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HARNESSING THE POWER OF COMMUNITY: LEVERAGING VETERAN NETWORKS TO TACKLE SUICIDE

HEARING

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JUNE 19, 2019

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HARNESSING THE POWER OF COMMUNITY: LEVERAGING VETERAN NETWORKS TO TACKLE SUICIDE

WEDNESDAY, JUNE 19, 2019

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

The Committee met, pursuant to notice, at 2:30 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

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

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

Chairman ISAKSON. I call this meeting to order—this hearing. I welcome everyone who is here and I think we will have a great hearing. We have the good fortune to have Secretary Wilkie here and we will hear his testimony in a second. We have a second panel of five guests which will be very important on many of the issues that are confronting us. We will have Q&A from all the Members, the Ranking Member ,and myself, as well.

I have a few things I want to say in my opening remarks and then I will turn it over to Senator Tester for his.

You know, last week was a great week for our country. It was the 75th anniversary of D-Day, the 75th anniversary of when the American soldiers, sailors, Marines, and paratroopers, went into France and then all of Europe and liberated the world from Adolf Hitler.

There would be no democracy in the world today were it not for those men that fought for us on those days. There would be no place like the U.S. Capitol. There would be no place like Washington, DC. There would be no diseases being cured. There would not be much of anything going on because that type of mentality did not have anything to do with the betterment of people.

Because the American soldier, the American military, and the American Congress at the time had the fortitude and the guts to commit the money and the resources, we beat overwhelming odds and won.

As I told a friend of mine the other day, I went to Normandy last week for the 75th anniversary of the invasion on D-Day, and for the 75th year in a row we won. [Laughter.]

I knew you would get it eventually. And, we won because we were the best men and women at the time. We beat insurmountable odds and we overcame unbelievable difficulties.

Yet, a second victory took place last week. The VA MISSION Act went into force. So, this was the anniversary. This was the 75th anniversary of invading D-Day, invading France. It was the first anniversary of trying to fix the Veterans Administration's delivery of health care.

I want to say—and Senator Tester and I did not practice this, but we have asked each other today twice, and then pinched each other when we answered it, and we know this is playing with fire to say this, and then all of a sudden you cause something to happen, but we have not had any complaints. I mean, I did not wake up Monday morning in the last 2 years without having a complaint from the VA within 3 or 4 minutes of getting up. I did not know what to do.

I looked around and all the VA hospitals and everything was hitting on every cylinder. The doctors were getting veteran patients on time to their CBOC or to the hospital they were going to. Veterans were getting appointments made in less than 30 days. Veterans with uniquely difficult injuries, or lifetime injuries I call them, the spoils of the type of wars we fight today with the type of weapons that we use, people are living that never would have lived before, and because of that they have to have specialized care with accessibility to specialized doctors, of which there are not that many.

But now, with the new MISSION Act in place, and with the VA's attitude—which I commend Secretary Wilkie, first and foremost, because every organization is, in a large measure, a reflection of its leadership—but what they have done to have a can-do attitude about tackling those problems and solving them is just unbelievable.

We have got a lot of problems that need solving; I mean, a lot of them. We can talk all day long about the few we have solved and be sad about the few we have not.

But, we are going in the right direction and I think this Committee deserves a lot of credit. Jon Tester deserves a lot of credit. I can tell you three occasions in the last year where the Ranking Member got us through a difficult time on a particular issue, that he could have scuttled if he wanted to. I knew it and he knew it. He did what he thought was right and we got the legislation done, and I am very proud to serve with him on this Committee.

There were times that I did some things for him that I wanted to do for him because of the same reason. If you are a good team and you are looking for the right goals, you can do anything. Well, we are a good team and our goal is to see to it that the MISSION Act is first and foremost our mission, to see to it that our veterans get the best possible health care.

So, I just want to thank the Secretary for being here today for this hearing and I am going to let you testify in just a minute. We are going to have an opening statement by Senator Tester. And, all of you that are here for the hearing, welcome to the hearing. With that said, I will recognize the Ranking Member, Jon Tester.

