transport, struck by/against, and other specified or unspecified injury.

In cases where the number of deaths in any one of the above categories was <10, the categories with the smallest numbers were combined until the minimum count of 10 was reached, and are presented in the lighter shade of blue. So, e.g. for West Virginia State Veterans, the category "other, poisoning, suffocation" collapses the Other, Poisoning and Suffocation categories listed above into 1 category. All data points in the sheets are presented suppressing any counts fewer than 10 to maintain confidentiality of the information.

Question 15. In the past, you have said that a repeal of the Affordable Care Act could lead to an uptick in enrollment in the VA. As the leader of the biggest integrated health network in the country, what role have you played in policy discussions around the future of the Affordable Care Act?

Response. VA has not played a role in policy discussions regarding national healthcare reform.

Question 16. In the next few weeks, there will be hopefully a new bill concerning how we fix non-VA care authorities. How are we equipping non-VA care providers with the military cultural awareness and training so that they can identify when something is wrong? In future legislation, what is needed to help outside of the VA providers be a more integral part in preventing veteran suicide?

Response. VA has proactively worked to equip non-VA providers with the skills they need in order to effectively recognize and respond to the challenges many Servicemembers and Veterans face. These efforts include several strategies, including widespread dissemination of a two hour gatekeeper training called SAVE to veterans and those who serve veterans (SAVE is available at the following link: https://www.va.gov/nace/*MyVA*/). In addition, in partnership with Psych Armor Institute, SAVE will become an online course available to any interested provider free of charge. VA also provides online resources on military culture training, suicide risk assessment, and suicide prevention safety planning tools. Access to VA's military culture training, with free continuing education credits, is available through TRAIN, a catalog of military culture training, at www.TRAIN.org. Other relevant resources

are available to the public via the Veteran Outreach Toolkit: Veteran Suicide Prevention in Everyone's Business, A Community Call to Action, which is available here: https://www.va.gov/nace/docs/myVAoutreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf. Finally, to ensure that we are able to measure the impact of these efforts, VA has included metrics in our written agreements with our strategic partners to document that non-VA providers have access to the necessary resources to successfully treat Veterans and Servicemembers.

In order to help non-VA providers be better equipped to prevent Veteran suicide, future efforts should focus on continuing to disseminate military culture training, including the specific challenges that Servicemembers and Veterans may face across the lifespan, to all health care providers, with an emphasis on those in mental health and primacy care. In addition, non-VA providers would benefit from training on suicide risk assessment and safety planning, including how to counsel at risk Veterans and Servicemembers and their families about lethal means safety.

Question 17. In August, a report came out from the IG that said that there were issues doing oversight on community care providers with opioids. In that the report the IG recommended several steps. Knowing that the Acting Undersecretary for Health concurred with these recommendations, what is your progress on responding to these recommendations?

Response. The responses below outline progress on each recommendation from the Department of Veterans Affairs Office of Inspector General, Report No. 17–01846–316, "Healthcare Inspection Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care," published July 31, 2017.

RECOMMENDATIONS:

• We recommended that the Acting Under Secretary for Health require all participating VA purchased care providers receive and review the evidence-based guidelines outlined in the Opioid Safety Initiative.

PROGRESS: VHA Office of Community Care will provide evidence-based guidelines for prescribing opioids, as outlined in the Opioid Safety Initiative (OSI). The guidelines will be provided to VA's third party administrators (TPAs) and will include a requirement to share these with all participating community care providers. Providers must confirm receipt of this requirement and review them. For those providers who have contracted directly with a VA Medical Center (VAMC) (e.g., sharing agreements, affiliate agreements, and direct contracts), VHA Office of Community Care will develop a distribution and confirmation policy and procedure for VAMC use. A module for community providers in the TRAIN system is being developed and is scheduled to deploy in late in October 2017. The TPA and the field will be given letters for distribution to all providers regarding OSI and the module, as well as information on accessing the clinical guidelines.

• We recommended that the Acting Under Secretary for Health implement a process to ensure all purchased care consults for non-VA care include a complete up-to-date list of medications and medical history until a more permanent electronic record sharing solution can be implemented.

PROGRESS: VA's consult process requirements currently specify that a complete up-to-date list of medications and all applicable medical history information (i.e., prior pain management treatment, controlled substance agreements, applicable behavior health flags) be included with community care consults sent to the TPAs and shared with VA community care providers. VHA Office of Community Care has recently implemented a medical documentation tool that simplifies the process of gathering and organizing all applicable medical history information and a complete up-to-date list of medications into one uniform document identified as the Referral Documentation Tool (REFDOC). This complete package is automated; therefore, assuring complete information is transmitted to the Non-VA provider. We currently have 123 sites utilizing the technology, with planned full deployment by the end of the calendar year.

• We recommended that the Acting Under Secretary for Health require non-VA providers to submit opioid prescriptions directly to a VA pharmacy for dispensing and recording of the prescriptions in the patient's VA electronic health record.

PROGRESS: Under the current Veterans Choice Program contract, VA is primarily responsible for supplying Veterans with all non-urgent/non-emergent medications prescribed in accordance with the VHA National Formulary Handbook, and as part of the health care treatment authorized by the VA. VA agrees that Veterans receiving community care should fill as many prescriptions as possible through VA pharmacies and will work with non-VA providers and Veterans to ensure greater awareness of this objective. VA developed a letter describing the OSI and also reminding community providers to return all prescriptions to the pharmacy is being

distributed to the full network by the end of the October 2017. In addition, similar to private industry, VA will be limiting urgent/emergent prescriptions (which can be filled in the community) to a 7 day fill instead of 14 days with the new pharmaceutical contracts included within the Community Care Network contracts, with estimated award by late FY 2018.

• We recommended that the Acting Under Secretary for Health ensure that if facility leaders determine that a non-VA provider's opioid prescribing practices are in conflict with Opioid Safety Initiative guidelines, immediate action is taken to ensure the safety of all veterans receiving care from the non-VA provider.

PROGRESS: There is a pilot in VISN 4 in which the local VAMC and VISN patient safety structure will begin to address patient safety reported events and perform necessary investigations. The OCC Patient Safety Guidebook is being finalized through this pilot and will be adopted as an appendix to the National Center for Patient Safety's handbook. After VISN 4, OCC staff will work to deploy this new effort across additional VISNs with the expectation that our current and future contracting partners will continue to be involved. Implementation is targeted in a staggered timeline throughout FY 2018. As with other patient safety concerns, all concerns regarding community provider prescribing practices can be reported through the VA patient safety infrastructure and action will be taken accordingly. It should be noted that VA must recognize the possibility that differences in opioid prescribing and monitoring practices disparities can/do exist between the VA and non-VA community providers. Reasoning includes a lack of comprehensive pain treatment modalities in many communities (e.g. acupuncture, pain specialists, etc.). Therefore, while VA agrees that our community providers should be educated and should attempt to adopt the evidence-based guidelines as outlined in the Opioid Safety Initiative. It is not assumed that their lack of adoption reflects poor quality of care without any evidence of egregious activity.

Question 18. In your testimony, you stated that "VA developed a chart "flagging" system to ensure continuity of care and provide awareness among providers about Veterans with known high risk of suicide. Do you know if DOD has a similar flagging system for servicemembers who are high risk for suicide on their Cerner EHR platform? As the VA transitions to the Cerner platform, what will the department be doing to ensure that this flagging system works both within the VA and with non-VA partners?

Response. VA's VistA has a number of Patient Record Flag (PRF) to alert the healthcare provider, to include one to identify individuals who are at risk for suicide. It is labeled "HIGH RISK FOR SUICIDE." In VA and DOD the clinical staff see each agency's national level flags and postings, from their EHR, in a single view from the Joint Legacy Viewer (JLV). Every time a clinician conducts patient search in JLV, a pop-up is displayed with all of the national level VA and DOD flags and postings. The DOD flag is called the "Behavioral Health 2—Harm to Self" that is received and displayed by JLV.

VA and DOD are moving toward using a single Joint EHR, which DOD has already deployed to several locations in Washington State. In the future, at any DOD and/or VA site that has the new Joint EHR, both agencies' staff will see the exact same patient record any associated Flags. As the VA transitions to the new EHR Modernization platform, we will ensure the VA Patient Record Flag is viewable in the new system and the legacy system during transition. Additionally, both VA and the Community Care Providers should also be able to exchange messages that can alert each other's systems that a Veteran is at high risk for suicide.

A P P E N D I X

PREPARED STATEMENT OF KEN FALKE, CHAIRMAN, BOULDER CREST & EOD WARRIOR FOUNDATION

The first week of October marks our Nation's 16th consecutive year of war—the longest stretch of conflict in our Nation's history. Over that period of time, we have lost more servicemembers and veterans to suicide than we have on the battlefield. This is true despite a great deal of attention and even more resources being poured into solving this scourge across the public and private sector.

As a 21-year Navy combat veteran, and the Chairman of the EOD Warrior Foundation and two privately-funded wellness centers—Boulder Crest Retreat Virginia and Boulder Crest Retreat Arizona—that serve combat veterans and family members struggling with suicidal thoughts and PTSD, we have gained a unique perspective not only on the question of why suicides continue to happen, but how we can prevent them.

THE CHALLENGE OF VETERANS SUICIDE

The data related to veterans' suicide paints an incredibly distressing picture. Only 6 of the 20 veterans who die by their own hand each day are active users of VA treatment. Only 50 percent of those in need of mental health care pursue it. Only 20 percent of those who do pursue mental health treatment complete their protocols. Only 40 percent experience benefits from their treatment; and fewer than 3 percent actually lose their PTSD diagnosis.

In short, our mental health system is not proving effective with PTSD or suicide prevention. These views are not my opinions, but the findings of the world's most prestigious medical journal—the Journal of the American Medical Association (JAMA). In August 2015, JAMA called for a new and innovative approach to PTSD for veterans. In January 2017, JAMA Psychiatry declared that, "*These findings point to the ongoing crisis in PTSD care for servicemembers and veterans. Despite the large increase in availability of evidence-based treatments, considerable room exists for improvement in treatment efficacy, and satisfaction appears bleak based on low treatment retention . . . we have probably come about as far as we can with current dominant clinical approaches*."

Since opening Boulder Crest Retreat Virginia in September 2013, we have hosted more than 2,800 combat veterans and family members, and run more than 80 short-duration, high-impact programs. Before, during, and after those visits and programs, we have spoken with guests about their struggles, their experiences with the mental health system, and why they pursued a non-clinical approach. The insights they offered, integrated into our work at Boulder Crest, provide a powerful roadmap for ensuring that we end the epidemic of veterans suicides, and more significantly, enable veterans to create lives worth living—the true opposite of suicide.

1. Veterans report that they have been trained not to acknowledge weakness and are experts at suffering in silence. Seeking mental health treatment while on active duty is often a career ender, and that thinking follows them out of the military.
2. Veterans are often unable to connect with their providers (often civilians who lack a strong understanding of the military culture and who have no basis for understanding combat experiences); this results in a lack of trust, safety, and an unwillingness to return for further treatment.
3. Veterans report that mental health treatments focus on helping them manage and mitigate their symptoms through a combination of talk therapy and medicine, rather than on living a great life. The majority of veterans are not interested in learning how to live as a diminished version of themselves.
4. Veterans report that a diagnosis-focused approach means that therapists and clinicians only want to hear enough to label and judge them, and have little interest in listening to them.

5. Veterans are seeking direction and purpose, and find that consistently talking about past experiences leaves them stuck in their struggle, and unable to move forward.

6. Veterans report that most programs and therapies they experience are catch-and-release. They feel better while they are at a program or in treatment, but as soon as it ends, they return back to their prior baseline.

A NEW, INNOVATIVE, AND EFFECTIVE APPROACH TO PTSD AND SUICIDE

In response to the input and feedback we received from guests in Virginia, we launched Warrior PATHH (Progressive and Alternative Training for Healing Heroes) in June 2014. Warrior PATHH is the Nation's first-ever program designed to cultivate and facilitate Posttraumatic Growth (PTG) amongst combat veterans. PTG is a decades-old science that provides a platform for transforming deep struggle into profound strength and lifelong growth. The underlying notion of PTG is best captured in the words of Nietzsche: "That which does not kill me makes me stronger."

Warrior PATHH is an 18-month program that begins with a 7-day intensive and immersive residential initiation. Warrior PATHH trains combat veterans through the proven framework of PTG: educating them about the value of struggle and what stress and trauma do to the mind, body, heart, and spirit; teaching proven non-pharmacological techniques designed to regulate thoughts and emotions; creating an environment of trust and safety to facilitate disclosure of past challenges from combat and pre-combat experiences; beginning to craft a new story that harnesses the lessons of the past and looks forward; and a renewed commitment to service—to one's family, community, and country—here at home.