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

Senator TESTER. Well, thank you, Johnny. You are way too kind. We appreciate your leadership. There is not a person that is sitting in this room that does not appreciate what you have done as Chairman of this Committee. It has been exemplary, so thank you.

We are here today to—we are here today because suicide is a national public health crisis. In different ways, it has impacted nearly one of us in this room and as many as 20 veterans die each day by suicide. That is 20. Stop and think about that number.

I think of folks like Commander John Scott Hannon, a Montanan and former Navy SEAL. After returning from war Scott rescued and rehabilitated wild animals from the Montana wild. He worked with at-risk youth at Habitat for Humanity and with the Prickly Pear Land Trust to help veterans access natural trails. He was open about his mental health challenges. In fact, he was involved with the Montana Chapter of the National Alliance for Mental Illness, and was passionate about improving veterans' access to mental health care.

This was a man that mattered. He defended lives while fighting our Nation's enemies and he dedicated himself to improving lives when he returned back home. Tragically, he ended his own life on February 25th of 2018. We need to reflect on folks like Scott Hannon before we start patting ourselves on the back for a job well done, because this job is far from done. What we have done is not enough.

VA needs to do more. Congress needs to do more. Everybody needs to do more. This is not a criticism. It is a reality to be acknowledged if we are going to tackle this crisis together, and I do not believe it will be solved unless we tackle it together. Ultimately, the VA must play a critical role in combating this crisis and coordinating veterans' care. We need a tip of the spear, someone that can be held accountable for the joint efforts moving forward. You, Secretary Wilkie, are that person.

I am pleased that you recently convened a meeting of the task force created by the President's PREVENTS Initiative, and I hope you continue to bring relevant stakeholders to the table for productive discussions that will lead to results.

The challenges are daunting and addressing the complex needs of a diverse veteran population will require a great deal of focus, energy, and creativity.

Women veterans are dying by suicide at nearly twice the rate of civilian women, but nobody can tell us why. Former members of the National Guard and Reserve who have never been activated represent an estimate 15 percent of former servicemembers who die by suicide, yet they lack access to many VA services. And, veterans with other-than-honorable discharges, many who were discharged because of behavior stemming from underlying mental health conditions, need constant outreach and access to VA services.

Senator Moran and I, plus several colleagues, have introduced the Commander John Scott Hannon Veterans Mental Health Care Improvement Act. I believe this legislation will improve VA's mental health services and ensure veterans have access to both the tradition and complementary mental health services that they need.

Mr. Secretary, to be frank, I need your help and support on this bill. It tracks closely with everything you said in your testimony and with what we have discussed in person. In States like Montana, which VA recently identified as the most underserved VA system in the country for mental health, we have got a lot of work to do. We know that the VA provides some of the best mental health care in the country. The problem is that many veterans do not know that and there are often no mental health care providers on the ground to provide that care.

I would like to see the VA increase and improve its outreach, expand its telehealth access, and do a better job recruiting and retaining mental health providers. I think you would agree with that.

I applaud the VA ATLAS Initiative for working with the VFW post in Eureka to set up a telehealth hub less than 10 months from the Hi-Line in Montana. Coordinating with outside partners can often make a tremendous difference, and I look forward to hearing from the community partners on the next panel. They deserve a seat at the table because their voices are also very important.

I also want to thank Major General Matt Quinn from the Montana National Guard. The Montana National Guard has been doing some great work partnering with the State of Montana to extend assistance and services to members of the Guard. General Quinn's efforts are a great example of local stakeholders coming together and finding a solution that makes a difference in the lives of our troops and of our veterans, and I want to welcome him also to the second panel.

I look forward to our discussion today, and as always, Mr. Secretary, it is good to hear from you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Wilkie, the floor is yours. It is yours at any time, except when you see this.

Secretary Wilkie. Yes, sir.