In January 2016, after more than two years of research, development, piloting, and success, the Marcus Foundation funded the development of the first-ever curriculum effort designed to cultivate and facilitate Posttraumatic Growth. The curriculum effort included Student and Instructor Guides, a Journal, Syllabus, and Schedule; four pilot programs; and an 18-month longitudinal study.

Now more than six months into the longitudinal study, conducted by UNC-Charlotte's Dr. Richard Tedeschi (the father of Posttraumatic Growth) and Dr. Bret Moore, a twice-deployed former Army psychologist, Warrior PATHH is delivering sustained results that far outpace the status quo approaches to PTSD:

- 100% of participants recommended Warrior PATHH to friends;
- 0% dropout rate
- 40–60% sustained reduction in PCL (PTSD Checklist) Scores;
- 50% sustained reduction in depression and anxiety (DASS–21);
- 40% sustained reduction in stress (DASS–21);
- 35% sustained improvement in participants' experiencing positive emotions; 28% reduction in negative emotions;
- 31% sustained improvement in couples satisfaction;
- 75% sustained improvements in participants' level of psychological, spiritual/existential and relationship growth (PTGI-X)

In short, Warrior PATHH is delivering results that far surpass traditional mental health treatments for veterans struggling with suicidal thoughts and PTSD. All 200 Warrior PATHH graduates are walking their path, and working toward lives worth living. No Warrior PATHH participant has ever dropped out or died by suicide, despite comparing the intensive 7-day Initiation to Navy SEAL Hell Week and Army Ranger School.

WHY WARRIOR PATHH WORKS

Warrior PATHH is modeled on military-style training. It is intensive, immersive, team-based, and provides participants with a new fire team to support their road to wellness, strength, and thriving.

Warrior PATHH is based on the decades-old science of Posttraumatic Growth, and provides veterans with a pathway to a life that is more authentic, fulfilling, and purposeful than ever before. This opportunity to continue growing and contributing speaks to the deepest needs of veterans, and allows them to feel valued and needed on the home front.

Warrior PATHH is delivered by a team of combat veteran peers, world-class life coaches, and therapists

Warrior PATHH is sustained over 18 months, and ensures that participants build connection, confidence, and capabilities over the long-term. The impact of this approach is demonstrated in the program evaluation study.

Warrior PATHH focuses on training not treatment, allowing veterans to harness the power of the military training and combat experiences and be Warriors and leaders in their own lives, and the lives of their families, communities, and country.

THE IMPORTANCE OF COMMUNITY PARTNERSHIPS

As was noted during the September 27th Senate Veterans' Affairs Committee hearing, the VA cannot and will not solve the suicide crisis amongst veterans on their own. Based on our experiences working primarily with veterans who have unsuccessfully been through treatment and those who will never seek it, it is clear that we must expand the scope of our work to include effective and proven alternative approaches. This is particularly true in the case of approaches that address the major barriers to veterans seeking and continuing treatment.

As we do so, we must be disciplined, data-informed, comprehensive, and supported by empirical data. To that end, we have engaged in meaningful conversations with many elements of the mental health community, including the VA, and we remain committed to doing so.

As we reflect on a potential roadmap for sustained collaboration, we see three critical paths.

1) The first is to engage in robust training for mental health providers, as well as for non-clinicians working in mental health on several key subjects: military culture, Posttraumatic Growth, Adverse Childhood Experiences (ACES), and Common Factors (including training into how to connect with veteran clients). In January 2018, we are launching the Boulder Crest Institute to provide precisely that training, leveraging our experience, success, and a blended team of combat veterans, civilian coaches, trained mental health professionals, and world-class psychologists.

2) The second is to expand the continuum of mental health treatments, and create a new front door for the world of mental health. This new front door would begin by focusing on non-clinical, non-pharmacological approaches to begin training (not treatment) for those struggling, and provide veterans with an accessible alternative to the often foreign world of mental health that they are clearly resisting. This pathway would expand available care options for veterans, and provide primary care doctors and nurses with alternatives to a mental health referral. We believe that PATHH, as well as other proven, effective, and empirically based programs, are an excellent option in that regard. There are a handful of instances where both DOD and VA therapists have referred patients to PATHH, and the result has been overwhelming success. In fact, we have received emails from therapists in Missouri and New York asking, "What did you do to my client?" They note that either their patient no longer requires treatment, or returns with an open mind and a focus and commitment previously lacking.

3) The third pathway references my previous experience in the world of improvised explosive devices, and the notion of prevention. In EOD (explosive ordnance disposal) parlance, the term is "left of boom." We have to look at how we prevent people from getting to the point of suicidal thoughts and intentions, and put in place approaches that stop issues before they ever emerge. Doing so in this context requires us to look in two areas: how we train our troops, and their leaders, to ensure that they are well in mind, body, finance, and spirit while on active duty; and how we transition our servicemembers. We have had countless instances of a veteran who has transitioned poorly, self-medicated in response, damaged relationships in the process, and found themselves in a mental health office. They are medicated, turn to disability payments, and become unproductive, unfulfilled, unworthy, and suicidal. What was a temporary issue of adjustment became a permanent diagnosis. We can and must do better to prepare transitioning servicemembers not just for a post-military job; we must prepare them for a post-military life. Critical elements of our program, particularly focused on education, could be used to that end, and a clear-eyed look of how transition goes wrong is critical to understanding how veterans end up at the brink of suicide. While we are part of VA efforts to explore changes in transition, in truth, this is far more of a Department of Defense (DOD) challenge.

CONCLUSION

As a retired Master Chief Petty Officer and service-connected disabled combat veteran, I know the power of military experience and the challenges associated with combat experiences. I also know that I am the man I am because of the United States Navy. More than two thousand years ago, the Athenian general and philosopher Thucydides said it best: "We must remember that one man is much the same as another, and that he is best who is trained in the severest school."

Combat veterans represent the finest among us, and we have only to look at the remarkable and enduring service of Generals Kelly, McMaster, and Mattis to see evidence of this fact. Rather than focusing on suicide prevention, we should be focused on ensuring veterans can live great lives at home—lives filled with joy, passion, love, service, and purpose. We should ensure my fellow veterans can use the

great military training they receive as a launching pad for a productive and purposeful life as a Warrior at home. We must ensure that, to paraphrase the words of a Marine General friend, their time in military service should not be the last great thing that they do.

Doing so requires an integrated and collaborative approach, and we look forward to being a part of the solution.

PREPARED STATEMENT OF KAYDA KELEHER, ASSOCIATE DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE COMMITTEE, On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on suicide prevention.

Veteran suicide is a topic that plagues the veteran community. It is also something the VFW takes very seriously. There is no reason for suicide to be one of the top 10 reasons Americans die, and there is without doubt zero reason why the veteran population should be overrepresented in the death by suicide population—22 percent as of 2010. Since 2001, the veteran rate of death by suicide has increased by 32 percent, more than 10 percent higher than non-civilians. Yet, correlation is not causation. Post-9/11 veterans are at risk of suicide, but they are not the population that needs the most attention if we intend to decrease veteran suicide.

The VFW believes that in order to address veteran suicide, the Senate and Department of Veterans Affairs (VA) must invest in more research, an increase in mental health providers at VA, better outreach to Pre-9/11 veterans and women, providing technical improvements to the Veteran Crisis Line (VCL), and expanding public-private partnerships in areas where VA does not have the authority or resources to provide veterans in need.

RESEARCH

In summer 2016, VA released the Nation's largest analysis of veteran suicide ever conducted. While this data is incredibly critical in addressing, and hopefully ending, veteran suicide, we need more analysis of the available data. From the data released in 2016, VA found that of the average 20 veterans who die by suicide each day, only six of those veterans are actively using VA. VA defines those six as veterans who have enrolled in or used VA within a year from the date they died. VA, veterans' service organizations, the Senate and the House need to know more about the 14 veterans not actively enrolled in VA. The VFW urges VA to analyze the demographics, illnesses, socioeconomic status and military discharges of those 14. There are questions that need to be answered in order to properly address this unfortunate problem. Did those 14 use private sector care? Were they eligible to use VA? Were they among the many who were discharged without due process for untreated or undiagnosed mental health disorders related to sexual trauma or combat? Were they discharged for unjust and undiagnosed personality disorders during the era of "Don't Ask, Don't Tell?" If we are going to honestly combat veteran suicide, we must know more about the 14 veterans who die each day without using VA.

As technology continues to increase, VA must continue researching new ways to reach those in need of mental health care. Over time, VA has excelled at making sure to offer user-friendly apps, such as PTSD Coach, for veterans to conveniently open in their time of need. Yet apps are not the avenue of prevention or intervention all veterans prefer. Studies must continue to be conducted to find reliable statistics regarding what platforms of technology veterans prefer for all era's and age groups. Those technologies should also be analyzed by VA researchers to further understand key phrases and actions taken by those experiencing mental health crisis and/or suicidal ideations. While most people know there are signs of possible suicide, such as an individual beginning to give their belongings away, linguistic psychologists in academia at schools such as Massachusetts Institute of Technology have found there are words used at increased frequency when individuals are experiencing suicidal ideations and mental health crisis. These words are not the "cliché" words taught to us in the military or at local high schools. This would be instrumental for providers and the general public to be aware of when being mindful of veterans and loved ones in a possible mental health crisis.

With the number of VA opioid prescriptions decreasing and the increased number of providers receiving training on effective psychotherapies specific to Post Traumatic Stress Disorder (PTSD) patients, the VFW believes VA has made great strides in treating this population. Yet, it still has more work to do.

Throughout the years, research on mental health issues associated with combat or sexual trauma, such as PTSD and Traumatic Brain Injury (TBI), has allowed doctors and researchers to understand and diagnose mental health disorders in ways never before possible. The VFW urges VA to continue this research to better understand biological implications for the diagnosis of PTSD and TBI to avoid misdiagnoses and treatment. The VFW also urges the Senate and VA to work together to incorporate new technologies and to research new and/or alternative forms of treatment, such as medicinal marijuana.

For veterans who are uninterested or do not believe traditional, empirically proven methods will work, VA must partner with more private organizations and groups to offer veterans the opportunity to partake in alternative and non-traditional therapy options. Psychosomatics and the placebo effect are very alive and real. The VFW believes veterans should have the opportunity to partake in whatever form of safe treatment is available, whether VA has the ability to provide it or not. This includes partnering with organizations that provide complementary and integrated medicine which has been proven to work as non-pharmaceutical alternatives to opioid therapy.

INCREASE PROVIDERS

The entire nation is experiencing a shortage of medical providers, and that is an even bigger issue for mental health care. Since the 2014 Phoenix crisis, applications to work at VA have significantly dropped and VA has struggled to meet the demand of veterans in need. The Senate must provide VA with the appropriations and authority the secretary needs to increase the number of mental health care providers within VA. This is critically important in addressing suicide as we know that out of the 20 veterans who die by suicide every day, only six of them are actively using VA. If more providers are available, more veterans can seek timely treatment at VA facilities.

Veterans who seek treatment for mental health at VA report that their treatment was effective, but this is not disregarding access to care issues VA has struggled with in the past. Veterans who choose to use VA for their health care must have access to treatment—particularly veterans struggling with mental health conditions such as PTSD.

VA is the largest integrated mental health care system in the United States with specialized treatment for PTSD. The number of veterans seeking treatment at VA for PTSD has continued to increase as more veterans from Iraq and Afghanistan leave the military and transition to civilian life. This is part of the cost of war. The Senate and VA must ensure those seeking these treatments are provided timely access to VA care.

Mental health staff members within VA have increasingly continued to receive training in areas such as prolonged exposure and cognitive processing therapy, which are the most effective and empirically proven therapies to treat PTSD. Medication treatments are also offered and, thanks to the VFW-supported Jason Simcakoski Memorial and Promise Act, medications are being more closely monitored. Through VA's Opioid Safety Initiative, opioids are being prescribed on a less frequent basis for mental health conditions and are being monitored for addiction and other negative consequences.

The VFW has long advocated for the expansion of VA's peer support specialists program. VA peer support specialists are individuals with mental health or co-occurring conditions who are trained and certified by VA standards to help other veterans with similar conditions and/or life situations. They are actively engaged in their own recovery and provide support services to others in similar treatment at VA. Veterans who obtain assistance from peer support specialists value the assistance they receive.

The VFW urges the Senate to make sure VA has the resources required to continue expanding this effective, low-cost form of assistance to veterans in need. To ensure VA is offering a holistic approach in effectively addressing PTSD within the veteran population, VA must have the ability to provide peer specialists outside of traditional behavioral health clinics. Veterans overcoming homelessness, veterans seeking employment, and veterans in mental health crisis going to the emergency room or urgent care center could all benefit from peer support services.