STATEMENT OF HON. ROBERT WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERAN'S AFFAIRS; ACCOMPANIED BY KEITA FRANKLIN, Ph.D., EXECUTIVE DIRECTOR, SUICIDE PREVENTION PROGRAM, OFFICE OF MENTAL HEALTH AND SUICIDE PREVENTION, VETERANS HEALTH ADMINISTRATION

Secretary WILKIE. Yes, sir. Yes, sir. Well, I cannot thank you both enough, not only for the many kindnesses that you have shown to me, but for making the cause of veterans in a very contentious time in America a nonpartisan endeavor. I thank you also for your mentioning of the MISSION Act and the wonderful work that thousands of VA employees across the country put into making that a success, and turning the corner on a new world of veteran service.

I am also—I would be remiss if I did not thank the person sitting next to me, Dr. Keita Franklin. I have had the privilege of working with Dr. Franklin both at the Department of Defense and the Department of Veterans Affairs. There is no person in this country who has done more to raise awareness and fight what is a terrible but preventable tragedy in this country, and that is the issue of

suicide. It is an honor for me to be here and I think it is wonderful that the Committee has asked her to be here.

Senator Tester said it—we are the tip of the spear in leading an American conversation about the deep causes of suicide. In this fiscal year we have screened 900,000 veterans for mental health issues, and of those 900,000 we are following 3,000 because they have given us every indication that they are in deep need of additional care.

Our Veterans Crisis Line has expanded to three call centers and is now taking over 1,700 calls a day, which we are, on a daily basis, following up with about 200 of those calls with active action.

That is how things have changed at Veterans Affairs. We have also seen the beginnings of the cultural change in the Armed Forces of the United States. In my father's day, Vietnam, nobody talked about mental illness. Nobody talked about feelings of anxiety. Now they do, and that will make VA's job in the future all that much easier. That is the first step in suicide prevention, being able to talk about this issue, both privately and publicly.

The second step is, as Senator Tester said, a national conversation, not just about the final tragic act of suicide but about factors leading up to that very, very sad day—mental health, substance abuse, and homelessness. We must have a conversation about the totality of life in America. We are just beginning the national conversation that we need, and this hearing is part of that beginning.

So far this year, I have had 85 media engagements, and nearly all of them have included a discussion about efforts to reduce veteran suicide. Last week I participated in a roundtable discussion hosted by the American Foundation for Suicide Prevention, hearing from many experts in the field.

Just 2 days ago, I chaired the inaugural meeting of the President's task force on veteran suicide, which is charged with developing a roadmap to combat this tragedy. This roadmap will create a template showing how government, at all levels, NGO's, and others can work together in this effort. It will be based on a whole-health approach recommended by experts. It will also take account of a whole-of-government effort that has been lacking, bringing together VA, Defense, HHS, NIH, and HUD to address the many factors that contribute to suicide.

If we only look again at the last tragic events in a veteran's life we will never get our arms around what we need to do to prevent this tragedy. Our whole-health approach will make inroads in suicide prevention, just as it has made inroads in the fight against homelessness. But, the key is flexibility. Mental health is the final frontier of medical science. I said to the *New York Times* last month, "We are not even at the Sputnik stage when it comes to getting our arms around mental health in this country, and an understanding of where we need to go will be a prime factor in combating the issue of veteran suicide."

So, there is still a lot we do not know as a Nation. One thing we do know is that many of those veterans who have taken their lives do not have a mental health diagnosis. They may be struggling with a change-of-life problem. About half of the veteran suicides involve people older than 50, dealing with the normal issues of aging, but tragically, most of those are from the Vietnam era.

For context, Lyndon Johnson left Washington, DC, 50 years ago, in January, and we are still dealing with the aftereffects of that terrible conflict in Southeast Asia.

So, we cannot just focus simply on mental health. If we are going to make a whole-health effort we have to be able to shift resources to where we need them, the one reason I applaud this Committee's efforts, in that it is contemplating legislation to fund suicide prevention grants that could cut red tape and get money and resources to the States, localities, and the NGO's, tribal governments, those people who are closest to those on the ground that we need to contact. Caring for veterans, wherever they are, will be the focus of the task force, and your support for that approach is much needed.

Finally, Mr. Chairman, I want to beg your indulgence and just mention something that you, Senator Tester, and I know I have had this conversation with Senator Brown, are concerned about, which is the Blue Water Navy issue. As soon as we were aware that the Federal court would be moving on Blue Water we began the process of creating the system that needs to be in place to address the claims of thousands of veterans who will come under the Blue Water rubric.

Our people are working. We are working with the Department of Defense and the Department of Navy to make sure that we have those adequate lists. I cannot tell you the numbers now. I can tell you we are working on them.

I will promise to come back to this Committee if we need additional resources, if there is an issue in terms of its effect on the progress of claims modernization and appeals modernization. But, I did want to assure this Committee, as I did several months ago, that I would not oppose the court decision and that I would move out smartly in making sure that the needs of those who served in the territorial waters of Vietnam were taken care of. I thank you for letting me get off the beaten track.

[The prepared statement of Secretary Wilkie follows:]

PREPARED STATEMENT OF HON. ROBERT WILKIE, SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE. I appreciate the opportunity to discuss the critical work VA is undertaking to prevent suicide among our Nation's Veterans. I am accompanied today by Dr. Keita Franklin, Executive Director, Suicide Prevention Program, Veterans Health Administration.

INTRODUCTION

The health and well-being of our Nation's men and women who have served in uniform is the highest priority for VA. VA is committed to providing timely access to high-quality, recovery-oriented, and evidence-based health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers. Our promise to Veterans remains the same: to promote, preserve, and restore Veterans' health and well-being; to empower and equip them to achieve their life-goals; and to provide them with state-of-the-art treatments.

Veterans possess unique characteristics and experiences related to their military service that may increase their risk of suicide. They also tend to possess skills and protective factors, such as resilience or a strong sense of belonging to a group. Our Nation's Veterans are strong, capable, and valuable members of society. Therefore, and it is imperative that we connect with them as early as possible as they transition into civilian life; facilitate that transition; and support them over their lifetime.

Suicide is a national public health issue that affects communities everywhere. Just as there is no single cause of suicide, no single organization can end Veteran

suicide. We must work side-by-side with our partners at all levels of Government and in the private sector to provide our Veterans with the mental health and suicide prevention services they need. As such, VA is dedicated to saving Veteran lives by using bundled approaches to prevention that cut across various sectors—faith communities, employers, schools, and health care organizations—to reach Veterans where they live, work, and thrive.

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

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

EXECUTIVE ORDER 13861: NATIONAL ROADMAP TO EMPOWER VETERANS AND END SUICIDE

Influenced by the National Strategy for Preventing Veteran Suicide, Executive Order (EO) 13861, the National Roadmap to Empower Veterans and End Suicide, was signed on March 5, 2019, to improve the quality of life of our Nation's Veterans and develop a national public health roadmap to lower the Veteran suicide rate. EO 13861 established the Veterans Wellness, Empowerment, and Suicide Prevention Task Force (Task Force) and charged the Task Force with the development of the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) that includes community integration; state and local collaboration aimed at integrating service delivery to and coordinating resources for Veterans; and an implementation strategy. The Task Force is also required to submit a legislative proposal that establishes a program for making grants to local communities that will enable them to increase their capacity to collaborate on and integrate service delivery to Veterans and to coordinate resources for Veterans. Additionally, EO 13861 calls for the development of a national research strategy that fosters greater collaboration. The focus of these efforts is to streamline research for the prevention of Veteran suicide, as well as to provide support service such as employment, health, housing, education, and social connection to Veterans at risk of suicide.

I, along with the Assistant to the President for Domestic Policy, co-chair the Task Force and much of the work outlined in EO 13861 is well underway. For example, the White House lead and co-chairs hosted the inaugural Task Force meeting on June 17th, bringing together EO mandated agency representatives, line of effort leads, and work group members. To accomplish its assigned duties, the Task Force is working with a variety of representatives from across public and private sectors.