Aside from veterans receiving support from fellow veterans who have recovered from similar health conditions and experiencing the bond and trust veterans share, peer support specialists also greatly assist in destigmatizing mental health conditions such as PTSD. For a veteran to become a peer support specialist they must have actively gone through treatment, and are living a relatively healthy lifestyle.

This allows veterans who may be struggling to see that their condition is treatable, manageable and not something that has to negatively impact or control their lives.

OUTREACH TO WOMEN AND OLDER VETERANS

Outreach works. In August 2017, the entertainer named Logic performed a song on live television about suffering from suicidal ideation and mental health crisis, but then eventually getting help and recovering. The song was titled "1–800–273–8255"—the National Suicide Prevention Lifeline. In the days following the performance, the National Suicide Prevention Lifeline saw a 50 percent increase in callers. This is just one example showing that VA must conduct more strategic outreach.

In today's society, it seems as though many people assume veterans at the highest risk of suicide are men who were in combat roles and served during the Post-9/11 era. That is where society is wrong. Veterans with the highest rates of suicide are males over the age of 50, and women veterans who do not use VA.

Since 2001, the rate of suicide among women veterans who use VA services increased by 4.6 percent, yet for women veterans who have not used VA their rate of suicide increased by 98 percent. The rate of female veteran suicide since 2001 has increased by nearly 100 percent for women who either choose not to use VA or are ineligible. To the VFW, that is atrocious and completely unacceptable.

Women veterans seeking mental health treatment often times face unique barriers or challenges. While people of all genders struggle with mental health for the same reasons, mental health conditions linked to sexual violence, such as PTSD, affects women at a much higher ratio than others in the veteran population. As the population of women veterans continues to rise, it is of the utmost importance that VA continues to prioritize their often overlooked health care needs.

The VFW urges the Senate and VA to continue expanding telemental health programs. These programs are often invaluable in decreasing risk of suicide to women veterans wanting to use group therapy for mental health linked to sexual violence. In VA's where there may not be enough women to get a group therapy session started, telemental health provides this opportunity. The VFW also urges VA to do two things. First, begin taking sex more seriously into consideration before prescribing psychopharmaceutical treatments. Medications have different effects on people of different sexes. The VFW asks VA to serve as a good example in prioritizing this factor. Second, VA must continue training mental health providers and employees on treatments and proper handling of patients with PTSD due to sexual trauma.

Better outreach must also be conducted to veterans who served prior to 9/11. Both in the civilian population and the veteran population, individuals over the age of 50 are the majority of those who die by suicide. Currently, veterans who are 50 or older make up approximately 65 percent of the total population of veteran suicide. For the civilian population, adults between the ages of 45 and 64 have the highest rates of death by suicide. More must be done to reach these populations. Post-9/11 veterans are more likely to enroll in VA, and since the recent conflicts VA has really excelled at providing access and doing outreach to this population. Now it is time to expand these outreach initiatives and increase access to women and middle aged men.

VETERANS CRISIS LINE

In 2007, the Department of Veterans Affairs Health Administration (VHA) established a suicide hotline. The hotline, which later became known as the VCL, was established to provide 24/7, suicide prevention and crisis intervention to veterans, servicemembers and their families. The VCL provides crisis intervention services to veterans in urgent need, and helps them begin their path toward improving their mental wellness. The VCL plays a critical role in VA's initiative of suicide prevention, and ongoing efforts to decrease the estimated 20 veterans who die by suicide each day. The VCL answers more than 2.5 million calls, responds to more than 62,000 text messages and initiates the dispatch of emergency services more than 66,000 times each year. Since opening its doors in 2007, VCL has expanded to three locations. Beginning in Canadaigua, New York. VA expanded to its second location in Atlanta during fall 2016. This was done to assure the increased number of veterans calling into the VCL were having their calls answered in a timely manner and receiving the intervention they needed. A third call center recently opened in September 2017. This call center is located in Topeka, Kansas.

Access to the VCL is plentiful, and the VFW believes VA has been successful in performing outreach to educate veterans about the crisis line. Still, the VFW believes there is room for improvement. If a veteran currently calls VA medical centers (VAMC) and some Community Based Outpatient Clinics (CBOC), the veteran hears the option to press the number seven on their phone for an automatic transfer

to the VCL. This has proven to be successful for VA, but there are still CBOCs without the technology requirements to implement the "Press Seven" option. The VFW believes all VAMCs, CBOCs and Vet Centers need to have this option for veterans calling in.

With that said, there are always unintended consequences. Precise numbers of non-veterans and veterans not in a mental health crisis calling VCL are unknown. Last year it was publicized that four callers were calling and harassing VCL employees thousands of times. Estimates of four percent of incoming calls were to harass VCL responders. Other veterans admit to calling VCL when not in mental health crisis because it is the first phone number they see publicly available. They have called in hopes of being able to schedule appointments or to complain about unsatisfactory care they received. Recent data reports show since VA's White House Hotline opened its lines in June 2017, VCL has experienced approximately an eight percent increase in non-crisis calls. Fortunately, VA's call centers have the ability to transfer callers to the right call line and staff are trained on how to handle callers not on the appropriate line for their need. Completely screening these calls and assuring only individuals in crisis are calling the VCL is not practical, and most callers are in need of some level of intervention. Crisis is defined individually, and everyone in crisis deserves support. Yet, the VFW is concerned some of the calls not being answered by VCL responders may be due to non-crisis callers clogging the system.

The VFW believes expanding VA's Office of Patient Advocacy would greatly benefit the VCL. By improving and expanding the patient advocacy offices throughout VA, employees of these offices would have better visibility and means to assist non-crisis patients. If veterans become more aware of the patient advocate mission and capabilities, non-crisis callers to the VCL would decrease. The VFW has been working to expand and improve patient advocacy within VA and we will continue to monitor progress. The VFW urges this Committee to conduct extensive oversight of the VA Patient Advocate Program to ensure veterans are able to have their non-emergent concerns addressed without having to call the VCL.

Employees at VCL undergo extensive training before being allowed to answer calls, and it takes at least six months before they may begin training to also answer chat and text conversations with veterans in crisis. Yet, it was not until late December 2016 that the VCL had the capability to record and monitor their calls. Without this crucial technological capability, there was no way for calls to be truly monitored for quality control. Now that this capability is available, the technology must be properly utilized. Staff at VHA and the VCL monitor some ongoing calls for quality assurance, but a better, constant process must be implemented to ensure these recordings are being used to improve the training and capabilities of VCL responders. This would not only improve crisis intervention, but would assist with ending allegations of responders not understanding or following protocol, instructions, and resources.

The VFW firmly believes the VCL has improved and will continue to improve. Though that improvement will continue to be slow, frustrating and life-endangering if the VCL does not begin collaborating with others. Aside from working with patient advocacy offices to cut down on non-crisis calls and VHA Member Services to readjust the advisory board and increase clinicians, the VCL must also work more closely with the Office of Suicide Prevention (OSP).

Member Services has undoubtedly assisted the VCL in quantity control, but OSP can also assist the VCL in quality control. If the goal of the VCL is to intervene for veterans in need of immediate assistance while they are in the middle of a mental health crisis, the VCL should be working with the subject matter experts and leaders in suicide prevention and outreach for VA. If all three offices could collaborate together, with better guidelines, Member Services would be able to continue improving the VCL call center expertise and business, while OSP could make sure the VCL is up-to-date with the most current clinical expertise on suicide prevention and outreach.

PUBLIC/PRIVATE PARTNERSHIPS

Since the enactment of Public Law 114–2, Clay Hunt SAV Act, VA has entered into new relationships with many private sector organizations to address PTSD within the veteran population as well as to combat veteran suicide. Some of these organizations include Bristol-Myers Squibb Foundation. This foundation has awarded over $15 million in grants to veterans service organizations and academic teaching hospital partners working to develop and improve innovative models of community-based care and support to improve the mental health and community reintegra-

tion of veterans. The VFW is also among the many organizations who have signed on to partner with VA.

This past year, the VFW launched a Mental Wellness Campaign to change the narrative in which America discusses mental health. We teamed with Give an Hour providers, One Mind researchers, the peer-to-peer group PatientsLikeMe, the family caregiver-focused Elizabeth Dole Foundation, the Nation's largest pharmacy Walgreens, and the Department of Veterans Affairs to promote mental health awareness, to dispel misconceptions about seeking help, and to connect more veterans with lifesaving resources. The goal of the VFW campaign is to destigmatize mental health, teach our local communities how to identify mental distress and what local resources are available to those struggling to cope with mental health conditions. To do this, VFW Posts and VA employees from Richmond, Virginia to Lakeside, California, and everywhere in-between, have held mental wellness workshops to spread awareness of VA's mental health care services, as well as how to properly identify a fellow veteran in distress. The VFW and VA talked with local veterans about the Campaign to Change Direction and their five signs of mental distress—personality change, agitated, withdrawal, poor self-care and hopelessness.

We know this campaign has saved lives. Our members have told us so. Veterans have told us of how they were suicidal—gun in hand—but they put the gun down when they saw the pamphlet from the Campaign to Change Direction. Those veterans are still alive after they called the Veterans Crisis Line and received help. That is the power of the public-private partnerships VA is continuing to develop.

Education is empowering. The more VA partners with private sector organizations and conducts outreach to educate people on signs of mental health crisis, ways to intervene and that the majority of Americans struggle at some point in their life with mental health, the more empowered people will be. By empowering veterans and their fellow Americans we help destigmatize mental health, and by doing that we allow for more open and honest conversations to comfortably take place. The VFW sincerely believes by talking and taking care of one another we can help lower the rate of veteran suicide. But nobody, not the VFW, not VA, not the House or Senate can totally eradicate veteran suicide without everyone working together to holistically address the problem at hand.

LETTER FROM PAUL LLOYD, STATE ADJUTANT, DEPARTMENT OF NEW HAMPSHIRE, VETERANS OF FOREIGN WARS

NEW HAMPSHIRE'S "ASK THE QUESTION" CAMPAIGN
PREVENTING SUICIDES BY ENGAGING THE COMMUNITY

Lt. Col. Stephanie Riley of the New Hampshire Air National Guard worked in an emergency room of a New Hampshire hospital in 2013. She often witnessed individuals presenting with symptoms of headaches, dizziness or hearing loss. These patients were diagnosed with a migraine, when they were actually veterans suffering with a Traumatic Brain Injury. They were not diagnosed accurately because they were never identified as a veteran during intake.

Later that same year, a veteran met with Lt. Col. Riley at the National Guard Medical Command Unit. This veteran had been to three different healthcare facilities in New Hampshire and not one of them asked if he had ever served in the military. By the time this veteran reached out to Lt. Col. Riley, it was too little, too late. And this veteran died by suicide.

Across our Country, over two-thirds of our veterans receive care in the community—and not from the Veterans Administration. As the VA continues to struggle with bureaucracy and service challenges, the number of veterans seeking care outside the VA continues to rise.

Our communities need to respond to this crisis.

20 veterans die by suicide each day. 6 of these veterans receive care at the VA; and 14 do not. While we know that the majority of our veterans receive care in the community, we also know that veterans don't feel completely understood by civilian, VA or military health care professionals. The New Hampshire Legislative Committee on PTSD and TBI conducted a survey of New Hampshire veterans asking about barriers in accessing care. The New Hampshire Veterans of Foreign Wars was honored to fund and support this survey. Survey results indicated that the top barrier identified was stigma, embarrassment and shame. The 2nd highest barrier in accessing care was a consistent comment from New Hampshire veterans stating, "I do not feel understood by the providers who serve me."

New Hampshire is working hard to keep our veterans safe and connected with the "Ask the Question" Campaign. The "Ask the Question" Campaign encourages all

service providers to ask the question, "Have you or a family member ever served in the military?" This simple question can open the door to greater communication. And communication and understanding is at the heart of good care and services.

New Hampshire's Community Mental Health Center (CMHC) Military Liaison Initiative is a powerful example of how one healthcare system in New Hampshire has "operationalized" the "Ask the Question" Campaign—as part of their successful efforts to support our military. Through "Ask the Question," we now know that 15% of clients served at the 10 New Hampshire Mental Health Centers are military connected. This new data is helping to create "intentional" strategies to serve our military by generating military culture trainings, developing internal military staff meetings, coordinating client referrals with the VA and providing greater supports for military families. The Mental Health Centers also created an internal Military Liaison in each of the 10 Centers to help move this initiative forward.

HOW we ask the question is critical to engaging our military. Not all veterans identify as a veteran, so it is important to ask, "Have you or a family member ever served in the military?" By asking the question, we are also acknowledging that military service is important. Many of us know a Vietnam Veteran or Korean War Veteran who may have served in the military for only a few years, yet his or her service defines who they are and how they lived and many continue to serve their Communities by being members of the Veterans of Foreign Wars or other Veteran Service Organizations.