PREVENTS (the roadmap) will use the National Strategy for Preventing Veteran Suicide as its foundation and will outline strategies to effectively lower the rate of Veteran suicide. Specifically, PREVENTS will be created by experts within the following five lines of effort: 1) workforce and professional development; 2) state and local Action team; 3) research strategies; 4); communications; and 5) partnerships. Through a holistic public health approach, PREVENTS will ensure extensive engagement with Veterans' local communities and will leverage the tremendous resources available to Veterans. PREVENTS' approach will include strategies and opportunities to harmonize existing efforts, and identify promising initiatives across the Federal, state, local, and territorial governments, as well as non-governmental entities.

The PREVENTS lines of effort are supported by work groups tasked with supporting implementation of EO 13861. For example, the Grant Making Work Group, which falls under the state and local Action team line of effort, will create a framework for awarding grants to local communities to increase collaboration and delivery of resources to Veterans. Part of this Work Group's objectives include developing program criteria for grant eligibility, eligible organization standards, and program evaluation. The purpose of the grant program is to promote community integration and bring together Veteran-serving community organizations to provide Veterans with coordinated streamlined access to services and supports such as employment, health, housing, benefits, recreation, education, and more.

The research strategies line of effort, comprised of representatives from multiple agencies and partners, including the White House Office of Science and Technology Policy, is charged with developing the national research strategy to improve the coordination, monitoring, benchmarking, and execution of research in the field of Veteran suicide prevention. Much of what we know about suicide has been revealed through research. By applying innovative and streamlined research, we will continue to develop and deepen our understanding of suicide prevention practices and interventions that save lives.

PREVENTS efforts, including roadmap and research strategy development are on track and several actions have completed. The completed actions include the development of charters and project management plans for each line of effort; the Research Strategies Request for Information; and the PREVENTS project plan and timeline.

The implementation of PREVENTS will empower Veterans to pursue an improved quality of life; prioritizes related research activities; and prompts collaboration across the public and private sectors, which furthers VA's efforts to collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they are engaging with VA. EO 13861, in addition to VA's National Strategy, advances the public health approach to suicide prevention by leveraging synergies and clearly identifying best practices across the Federal Government that can be used to save Veterans' lives.

Through PREVENTS, VA strengthens the national strategy's call to action to every community, organization, and system interested in preventing Veteran suicide. VA has made great strides in developing partnerships. We are leveraging a network of more than 60 partners in the public, private, and non-profit sectors to help us reach Veterans where they live, work, and thrive, and our network is growing weekly. For example, VA and the PsychArmor Institute (PsychArmor) have a non-monetary partnership focused on creating online educational content that advances health initiatives to better serve Veterans. Our partnership with PsychArmor Institute resulted in the development of Signs, Ask, Validate, and Encourage and Expedite (S.A.V.E.) a free online training course that enables those who interact with Veterans to identify signs that might indicate a Veteran is in crisis and how to safely respond to and support a Veteran to facilitate care and intervention. Since its launch in May 2018, S.A.V.E. training has been viewed more than 18,000 times through PsychArmor's internal and social media system and 385 times on PsychArmor's YouTube channel. S.A.V.E. training is also mandatory for VA clinical and non-clinical employees. Ninety-three percent of VA staff are compliant with their assigned S.A.V.E. or refresher S.A.V.E. trainings since December 2018. This training continues to be used by VA's Suicide Prevention Coordinators at VA facilities nationwide, as well as by many of our Veterans Service Organizations. By bringing together Federal entities, PREVENTS assists VA in our efforts to improve the quality of life of our Nation's Veterans and develop a national public health roadmap to lower the Veteran suicide rate.

MENTAL HEALTH AND SUICIDE PREVENTION

We know that an average of approximately 20 Veterans die by suicide each day; this number has remained relatively stable over the last several years. Of those 20 Veterans, only six used VA health care in the two years prior to their deaths. In addition, we know from national data that more than half of the Americans who died by suicide in 2016 had no mental health diagnosis at the time of their deaths.