New Hampshire has learned that in order to best serve our military, we need to first identify them. And we need to identify them within our hospitals, mental health centers, senior centers, employment offices, law enforcement, courts and schools.

Veterans are often hesitant to ask for help because of pride, shame or stigma. Many veterans don't ask for help because they want to save that help for their brother or sister who served. The "Ask the Question" Campaign puts the responsibility on the service provider—removing possible barriers from the veteran, servicemember or their families.

The "Ask the Question" Campaign truly opens the door to how we define a veteran, and creates opportunities to better understand our military community—through communication, resources and connections.

Lt. Col. Stephanie Riley of the New Hampshire Air National Guard Riley died of cancer in December 2014. But she continues to serve her Country through the "Ask the Question" Campaign.

The "Ask the Question" Campaign was recently approved to be included in the National Suicide Prevention Plan.

Thank you, Lt. Col. Riley, for your service to our State and your service to our Country.

Respectfully,

PAUL LLOYD,
State Adjutant,
Department of New Hampshire,
Veterans of Foreign Wars.

PREPARED STATEMENT OF KENNY SMOKER JR., DIRECTOR, FORT PECK TRIBES HEALTH PROMOTION/DISEASE PREVENTION, FORT PECK INDIAN RESERVATION, POPLAR, MONTANA

My name is Kenny Smoker, Jr., the Director of the Fort Peck Tribes' HPDP program located on the Fort Peck Indian Reservation in Poplar, Montana. I have been a long time employee in health care systems on the Fort Peck Reservation and have collaborated with several tribes across Montana to improve health care for all people on reservations.

Montana has been at or near the top in the Nation for the rate of suicide for nearly four decades. From January 1, 2014 to March 1, 2016 there were 556 suicides in Montana. The number of veterans that died by suicide during this time was 42, of which 8 were American Indians. Nationally 18% of suicides are veterans. In Montana, 22% of suicides are veterans. In Montana, 19% of suicides are American Indian Veterans.

Some of the challenges Montana tribal veterans face as it relates to mental health are:

- Access to health care and mental health services
- Addressing on-going Substance Abuse issues—56% of American Indian suicide completions had alcohol in their system
- Lack of individual drive to seek care due to depression

The VA can do to better with local communities and providers to enhance access to these critical services by implementing a few key strategies:

- Supporting Tribal Veteran Centers:
  - – Support an Army of VISTA's to assist communities in building capacity for local Tribal Veteran's Representatives alongside community professional and natural support in order to provide outreach and assistance for veterans to access needed services such as face to face mental health provider encounters, transportation, and developing camaraderie groups to safely engage other veterans in shared experiences
  - – Increase access to tele-psychiatry and other health services
  - – Support wraparound services to empower individuals to seek care, utilizing the Social Determinates of Health concept
  - – Increase peer to peer supports to build capacity for seeking and accessing care by veterans
- Increase support for Tribal Veteran's Representatives
- Increase communication and collaboration between Tribal, State and Federal programs to engage all veterans in rural and tribal areas from within their own cultural context in order to serve them better- a culturally matched transition from soldier to veteran
- Give Veterans a "Sense of Purpose"
- Assessing the right fit for employment opportunities

Resources:

Montana Strategic Suicide Prevention Plan—
http://dphhs.mt.gov/suicideprevention

Senator Isacson, Senator Testor, and Members of the Committee. We sincerely appreciate the opportunity to have our thoughts and testimony entered into the record.

As many of you are aware, our son, Daniel Somers, took his own life on June 10, 2013, after two deployments to Iraq, and 10 years of what he described as "fighting his demons." He left a remarkable suicide letter, which we have included as **Attachment 1**. Because of his letter, we have dedicated ourselves to trying to help our Service Members, Veterans and their families, deal with the issues Daniel faced. We have also made it our mission to try to change the system to better address proactively the many issues, especially suicide, facing our transitioning Service Members and Veterans.

In the course of our journey, we have become convinced that the best way to positively affect the tragedy of suicide within the Veteran community is to dramatically change the entire **Transition Process**. We strongly feel that DoD must provide a more in-depth period of transition, not just a five day, 8 hours a day round of PowerPoint presentations. If it took months of intense training to transform Daniel from a civilian into a soldier, it should certainly take at least that same amount of time to help him transition back to civilian life. This is an idea that has gotten significant support both at VA and DoD. There are several white papers circulating within the VA & DoD space that outline very specific details for such a program. The two that we are most familiar with were both prepared by Jason Roncoroni, LtCol USA, Ret, and the former Executive Director of Stop Soldier Suicide. They are based on his own experience: Reverse Boot Camp and TRIBE. We would like to describe TRIBE, the more comprehensive of the two.

TRIBE (Transition, Renewal, Integration, Becoming, Empowerment), Attachment 2, is in response to the ongoing suicide epidemic that the military and veteran communities face. This proposal was presented at VA's recent Innovation Conference in Boston and was one of the three prize winners. In essence, it represents a new way to offer veterans the opportunity to discover

"an empowering path for a new life after the military". What it does is commit everyone, DoD, VA, families, VSO's, the general community and the veterans themselves to bridging all of the gaps during the transition process in order to ensure long term success. Of critical importance is the way the program eliminates the stigma attached to seeking mental health support by making assessments, monitoring and wellness programs mandatory for everyone.

What makes TRIBE different from all other programs is that it uses a peer-support model to work with a veteran's inner strengths to heal the person as a whole.

Amazingly, even though DoD has created and implemented more than 900 suicide programs since 2001, suicide rates more than doubled from 2001-2013. Utilization of the Veterans' Crisis line continues to rise even as the number of veterans diminishes. The overall goal of all of our efforts must be the termination of crisis related services. That is the ultimate measure of the success of our efforts. We are all aware that expenditures for VA care have increased 300% since 2001. This year's budget request was $182.3 billion. In spite of this less than 43% of the 21.6 million veterans in 2014 were enrolled in VA. Disability compensation for veterans has more than doubled since 2011, from $39 to almost $80 billion. Most people don't realize that this represents the largest chunk of VA's expenses. These figures are unsustainable in the long term.

In years past communities and cultures have worked together to welcome warriors back from the battlefield. Native Americans continue to use elaborate ceremonies and rituals for this purpose. This is the only way we will successfully re-integrate our returning service members back into society.

The Phases of TRIBE

Transition

This phase has two objectives. First, the transitioning Service Member relinquishes all official duties, responsibilities, and positions of authority in the military. Second, all follow-on activities

for the next year of the program are coordinated. At the same time, all of the administrative requirements to depart the service are completed.

Renewal

This phase addresses guilt, shame and regret. It includes treatment and therapy necessary for core healing, by dealing directly with moral injury. We know this was a tremendous factor in Daniel's inability to deal with his demons. Innovations include mandatory, extensive, behavioral health assessments, and training in mindfulness and meditation.

Integration

This is the community celebration of honorable military service, which renews a tradition that modern society has lost. Instead of a veteran's first experience being in a hospital or through a form letter and bureaucratic morass, the Veteran Integration Ceremony initiates a very positive experience.

Becoming

This is the process by which veterans decide on what they want to do and how they want to do it after the military. The various features include:

Professional Coaching - Credentialed life coaches, all veterans themselves, partner with new veterans for three months of life and transition training.

Transition Benefit Program - There would be a 6-month severance program of pay and benefits for those who qualify. The qualifying factors include duration of honorable service, combat or some combination. This would avoid the need to immediately find a job after separation.

Career Services - This phase follows the three months of professional coaching, and encompasses the final 3 months of the TRIBE program.

Empowerment

Towards the end of the 3-month coaching program, the veteran is connected with peer support and VSO's. An added incentive is that qualifying veterans have the opportunity to sponsor those who might not be progressing as well through the duration of the 3-month program, and even beyond.

TRIBE Program Benefits

It Eliminates Mental Health Stigma.

By providing a mandatory schedule of mental health evaluations and assessments, the burden of self-selection for mental health treatment is resolved. In short, the issue of perceived weakness and shame for requesting mental health care is turned into one of acceptance and expected intervention. As there are mandated evaluations throughout the program, documentation, progress and anticipated future needs are easily recognized.

It Improves Military Readiness

Currently, service members are encouraged to begin preparation for transition up to 18 months prior to separation. This forces the individual to divide their attention between their actual job and combat readiness and the transition process.

It Improves Veteran Engagement

At this time, less than 45% of veterans are connected to VA through its services and programs. In contrast, TRIBE proactively connects all veterans to VA early in the transition process. We would like to see, even before this initiative is adopted, that Congress mandate an "opt out" provision for VA services, rather than the "opt in" process that is currently in effect. This would provide a seamless passage between DoD and VA medical care, and eliminate many of the bureaucratic barriers that end up hindering veterans from enrolling in VA.

It Heals Moral Injury

As we have said, and as you've heard from Daniel's letter, moral injury played a huge part in his mental anguish. VA still has no protocols to address this issue. As moral injury is not an official diagnosis, it cannot be diagnosed or treated directly, only as part of an officially recognized mental health condition. Many feel that the lack of approved treatment programs specifically targeting moral injury is potentially the greatest weakness in the ongoing struggle against military related suicide. TRIBE attacks this issue head on.

It Sustains Behavioral Wellness

By educating and training every veteran in mindfulness and meditation, the program automatically forms a peer network for support in the long term.

It Celebrates Honorable Military Service

Veteran Integration Ceremonies (VIC) restore the ancient tradition of welcoming warriors back into society. They allow the public to acknowledge and accept veterans' service and sacrifice.

It Reframes Veteran Engagement with VA

Instead of first experiencing VA at a hospital or as a victim of a bureaucratic maze, the first exposure the veteran has with VA is through the VIC. The ensuing coaching program provides a positive guide towards the future.

It Has Certified Coaching

All coaches would be International Coaching Federation (ICF) certified, and fellow veterans. As part of the coaching experience, veterans will identify their inner purpose and passion with their preferred post-military career path. It goes without saying that this will dramatically reduce veteran unemployment and job turnover rates that are so high within the first two post-service years.

It Promotes Financial Stability

Qualifying veterans will receive 6 months of pay and benefits after separation from the military. As such, veterans and their families can concentrate on learning how to relate to one another instead of worrying about employment and income.

It Inverts the Current Cost Structure

By healing warriors before they leave the service, we can stop the long-term payments for potentially treatable conditions and offer veterans a life of meaning and purpose. The idea is to heal the wounds proactively, not continue to pay retirement and disability benefits.

The current state of affairs is not sustainable. If things don't change, we run the risk a continued increase in the number of military-related suicides, and running out of money to treat those individuals who we can identify as being at risk. Current prevention and intervention programs are not working. Every year approximately 200,000 men and women transition from service member to veteran. We must fundamentally improve the approach to veteran health and wellness, or we will never see a reduction in the number of suicides, or the other multitude of issues that adversely affect our former warriors. For every veteran, the transition process is a critical part of the post military journey. Unless that process is fundamentally transformed, we will not see any progress. The TRIBE program provides a blueprint that allows our service members to discover a post-military path to empowerment. We are absolutely convinced that TRIBE would have been of immeasurable help for Daniel.

Support Network

We have proposed a Support Network **(Attachment 3),** that we feel would be an invaluable aid to the family and loved ones of our Service Members and Veterans. National Guard Headquarters, DSPO, and the staffs of the Armed Services Committees of both Houses of Congress have endorsed this idea, along with many members of both House of Congress. We feel every new service member must be afforded the opportunity to provide a list people (say 5 or 10) that they consider the people they would turn to with good news or bad. The DoD would take that information and put it on a listserv, possibly through a neutral party such as the USO, that would routinely send out generic information to that network. Information about what basic training is like, what happens when a unit is called up for deployment, what deployment means, what physical, psychological and transitional issues returning service members are experiencing. It would include specific links with more in-depth information about these issues, and highlight national AND local organizations that the service member, veteran, family member or friend could turn to for additional assistance and information. This knowledge will save lives by empowering those in the Support Network with the confidence necessary to know what to say, how to say it and where to find appropriate resources. The receiving party could opt out at any time and the service member would be notified. Likewise, if the service member deleted a previously listed name, that person would be notified. This would have been a HUGE red flag for us.

Gun Research

Why has Congress mandated that no research can be done on firearms and what part easy access to firearms plays in veteran suicides?

Until early 2016 when we participated in a conference on Lethal Means and Suicide we did not know of this ban on gun research. While the two of us have never been advocates for or against gun

ownership, Daniel had a fascination with guns since his early teens when he joined a Police Explorer club in Phoenix where he was taught the use and responsibility of owning a gun. Daniel was a member of the NRA and a strong believer in the 2nd Amendment, but we believe he would have disagreed with a ban on gun research. In other high death risk activities, where there has been prevention research, the results of that research have lowered the numbers of those that have died: motor vehicle accidents, fires and drowning. When using a firearm, 85% of suicide attempts are successful, but if the attempt is made with any other means, the completion rate is 5%. The fact is that seventy percent of those attempting suicide make the decision within one hour before the attempt. Now let's add in veteran factors like TBI. Depending on the number and severity of TBIs there is a 7-22% increase in the likelihood of this population to attempt suicide.

Though VA has a robust gun lock program, we feel that more can be done by both VA and DoD to permit and encourage providers to counsel all veterans about lethal means safety. While formal gun violence restraining orders may not be the answer, voluntary surrender of firearms to a friend or family member when one is feeling stressed could indeed be a way to ease a veteran's discomfort with giving up control.

Mental Health Infrastructure

As a society, we have not prepared ourselves as regards our mental well-being. We need to begin with our children - today - and provide them with regular mental health screenings just as we do their physical and dental screenings so that it becomes a way of life. To do these mental health screenings, we need to drastically improve our mental health infrastructure. Not only do we require more mental health providers at all levels, we need to provide expanded mental health training to other healthcare professionals. Specifically, we see the need to increase mental health training in Internal Medicine, Emergency Medicine, OB/GYN, Primary Care and

Pediatric specialty programs. We need to provide access to mental health training programs for teachers and coaches. We need to bring mental health issues out of the closet, out from being the step-child of physical medicine and give it fiscal parity. The only way we are going to improve mental health care amongst our service members and veterans is to de-stigmatize it in our society as a whole. We must talk about the brain as an organ that has its own set of diseases and maladies as does every other part of our body.

Other Than Honorable Discharges

We believe that Secretary Shulkin's initiative to allow those with OTH discharges to seek emergency Mental Health care at VA facilities is a good first step. However, it is unconscionable that DoD continues to discharge Service Members with years of honorable service and, in many instances, multiple deployments, with less than honorable discharges because of an episode that likely was due to the psychological effects of their military service. This is an injustice that must be corrected, especially with regards to those handcuffed by this injustice. Innumerable lives will be saved when this is accomplished.

Engaging the Entire Medical Community

As Dr. Shulkin says, "VA should do what VA does best." We see a need to engage our full community. We can do that best for our veterans by re-focusing VA healthcare to its core mission of being a center of excellence for service-related issues. In addition to mental health, rehabilitation and polytrauma specialists, we need to have a team of highly trained primary care physicians at VA, coordinating the best possible care for each veteran. By referring our veterans out into their communities for "everyday" care that we all have in common, those many highly qualified medical professionals and better- staffed medical facilities will see and treat our veterans and immediately send reports back to VA. This will free up our VA facilities to see and treat conditions that are specific to our service members and veterans, notably in the fields of mental

health and rehabilitation. It will continue the VA tradition of identifying symptom clusters, provide greater numbers of research opportunities and, we believe, increase the number of eligible veterans willing to seek VA care while providing greater transparency of the agency itself.

Opt-Out vs. Opt-It

Currently, only 43% of eligible Veterans are enrolled in VA. Of the 20 Veterans who take their own lives every day, only 6 are enrolled in VA. Of those 6, only 3 have been seen by Mental Health professionals. We feel that one way to dramatically improve these figures is to change current regulations to have eligible separating Service Members automatically enrolled in VA prior to their discharge from DoD. At present, those eligible have to make the conscious decision to "opt-in" after discharge, and are subsequently faced with the bureaucratic nightmare of signing up for VA. If those already eligible are already enrolled, the numbers utilizing VA services will dramatically increase, thereby allowing those who need services to easily obtain them. VA will also know in advance how many patients to prepare for. This is an issue that **TRIBE** addresses as well.

Summary

When we first started our advocacy efforts, we were often amused by DC "buzzwords", like "low hanging fruit" and "silos", but one word that we really liked was "resiliency". It is why we believe that our Support Network idea and an expanded transition program are so vital. From the moment a person walks into a recruitment center, the idea of returning that person to their community as a better person, a leader, should be paramount. Our mothers used to say that you should always leave things better than how you found them. That is something that is quite foreign to our military leaders. They've always believed their goal was to win the war, but that cannot be a singular goal. As Arthur DeGroat said, "Failing to effectively transition this generation of veterans from military service to productive private citizens will yield consequences that

are strategic in nature and national in scope. Severe damage will be done to the American civil-military relationship, the viability of our Armed Forces, the Post-9/11 Era veteran population, and society at large for decades to come."

Thank you for the opportunity to add our voices to the discussion on how to prevent Veteran suicide. We look forward to continuing to work with you to address this incredibly important issue.

ATTACHMENT 1: DANIEL SOMERS FAIRWELL LETTER

I am sorry that it has come to this.

The fact is, for as long as I can remember my motivation for getting up every day has been so that you would not have to bury me. As things have continued to get worse, it has become clear that this alone is not a sufficient reason to carry on. The fact is, I am not getting better, I am not going to get better, and I will most certainly deteriorate further as time goes on. From a logical standpoint, it is better to simply end things quickly and let any repercussions from that play out in the short term than to drag things out into the long term.

You will perhaps be sad for a time, but over time you will forget and begin to carry on. Far better that than to inflict my growing misery upon you for years and decades to come, dragging you down with me. It is because I love you that I can not do this to you. You will come to see that it is a far better thing as one day after another passes during which you do not have to worry about me or even give me a second thought. You will find that your world is better without me in it.

I really have been trying to hang on, for more than a decade now. Each day has been a testament to the extent to which I cared, suffering unspeakable horror as quietly as possible so that you could feel as though I was still here for you. In truth, I was nothing more than a prop, filling space so that my absence would not be noted. In truth, I have already been absent for a long, long time.

My body has become nothing but a cage, a source of pain and constant problems. The illness I have has caused me pain that not even the strongest medicines could dull, and there is no cure. All day, every day a screaming agony in every nerve ending in my body. It is nothing short of torture. My mind is a wasteland, filled with visions of incredible horror, unceasing depression, and crippling anxiety, even with all of the medications the doctors dare give. Simple things that everyone else takes for granted are nearly impossible for me. I can not laugh or cry. I can barely leave the house. I derive no pleasure from any activity. Everything simply comes down to passing time until I can sleep again. Now, to sleep forever seems to be the most merciful thing.

You must not blame yourself. The simple truth is this: During my first deployment, I was made to participate in things, the enormity of which is hard to describe. War crimes, crimes against humanity. Though I did not participate willingly, and made what I thought was my best effort to stop these events, there are some things that a person simply can not come back from. I take some pride in that, actually, as to move on in life after being part of such a thing would be the mark of a sociopath in my mind. These things go far beyond what most are even aware of.

To force me to do these things and then participate in the ensuing coverup is more than any government has the right to demand. Then, the same government has turned around and abandoned me. They offer no help, and actively block the pursuit of gaining outside help via their corrupt agents at the DEA. Any blame rests with them.

Beyond that, there are the host of physical illnesses that have struck me down again and again, for which they also offer no help. There might be some progress by now if they had not spent nearly twenty years denying the illness that I and so many others were exposed to. Further complicating matters is the repeated and severe brain injuries to which I was subjected, which they also seem to be expending no effort into understanding. What is known is that each of these should have been cause enough for immediate medical attention, which was not rendered.

Lastly, the DEA enters the picture again as they have now managed to create such a culture of fear in the medical community that doctors are too scared to even take the necessary steps to control the symptoms. All under the guise of a completely manufactured "overprescribing epidemic," which stands in stark relief to all of the legitimate research, which shows the opposite to be true. Perhaps, with the right medication at the right doses, I could have bought a couple of decent years, but even that is too much to ask from a regime built upon the idea that suffering is noble and relief is just for the weak.

However, when the challenges facing a person are already so great that all but the weakest would give up, these extra factors are enough to push a person over the edge.

Is it any wonder then that the latest figures show 22 veterans killing themselves each day? That is more veterans than children killed at Sandy Hook, *every single day*. Where are the huge policy initiatives? Why isn't the president standing with *those* families at the state of the union? Perhaps because we were not killed by a single lunatic, but rather by his own system of dehumanization, neglect, and indifference.

It leaves us to where all we have to look forward to is constant pain, misery, poverty, and dishonor. I assure you that, when the numbers do finally drop, it will merely be because those who were pushed the farthest are all already dead.

And for what? Bush's religious lunacy? Cheney's ever growing fortune and that of his corporate friends? Is this what we destroy lives for?

Since then, I have tried everything to fill the void. I tried to move into a position of greater power and influence to try and right some of the wrongs. I deployed again, where I put a huge emphasis on saving lives. The fact of the matter, though, is that any new lives saved do not replace those who were murdered. It is an exercise in futility.

Then, I pursued replacing destruction with creation. For a time this provided a distraction, but it could not last. The fact is that any kind of ordinary life is an insult to those who died at my hand. How can I possibly go around like everyone else while the widows and orphans I created continue to struggle? If they could see me sitting here in suburbia, in my comfortable home working on some music project they would be outraged, and rightfully so.

I thought perhaps I could make some headway with this film project, maybe even directly appealing to those I had wronged and exposing a greater truth, but that is also now being taken away from me. I fear that, just as with everything else that requires the involvement of people who can not understand by virtue of never having been there, it is going to fall apart as careers get in the way.

The last thought that has occurred to me is one of some kind of final mission. It is true that I have found that I am capable of finding some kind of reprieve by doing things that are worthwhile on the scale of life and death. While it is a nice thought to consider doing some good with my skills, experience, and killer instinct, the truth is that it isn't realistic. First, there are the logistics of financing and equipping my own operation, then there is the near certainty of a grisly death, international incidents, and being branded a terrorist in the media that would follow. What is really stopping me, though, is that I simply am too sick to be effective in the field anymore. That, too, has been taken from me.

Thus, I am left with basically nothing. Too trapped in a war to be at peace, too damaged to be at war. Abandoned by those who would take the easy route, and a liability to those who stick it out - and thus deserve better. So you see, not only am I better off dead, but the world is better without me in it.

This is what brought me to my actual final mission. Not suicide, but a mercy killing. I know how to kill, and I know how to do it so that there is no pain whatsoever. It was quick, and I did not suffer. And above all, now I am free. I feel no more pain. I have no more nightmares or flashbacks or hallucinations. I am no longer constantly depressed or afraid or worried.

I am free.

I ask that you be happy for me for that. It is perhaps the best break I could have hoped for. Please, accept this and be glad for me.

Daniel Somers



Transition, Renewal, Integration, Becoming, Empowerment

A Program of Community Reintegration

2 June 2017

Copyright Pending. All Rights Reserved

Foreword

Jason Roncoroni is a former battalion commander with more than 33 months of combat service in Afghanistan and the creator of the TRIBE innovation. Jake Clark is a veteran, former federal agent, and the founder and President of Save A Warrior, a national non-profit organization for healing moral injury. Together, they are committed to ending the epidemic of veteran suicide.

The ongoing suicide epidemic is the most urgent crisis facing our veterans and their families. Traditional methods and existing protocols have proven largely ineffective and extremely costly. If we hope to solve this problem, it is time to try something different. It is time for TRIBE (Transition, Renewal, Integration, Becoming, Empowerment). Unlike the current strategies to the suicide problem, TRIBE is not a program of prevention or intervention. TRIBE represents an innovative, cultural shift. TRIBE offers veterans the opportunity to discover an empowering path for a new life after the military.

TRIBE is essential for reintegration back to civilian society. This paper describes the five-phase, structured process to transform veterans from military heroes to community leaders – veterans with the wisdom and power to continue a life of service. It also outlines the rationale behind this human-centered design and makes a compelling case for why this effort must begin now. Lastly, this paper describes how TRIBE is both a symbolic and substantive change from the current approach to military transition.

Symbolically, TRIBE sends a powerful message to military families, veteran communities, and external audiences. It asserts the commitment to the long-term wellness and success of service members beyond their transition date. Externally, the implementation of TRIBE will demonstrate every veteran's potential to become a valuable asset to society. Substantively, the advent of TRIBE represents a quantum moment, ushering in a comprehensive approach for achieving whole-person wellness while optimizing career potential to further ease a veteran's reintegration into a new societal role. It eliminates the crippling stigma to mental health support by incorporating mandatory assessments, monitoring, and wellness programs. As a collaborative initiative, TRIBE leverages a broad spectrum of community resiliency programs in a coalition of intentional, supportive services for transitioning service members to discover a post-military life with a renewed sense of purpose, meaning, and empowerment as servant leaders.

TRIBE is the key to ending the suicide crisis. For the sake of our veterans, TRIBE is an idea whose time has finally come.

Jason Roncoroni
LTC, U.S. Army (Retired)
TRIBE Creator

Jake Clark
Founder, President
Save A Warrior™

Contents

Foreword ii

TRIBE: A Program of Community Reintegration 4

Executive Summary 4

The Problem 4

Why Our Military and Veteran Communities Need TRIBE 5

Why Now? 6

Theoretical Foundation 8

TRIBE Program for Military Transition 8

TRIBE Program for Veterans 11

Strategic Vision 13

The Value Proposition 13

TRIBE Program Benefits 14

Conclusion 16

Notes 17

TRIBE: A Program of Community Reintegration

"If warriors are returned home having had better psychological and spiritual preparation, they will integrate into civilian life faster and they and their families will suffer less"[1]

- Karl Marlantes, Author, USMC Veteran

Executive Summary

The veteran suicide epidemic is a symptom of the broader social decay of the veteran population. Despite the massive investment and expansion of public, private, and non-profit services over the past decade, suicide remains an elusive problem. The conventional approach of prevention and intervention has proven both costly and ineffective. In order to solve this problem, we must reframe the approach to veteran wellness to one that recognizes the potential of all veterans to continue an empowering life of service after the military. What the veteran community requires is TRIBE.

TRIBE addresses the core issue of disconnection that leads too many veterans down the path of isolation and despair that often ends in suicide. The acronym "TRIBE" stands for Transition, Renewal, Integration, Becoming, and Empowerment. As a program, it bridges the gap between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) in the current model of military transition. As a proactive, comprehensive approach to wellness, TRIBE inverts the conventional approach to mental and emotional health and first addresses the shame from moral injury and psychological suffering. As a reintegration process, TRIBE represents a sustainable solution to repurpose and unleash the veteran's potential for a meaningful life of service after the military.

The Problem

Suicide hides in the shadows at the end of a long road of mental, emotional, and spiritual suffering. Unfortunately, the widespread implementation of intervention and prevention initiatives over the past decade has been unable to reverse the ongoing epidemic. By continuing to frame solutions from the perspective of prevention and intervention, marginal improvements remain the most optimistic outcomes. An enduring, sustainable solution comes from an alternative path from the isolation and lack of purpose that loses so many veterans to the darkness of despair.

Examining the suicide problem from the perspective of wellness reveals a much more disturbing socioeconomic view of the veteran population. As shown in Figure 1, the combination of factors that includes suicidal behavior, mental health, dissolution of the family, substance abuse, job security, and homelessness highlights the overwhelming failure of veterans to successfully reintegrate back into society.

By the Numbers : The State of Veteran Decay in America in 2017	
> 2,800,000	Number of calls by struggling and suicidal Veterans into the Veteran's Crisis Line from 2007 to early 2017.[2]
708,062	Number of mental disorder diagnoses for Veterans who served between October 1, 2001 to June 30, 2015. This figure represents 58.1% of Veterans who used VA health care.[3]
> 74,000	The number of times operators from the Veteran's Crisis Line dispatched first responders to high risk Veterans between 2007 and early 2017.[4]
39,471	Number of homeless Veterans Every Night in the United States in 2016.[5]
259%	During an 11-year period ending in 2013, the number of prescriptions from the VA for pain meds like oxycodone and morphine surged 259 percent nationally.[6]
88%	Percentage increase in reported cases of sexual assault in the military from 2007 to 2013.[7]
65%	Percentage of Veterans who will change jobs within the first two years after departing military service.[8]
62%	The higher rate of divorce for combat Veterans.[9]
53%	Percentage of Veterans who will collect unemployment within 15 months after departing Military Service[10]
50%	Percent of Veterans seeking treatment for PTSD or combat-related mental health issue who commit some form of domestic assault.[11]
45%	The higher rate of motor vehicle accident deaths for Veterans compared to the general population. Some of these may be intentional while others indicate the practice of high-risk behavior.[12]
39%	Percent of Veterans returning from Iraq and Afghanistan with problematic alcohol use.[13]
21%	Percent of domestic violence across the United States attributed to combat Veterans.[14]
12%	Percentage of Veterans who received a substance use disorder diagnosis from 2001-2010. Veterans abuse prescription drugs at a rate twice the rate of non-Veterans.[15]
9%	The higher rate of PTSD among military wives when compared to non-military wives.[16]

Figure 1: State of Veteran Decay in America in 2017

Addressing the poor state of wellness among veterans starts at the beginning. It starts at the transition process - the point in time where the military journey ends and the veteran life begins. Done correctly, the transition program repurposes service members into a fulfilling life as leaders in our communities throughout society. Veterans become assets. Done incorrectly, veterans struggle to connect to a society that is increasingly estranged from the military experience. Isolated, suffering, and alone, veterans become a burden on society. The right transition program is perhaps the most significant and important endeavor to improve the welfare of the veteran population.

Why Our Military and Veteran Communities Need TRIBE

TRIBE reinvigorates the deep psychological and spiritual healing currently absent from the contemporary military transition process. This omission has been a major cause of our failure as

a nation to deal with the massive suicide rates among veterans and active-duty military personnel. TRIBE provides the initiation experience for long-term behavioral changes conducive to accelerated healing. The initiation experience is grounded in the collective traditions from our shared culture throughout history. Whereas the traditional medical model uses a distant clinician, TRIBE employs a "parallel" process. TRIBE utilizes a peer-support program to work with a veteran's pre-existing strengths to create an opportunity for healing the whole person.

Why Now?

There are two compelling reasons why we must act now.

First, the traditional approach of prevention and intervention is simply not working. Even though the DoD implemented more than 900 suicide prevention programs since 2001, suicide rates in the military more than doubled from 2001 to 2013.[17] As shown in Figure 2, the utilization of crisis resources like the Veteran's Crisis Line (VCL) continue to rise even as the overall population of veterans continues to shrink. The Department of Veterans Affairs has struggled to keep pace with the increasing demand for crisis related services.[18] In the wake of investigations and hearings to improve the performance of intervention programs like the Veteran's Crisis Line, we have overlooked the more pressing question: Why aren't the number of crisis related events *decreasing*? Given the ongoing investment into the status quo for veteran support, those numbers in Figure 2 are trending in the wrong direction. Termination – not expansion – of crisis related services should be the overall objective and greatest measure of effectiveness for veteran wellness initiatives.

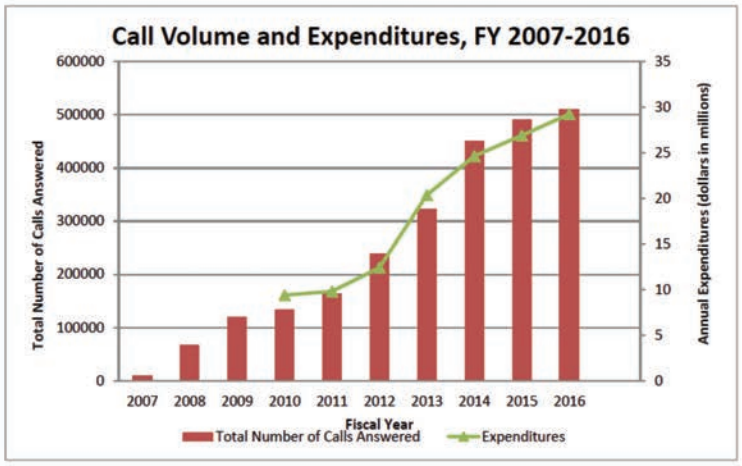


Figure 2: Veteran's Crisis Line Call Volume and Expenditures, FY 2007-2016[19]

Second, the cost structure for the existing model is rapidly approaching unsustainable levels. Over the past two decades, the VA ballooned to more than 1,203 outpatient sites, 144 hospitals, and 300 Vet centers, and 56 regional offices.[20] In 2017, the budget request for the VA was $182.3 billion and included funding for over 366,000 employees.[21] That figure represents a 300% increase in funding since the terrorist attacks in 2001.[22] This massive investment comes at a time when the veteran population actually decreased by 17% from 2001 to 2014, and only 62% of Veterans who qualify for health benefits actually utilize VA Healthcare.[23] Of the more than 21.6 million Veterans in 2014, slightly more than 9.1 million - less than 43% of the total population - were even enrolled with the VA.[24] Why do we continue to invest in an approach that doesn't connect with more than half of the veteran population?

For those veterans enrolled in the VA, service connected disabilities and costs related to treatment and compensation benefits have skyrocketed. Funding for mental health more than doubled over the past decade to a staggering $7.8 billion in 2017.[25] The funding and capacity expansion fails to keep pace with demand as more than 300,000 veterans continue to wait up to two months for medical appointments.[26] As shown in Figure 3, the number service connected disabilities and the commensurate compensation benefits have exploded over the past decade.

Metrics from the Department of Veterans Affairs Annual Benefits Reports	2007	2015	Growth Rate
Number of NEW service connected mental health disabilities receiving compensation	42,936	110,420	**157%**
Total Number of Veterans with service connected mental health disabilities	629,475	1,368,427	**117%**
Estimated cost of disability compensation for NEW mental health disability claims	$518,609,242	$1,497,997,892	**189%**
Estimated total cost of disability compensation for mental health disability claims	$7,603,212,978	$18,564,578,534	**144%**

Figure 3: Disability and Compensation Metrics from Annual Benefits Reports from the Department of Veterans Affairs.[27]

Disability compensation for veterans more than doubled from $39 billion in 2011 to almost $80 billion in 2017.[28,29] Should this growth rate continue, the annual payment of compensation benefits (checks in the mail) for mental health disabilities in 2030 will exceed the entire budget for the VA from 2017.

The condition of the veteran population hasn't improved anywhere near a level acceptable to justify the unsustainable costs. At what point do we secede failure? Do we wait until the veteran population shrinks to a sustainable level of funding, or are we ready to try something different? Why not consider the possibility of disrupting the entire ecosystem? The solution to end this problem is TRIBE.

Theoretical Foundation

The process of returning warriors to society existed long before the creation of federal institutions and government bureaucracies. Citizens from within the community shared the responsibility to recognize, accept, and welcome warriors back into society. Through a combination of rituals and ceremonies, the citizens of the tribe facilitated the healing and spiritual evolution for successful integration back to civilian life. As our modern culture becomes increasingly more self-reliant, we fail to facilitate those connections necessary to nurture the deep psychological and spiritual needs of returning warriors. We can move forward and improve the welfare of the veteran population by first stepping back and reinvigorating an evidence-based, anthropologically sound process to transform warriors back into civilians.



Figure 4: The Hero's Journey.[30]

TRIBE is a contemporary application of the Hero's Journey, a transcendent, Jungian approach to healing, personal transformation, and empowerment (see Figure 4). As a human-centered design, this application represents a catalytic innovation to improve the entire condition of the veteran population. The word TRIBE itself harkens back to the cornerstone of community and a shared commitment to serve. TRIBE addresses moral injury, the underlying psychological trauma, and – most importantly – the shame. *Shame* is what disconnects and isolates so many veterans in society today. TRIBE is the vital link between the warrior that once was and the future veteran empowered to continue a life of service in society.

TRIBE Program for Military Transition

As a program of military transition, TRIBE bridges the gap between the Department of Defense and the Department of Veterans Affairs. As shown in Figure 5, the first two phases of TRIBE – Transition and Renewal – occur through the military. Integration occurs at the point of

transition, and the final two phases – Becoming and Empowerment - occur after the service member has departed the military.

Transition. The life of every veteran begins with the application process and administrative requirements necessary to leave the military. As the first phase of TRIBE, the Transition Phase has two objectives. First, the service member is removed from official duties, responsibilities, and positions of authority in the military. Second, the transitioning service member coordinates all follow-on activities for the next year of the program. While the member is relinquishing authority and responsibility of their assigned position, they also complete the administrative requirements to depart the service. This includes the exams, evaluations, and briefings commensurate with

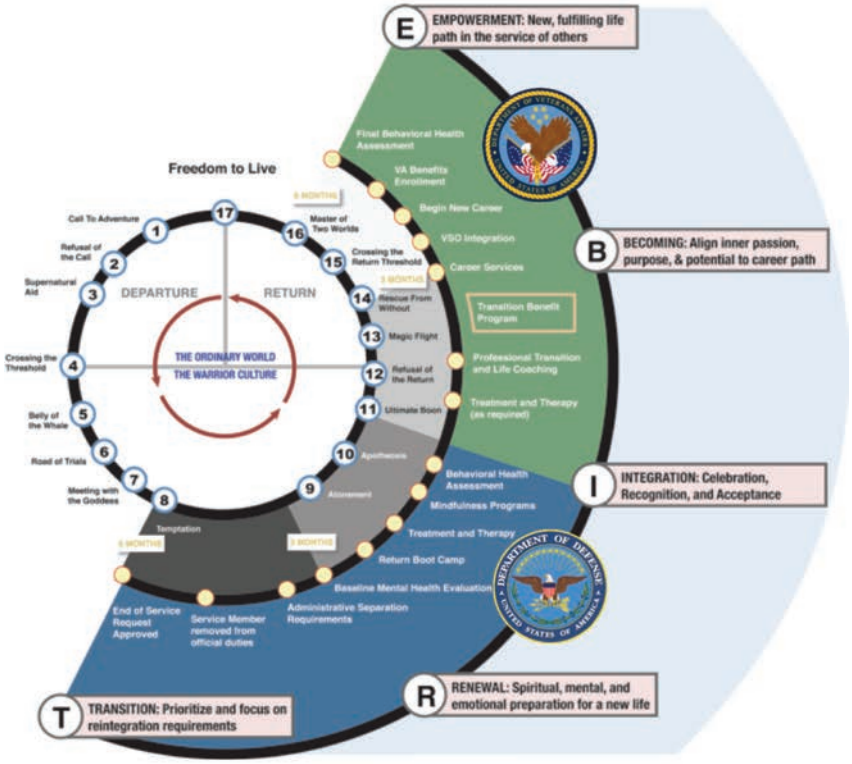


Figure 5: The TRIBE Program for Transitioning Service Members

current service transition requirements. At the conclusion of the Transition Phase, the service

member is administratively prepared to leave the military. The member's only remaining duty is to become a healthy, empowered civilian in society.

Renewal. The Renewal Phase accomplishes the core healing, treatment, and therapy essential for post-traumatic growth and reintegration. It is distinctive from the current medical model because it addresses guilt, shame, and regret – three emotions typically associated with moral injury. Innovations in this phase include:

- Mandatory, comprehensive behavioral health assessments.
- Spiritual initiation through a Return Boot Camp (as currently provided through the Save A Warrior™ program).
- Training in evidence-based, best practices for mindfulness and meditation.

The Renewal Phase infuses structure and rigor to transform the warrior back into a civilian with the power and wisdom to continue a life of service in society.

Integration. The celebration of honorable military service is a tradition lost in modern society. The Veteran Integration Ceremony renews that tradition. Most veterans are introduced to the VA in crowded hospital hallways and antiseptic correspondence while navigating the bureaucracy and enrollment procedures. Imagine the potential of a lifelong partnership that begins with a community wide commencement to recognize and welcome veterans back into society. The first experience the veteran has with the VA should be a positive one.

Becoming. Veterans earn the opportunity to become something more in life after the military. Becoming is the process of introspection to discover and align purpose and passion with external goals and strategies to achieve them. The distinctive features from this phase include:

- Professional Coaching – A credentialed life coach partners with new veterans for three months of life and transition coaching. Professional coaching enables the veteran to bridge the gap between the identity and role from the past with a new passion and purpose for the future.
- Transition Benefit Program – A 6 month severance program of pay and benefits supplants the immediacy of job placement. Duration of honorable, military service, combat experience, or a combination of both would qualify transitioning service members for this benefit program.
- Career Services – Career services follows professional coaching during the final three months of the TRIBE program. Ensuring comprehensive wellness, departing the military, and discovering a new purpose are the appropriate sequence of activities that should occur before the job search process begins.

Empowerment. Empowerment is the desired state of being for the veteran community. It is the opposite path from the isolation and despair that contributes to the slow decay that ends in suicide. As an alternative to prevention and intervention strategies, TRIBE builds an affirming life path to unleash every veteran's potential as they begin a new, civilian life in society.

TRIBE Program for Veterans

The current veteran population was not afforded the opportunity for social reintegration. As a result, many veterans remain stuck somewhere between military and civilian roles. They may no longer be a part of the military, but they also lack a sense of belonging in civilian society. This precipitates the slow decay highlighted earlier in Figure 1. The suicide epidemic is the unfortunate end of this failed process of reintegration.

In order to improve the welfare of the veteran population, we must apply the transformative aspects of TRIBE to the veteran community. As shown in Figure 6, applying the Renewal, Becoming, and Empowerment phases of TRIBE over a period of three months can repurpose struggling veterans toward a new path of wellness, personal fulfillment, and continued service.

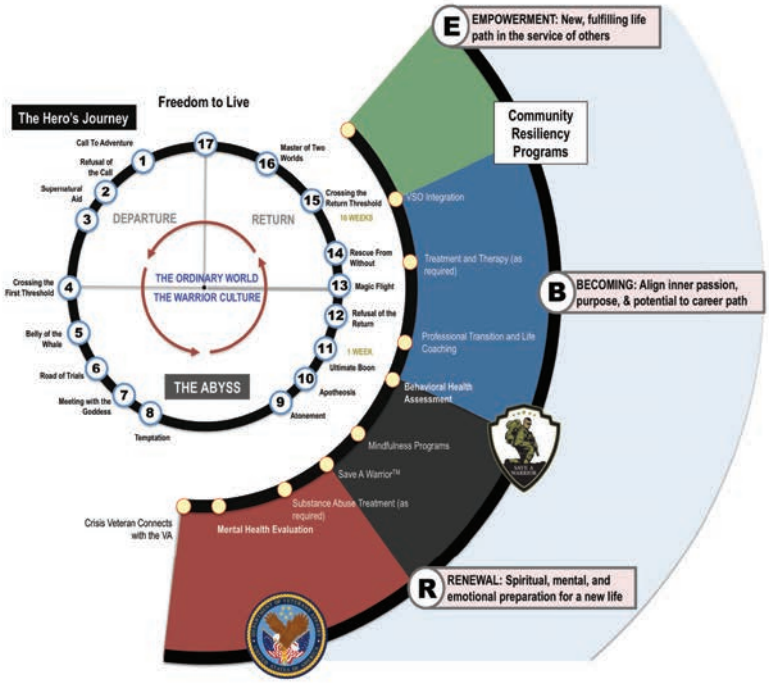


Figure 6: The TRIBE Program for Veterans

Renewal. For veterans, the core of TRIBE is the Save A Warrior™ program of secular spiritual

initiation. This program addresses the accumulation of shame from childhood through combat service. After burning off the shame, Save A Warrior furnishes every veteran with evidence-based programs in mindfulness, such as Warrior Meditation™, to establish and maintain a lifelong practice of sustained emotional and mental wellness.

The impact from SAW on symptoms of suicidality, PTSD, and major depression has been extraordinary. The results in Figure 7 suggest that shame is the underlying factor manifesting through various symptoms in more traditional diagnoses of mental disorders. By addressing the shame, conventional treatments and therapies can resonate more effectively with veteran patients.

Suicide Behaviors Questionnaire-Revised

Score above **7** indicates an *individual at risk of suicide*

Metrics	Before SAW	After SAW	Change	Percent Change
Number of individuals at risk of suicide (score above 7)	38	15	-23	-61%
Percent of the Total Population Sample	64%	25%	-39%	
Average Score for individuals at risk of suicide	11.92	6.87	-5.05	-42%

Conclusion: Average score of "at risk" inviduals is below the risk threshold of suicide based on this metric

Patient Health Questionnaire (PHQ-9)

Score above **10** has a sensitivity of 88% and a specificity of *88% for major depression*. Score above **15** represents moderately severe depression. Score above **20** represents severe depression.

Metrics	Before SAW	After SAW	Change	Percent Change
Number of individuals reporting major depression (score above 10)	43	5	-38	-88%
Percent of the Total Population Sample	73%	8%	-64%	
Average Score for individuals with major depression	19.63	4.43	-15.20	-77%

Conclusion: Average score of individuals with major depression, bordering on severe depression was reduced below the minimal threshold for this instrument after SAW

Post-Traumatic Stress Assessment (PCL-M)

Score above **34** indicates *moderate symptoms for Post-Traumatic Stress*. Score above **44** indicates *HIGH symptoms for Post-Traumatic Stress*

Metrics	Before SAW	After SAW	Change	Percent Change
Number of individuals at risk for moderate Post-Traumatic Stress (score above 34)	52	12	-40	-77%
Percent of the Total Population Sample	88%	20%	-68%	
Average Score for individuals with moderate or HIGH symptoms of PTSD	62.13	29.77	-32.35	-52%

Conclusion: Average score of individuals presenting symptoms of PTS reduced from HIGH to LOW after SAW.

Figure 7: Save A Warrior Survey Data for Suicidality, PTSD, and Symptoms of Depression[31]

Becoming. The Becoming Phase includes a ten-week program of professional life coaching for veterans. Once the veteran conquers the accumulated shame, a certified coach helps the veteran discover passion and purpose for a higher form of self-actualization. Life coaching from a certified professional is both a distinctive and decisive component of this program. Life coaching enhances goal attainment and quality of life, and life coaching also reduces depression, anxiety, and stress as veterans begin to discover a meaningful life after the Renewal Phase.[32] The coaching partnership reveals the purpose and identity, and the coach, as a fellow veteran, also facilitates accountability for continued mental, emotional, and spiritual growth.

Empowerment. Towards the end of the ten-week coaching program, the coach connects the veteran with peer support and related veteran service organizations. Some examples of such organizations include the American Legion, the Veterans of Foreign Wars, The Mission Continues, Team Rubicon, and Team Red White and Blue. Additionally, qualifying veterans earn the opportunity to sponsor other struggling veterans through the duration of the three-month program and beyond. Empowerment means repurposing that passion for service in a new role as an emerging leader in society.

Strategic Vision

TRIBE reframes the entire approach to the ongoing suicide epidemic. The objective of TRIBE is to create an affirming life path of leadership in the service of others. By leveraging an archetypal approach to healing, personal transformation, and empowerment, we transform military leaders into community leaders with the wisdom and power to serve and improve society. TRIBE closes the gap between the Department of Defense and the Department of Veterans Affairs to provide a comprehensive transition program for service members and their families. For veterans, TRIBE addresses the critical, overlooked steps in the reintegration process to discover a positive, fulfilling destiny.

Because many organizations already perform aspects of TRIBE for veterans and their families, testing and conceptual development of this initiative should necessarily begin in the veteran community. Many non-profit entities have already abstracted out all the complexities for delivering various phases of the TRIBE program, leaving only scaling and integration as the most pressing issues for institutional acceptance and implementation. Validating and improving TRIBE could occur in under a year followed by a deliberate process of implementation across the Department of Veterans Affairs with a cross-collaborative plan to replace the existing model of transition assistance in the Department of Defense. Given the work already underway, TRIBE could easily supplant the existing transition program within the next five years.

The Value Proposition

TRIBE is a catalytic innovation that intends to end the suicide epidemic. TRIBE addresses the accumulated residue from the warrior role that begets shame. It is a deeper, more lasting approach to wellness that starts before the veteran life begins. Because TRIBE heals the

underlying psychological trauma and shame, it has the potential to reduce if not outright eliminate the need to perpetuate compensation benefit payments for treatable disorders related to mental and emotional health. TRIBE is the initiative that will end the Veteran's Crisis Line and reduce the otherwise rising demand on an overburdened VA Healthcare system. TRIBE offers a more cost-effective, inclusive solution to unleash the leadership and service potential of veterans in society.

TRIBE realizes substantial, long-term cost savings from the current model of veteran support by proactively treating latent mental and emotional health related conditions. If we document and monitor the improved mental and emotional wellness of transitioning members over the period of a year, we can systematically reduce the magnitude of disability ratings for mental health disorders. Furthermore, we create a baseline of documentation to more efficiently process future claims. Proactive engagement and sequencing are the imperatives. The cost offsets would not only cover the expense of severance payments for the Transition Benefit Program, but they will also pay for the entire TRIBE program and reduce the skyrocketing, mandatory financial obligations in the VA's budget.

TRIBE Program Benefits

TRIBE is a human centered design with the potential to completely disrupt the ecosystem of programs and services intended to support the veteran community.

The TRIBE program . . .

Eliminates Mental Health Stigma. A mandatory schedule of provider assessments relieves the burden of self-selection for mental health treatment. This policy would eliminate the mental health stigma since every service member would partake in evaluations, treatment, and related therapy. The culture for mental health services would evolve from one of perceived weakness and shame to one of acceptance and proactive intervention. Additionally, mandating comprehensive mental health evaluations at selected points throughout the TRIBE process facilitates documentation, monitors progress, and helps anticipate future service demand.

Improves Military Readiness. The current construct of military transition encourages service members to begin preparation up to 18 months before departing the military.[33] This guidance competes with service imperatives to optimize combat readiness. TRIBE extends beyond the military transition date to relieve this tension and support military readiness. Additionally, TRIBE provides structure to the process of personnel management by reducing the volatility from personnel turnover.

Improves Veteran Engagement. Less than 45% of veterans are connected to services and programs through the Department of Veterans Affairs. TRIBE proactively connects all veterans to the VA early in the transition process. Therefore, TRIBE more than doubles the VA's current level of engagement with the veteran population.

Heals Moral Injury. The Department of Veterans Affairs currently has no protocols to

address the shame and related social disconnection from moral injury. Neither the American Psychiatric Association nor the VA considers "moral injury" an official diagnosis. This shortcoming limits practitioners to treat symptoms of moral injury common to approved diagnoses for mental disorders. Practitioners cannot diagnose and treat the condition of moral injury directly. The lack of approved treatment programs specific to moral injury is perhaps the greatest vulnerability in the ongoing struggle against military-related suicide. TRIBE provides the solution to this problem.

Sustains Behavioral Wellness. TRIBE educates and trains every veteran in evidence-based, best practices in mindfulness and meditation. Cohorts of veterans who participate in the program form a peer network for mutual support well beyond the duration of the program. Shared accountability to one another facilitates a supportive culture not unlike that of the military.

Celebrates Honorable Military Service. Veteran Integration Ceremonies restore the tradition to welcome service members back into society. As the number of American families personally connected to military service continues to shrink, this forum provides a vehicle for shared public meaning for military service. It provides an opportunity to acknowledge and accept veterans back into society.

Reframes Veteran Engagement with the VA. For many veterans, their first exposure to the VA occurs in the crowded hallways of VA medical centers. These preliminary engagements focus on negative aspects of the veteran's life – injuries, disabilities, and health problems. After this experience, many veterans refuse to return to any VA medical facility. TRIBE reframes that relationship. The first exposure the veteran has with the VA is through the Veteran Integration Ceremony. The coaching program that follows provides a positive, empowering focus toward the future. These initiatives can repair the strained relationship and rebuild the fractured trust between the VA, veterans, and their families.

Certified Coaching. TRIBE leverages the benefits of International Coaching Federation (ICF) certified coaching to identify and align the veteran's inner purpose and passion with outer goals and strategies to achieve them. As the precursor to career services, veterans can discover their best career path after the military. By focusing inward before seeking job opportunities outward, TRIBE can reduce the unemployment rate of veterans and the job turnover that occurs within the first two years after leaving military service.

Promotes Financial Stability. The Transition Benefit Program provides six months of pay and benefits for qualifying veterans upon departure from the military. This program relieves the urgency of seeking new employment and provides both veterans and their families the opportunity to focus on collective impacts of transition across the entire family.

Inverts the Current Cost Structure. This proactive approach disrupts and replaces the current cost structure. Why debate the urgency of concurrent retirement and disability payments when we can address and even heal the disability directly? By healing veterans, we can stop the perpetuity payments for treatable conditions and offer veterans something more valuable in return

– a meaningful life of purpose.

Conclusion

If we don't fundamentally change the current approach to veteran health and wellness, we run the risk of running out of veterans, money, or both. Prevention and intervention are not working. It is time to disrupt the status quo and change the entire ecosystem of programs and services that support our veterans. Every year, approximately 200,000 service members join the ranks of our veterans. For every veteran, the post-military journey begins with the transition process. That is our entry point to improve the welfare of the veteran population. TRIBE is an idea whose time has come. It is time to create a process-oriented program to enable our service members to discover a post-military path to empowerment. Most urgently, it is time to finally end the epidemic of military related suicide.

Notes

[1] Karl Marlantes, *What It is Like to Go to War* (London: Corvus, 2011), 1.

[2] "About the Veterans Crisis Line," Department of Veterans Affairs, accessed April 5, 2017, https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx

[3] Veterans Health Administration, "Analysis of VA Health Care Utilization Among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st Qtr FY2002 through 3rd Qtr 2015 (October 1, 2001-June 30, 2015)," Veterans Health Administration, January 2017, 11, accessed April 05, 2017, http://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization/.

[4] "About the Veterans Crisis Line."

[5] "National Coalition for Homeless Veterans," National Coalition for Homeless Veterans, accessed April 05, 2017, http://nchv.org/index.php/news/media/background_and_statistics/.

[6] Mark Brunswick, "Cut off: Veterans Struggle to Live with VA's New Painkiller Policy," *Star Tribune*, July 12, 2015, accessed April 05, 2017, http://www.startribune.com/cut-off-veterans-struggle-to-live-with-va-s-new-painkiller-policy/311225761/.

[7] Sara Kintzle, Ashley C. Schuyler, Diana Ray-Letourneau, Sara M. Ozuna, Christopher Munch, Elizabeth Xintarianos, Anthony M. Hasson, and Carl A. Castro, "Sexual Trauma in the Military: Exploring PTSD and Mental Health Care Utilization in Female Veterans," *Psychological Services* 12, no. 4 (2015): 394, doi:10.1037/scr0000054.

[8] Leo Shane, III, "Survey: 65% of Vets Likely to Leave 1st Civilian Job within 2 years," *Military Times*, October 01, 2014, accessed April 05, 2017, http://www.militarytimes.com/story/veterans/careers/civilian/2014/10/01/survey-65-of-vets-likely-to-leave-1st-civilian-job-within-2-years/16527601/.

[9] Michael Smart, "Study: Combat Vets 62 Percent More Likely to Lose Marriages," News.byu.edu, April 20, 2003, accessed April 5, 2017, https://news.byu.edu/news/study-combat-vets-62-percent-more-likely-lose-marriages.

[10] Department of Veterans Affairs, *2015 Veteran Economic Opportunity Report* (Washington DC: Department of Veteran Affairs, 2016), i, accessed April 5, 2017, http://www.benefits.va.gov/benefits/docs/veteraneconomicopportunityreport2015.pdf.

[11] Stacy Bannerman, "Husbands Who Bring the War Home," *The Daily Beast*, September 25, 2010, accessed April 05, 2017, http://www.thedailybeast.com/articles/2010/09/25/ptsd-and-domestic-abuse-husbands-who-bring-the-war-home.html.

[12] Tim A. Bullman, Han K. Kang, Derek J. Smolenski, Nancy A. Skopp, Gregory A. Gahm & Mark A. Reger, "Risk of Motor Vehicle Accident Death Among 1.3 Million Veterans of the Iraq and Afghanistan Wars," *Traffic Injury Prevention*, December 8, 2015, accessed April 5, 2017, http://www.tandfonline.com/doi/abs/10.1080/15389588.2016.1206201.

[13] Susan V. Eisen et al., "Mental and Physical Health Status and Alcohol and Drug Use Following Return From Deployment to Iraq or Afghanistan," *American Journal of Public Health* 102, no. S1 (2012): S66, doi:10.2105/ajph.2011.300609.

[14] Stacy Bannerman, "High risk of military domestic violence on the home front," *SFGate*, April 04, 2014, accessed April 06, 2017, http://www.sfgate.com/opinion/article/High-risk-of-military-domestic-violence-on-the-5377562.php.

[15] Karen H. Seal, Greg Cohen, Angela Waldrop, Beth E. Cohen, Shira Maguen, and Li Ren, "Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001–2010: Implications for screening, diagnosis and treatment," *Drug and Alcohol Dependence* 116, no. 1-3 (2011): doi:10.1016/j.drugalcdep.2010.11.027.

[16] Carl Prine, "Mental Illness, Alcohol Abuse More Prevalent Among Military Wives," *The San Diego Union-Tribune*, November 04, 2016, accessed April 06, 2017, http://taskandpurpose.com/mental-illness-alcohol-abuse-prevalent-among-military-wives/.

[17] Bob Brewin, "Military Suicides Are Up, Despite 900 Prevention Programs," *Nextgov*, March 21, 2013, accessed April 06, 2017, http://www.nextgov.com/defense/2013/03/military-suicides-are-despite-900-prevention-programs/62019/.

[18] John D. Daigh, *Evaluation of the Veterans Health Administration Veterans Crisis Line*, Report No. 16-03985-181, Office of the Inspector General, Department of Veteran's Affairs (Washington DC: Department of Veteran Affairs, 2017), iii.

[19] John D. Daigh, 6.

[20] Department of Veterans Affairs, *2016 Functional Organization Manual - Description of Organization Structure, Missions, Functions, Task, and Authorities*, vol. 3.1 (Washington DC: Department of Veterans Affairs, 2016), 1, accessed April 6, 2017, https://www.va.gov/ofcadmin/docs/VA_Functional_Organization_Manual_Version_3-1.pdf.

[21] Department of Veterans Affairs, "Department of Veterans Affairs - Budget in Brief," Department of Veterans Affairs, 1, accessed April 6, 2017, https://www.va.gov/budget/docs/summary/Fy2017-BudgetInBrief.pdf.

[22] Christine Scott, *Veterans Affairs: Historical Budget Authority, FY1940-FY2012* (CRS Report No. RS22897) (Washington, DC: Congressional Research Service, 2012), 4. https://fas.org/sgp/crs/misc/RS22897.pdf.

[23] Erin Bagalman, The Number of Veterans That Use VA Health Care Services: A Fact Sheet (CRS Report No. R43579) (Washington, DC: Congressional Research Service, 2014), 2-3. https://www.fas.org/sgp/crs/misc/R43579.pdf.

[24] Erin Bagalman, 3.

[25] This statistic was derived from multiple sources within the Department of Veterans Affairs. The 2017 number comes from "VA 2017 Budget Request: Fast Facts" found at https://www.va.gov/budget/docs/summary/Fy2017-FastFactsVAsBudgetHighlights.pdf. The "more than doubled" comes from a 2011 figure derived from a press release

https://www.va.gov/opa/pressrel/pressrelease.cfm?id=1848. Both of these sites were accessed April 06, 2017.

[26] Patricia Kime, "Some Veterans Still Wait Months for Medical Care," Military Times, June 3, 2016, accessed April 06, 2017, http://www.militarytimes.com/story/veterans/2016/06/03/some-veterans-still-wait-months-medical-care/85350810/.

[27] The statistics from this chart were derived from the "Compensation and Benefits" portion of the VA's Annual Benefits Reports from 2007 and 2015. The number of new service connected mental health disabilities were taken directly from these reports, as were the total number of service connected mental health disabilities. The estimated cost of new and total compensation for mental health disabilities were calculated using the estimated average amounts of annual benefits paid for the combined degree of disability multiplied by the number of veterans with those associated disability ratings to determine a weighted average, or the cost per individual receiving compensation benefits for mental health disorders.

[28] Veterans Benefits Administration, *Annual Benefits Report 2011* (Department of Veterans Affairs: Washington DC, 2012), 9.

[29] Department of Veterans Affairs, *Department of Veterans Affairs – Budget in Brief* (Department of Veterans Affairs: Washington DC, 2016), 13, accessed April 6, 2017, https://www.va.gov/budget/docs/summary/Fy2017-BudgetInBrief.pdf.

[30] Joseph Campbell, *The Hero with a Thousand Faces*, 3rd ed. (Novato: New World Library, 2008), 23-210. The picture is a adaptation of the graphic on page 210 based on the steps Campbell outlines in this portion of the book.

[31] The data was provided by Save A Warrior from cohorts 16-20 from December, 2014 through December, 2015. The data was collected at the request of the California National Guard to quantify the effectiveness of the Save A Warrior program.

[32] Anthony M. Grant, "The Impact of Life Coaching on Goal Attainment, Metacognition, and Mental Health," *Social Behavior and Personality* 31, no. 3 (2003): 259.

[33] Adrienne Aanderson, "Transitioning Soldiers get earlier start with ACAP," www.army.mil, February 14, 2013, accessed June 01, 2017, https://www.army.mil/article/96491/Transitioning_Soldiers_get_earlier_start_with_ACAP.

Basic Premise

To allow for a Service Member's civilian network to remain engaged with their loved one during their time in the service, and to learn about and gain an understanding of what Active Duty and post military experiences and potential problems involve.

To educated the Service Member and their Support Network about resources that are available to them if problems arise subsequent to military service. This will enable those around the Service Member/Veteran to understand how to approach their loved one, how to recognize issues that might arise, and how to and where to reach out for assistance if necessary.

The Program

This is a voluntary program, although it is felt that with the proper encouragement all new recruits will take advantage of it.

In boot camp/basic training, new Service Members would be asked to supply a number of names (?4,5,10) of those people they feel closest to (spouses, parents, friends, teachers, etc.). Those on the list may remove themselves at any time. The Service Member may remove anyone as well, but that person would be notified of the change in status. These people represent the "Support Group". DoD (or a third party, e.g. USO) will then push out on a regular basis (quarterly, semi-annually) information deemed important in the following areas. For example:

1. This is what Basic Training involves
2. How to contact DoD in case of emergency.
3. This is what MOS training involves.
4. This is what it means when National Guard/Reserve is activated.
5. These are the steps taken prior to deployment.
6. These are the experiences that one might have while deployed, and the differences between the combat and non-combat experiences.
7. These are the issues that have been identified in returning Service Members. These are the signs and symptoms connected with those issues.
8. These are the resources that are available for Service Members,Veterans, family and friends in DoD, VA, and civilian community.

○