When we look at our data, we are concerned that, in the past two years, we are seeing a rise in the rates of Veteran suicides among those aged 18 to 34. Efforts are already underway to better understand this population and other groups that are at an elevated risk, such as: women Veterans; never federally-activated Guardsmen and Reservists; recently separated Veterans; and former Servicemembers with Other Than Honorable discharges.

We have seen a notable increase in women Veterans coming to us for care. Women are the fastest-growing Veteran group, comprising about nine percent of the Veteran population, and that number is expected to rise to 15 percent by 2035. Although women Veteran suicide counts and rates decreased from 2015 to 2016, women Veterans are still more likely to die by suicide than non-Veteran women. In 2016, the suicide rate of women Veterans at 257 was nearly twice the suicide rate of non-Veteran women after accounting for age differences.

These data underscore the importance of our programs for this population. VA is working to tailor services to meet their unique needs and have put a national network of Women's Mental Health Champions in place to disseminate information, fa-

cilitate consultations, and develop local resources in support of gender-sensitive mental health care.

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

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

PROMOTING VA SUICIDE PREVENTION, WHOLE HEALTH, AND MENTAL HEALTH SERVICES

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

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

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

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

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

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

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

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

are increasing, and we are focusing on channels and strategies to get in front of this audience.

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

CONCLUSION

VA's goal is to meet Veterans where they live, work, and thrive and walk with them to ensure they can achieve their goals, teaching them skills, connecting them to resources, and providing the care needed along the way. I am honored to co-chair the Task Force with the Assistant to the President for Domestic Policy. We will utilize a public health approach and include input from cross sectors at all levels of government and non-governmental entities. Within one year of the EO 13861 signing, the Task Force will submit to the President a roadmap to empower Veterans to pursue an improved quality of life, prevent suicide, prioritize related research activities, and strengthen collaboration across public and private sectors. The Task Force will monitor the implementation of PREVENTS and disband two years following the submission of the Roadmap to the President. I want to thank the Committee for your ongoing support for improving the lives of Veterans and in preventing Veterans Suicide.

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

Chairman ISAKSON. Thank you for getting off the beaten track because the next question I was going to ask was about that. So, we are glad that you have taken that initiative.

Let me ask, Senator Brown, did you get a response? You left me a voicemail before—you said the Blue Water Navy had some question about eligibility?

Senator BROWN. Yes, thank you. I spoke with Senator Tester about it. We do not know for sure yet, but I know you have been cooperative throughout the whole process. There may have been some language that was not quite precise, which I talked to my staff about and I know they have talked to yours since then. But, we will follow up, and thank you.

Chairman ISAKSON. I wanted to make sure that got addressed, first of all, and as soon as you know what you can put your finger on, if it is there, get it to Secretary Wilkie and we will try to work on it together.

Thank you for what you are doing, Secretary Wilkie, as the head of the VA. A couple of questions I want to ask you about—and can we ask questions directly to Ms. Franklin?

Secretary WILKIE. Oh, yes.

Chairman ISAKSON. OK. Well, I will ask this to Dr. Franklin. Dr. Franklin, how successful are our hotlines that we have put in? We put three hotlines in, I think a year ago, around the last year, for better access for our veterans when they are in a time of trouble and strife. How well has that performed? Has it improved accessibility for veterans? What experience are we having with it?

Ms. FRANKLIN. I believe the access has improved. We have same-day access to care and we are doing everything we can to streamline access. I actually brought the figures with me in terms of how many people come in under these same-day access hotlines. I can just pull them if you would like.

Chairman ISAKSON. Please.

Ms. FRANKLIN. Off the top of my head I remember over 100,000, but 1 second. I have the figures with me. [Pause.]

I am sorry. I cannot put my fingers on it this quickly.

Chairman ISAKSON. That is OK. I do that all the time.

Ms. FRANKLIN. I am sorry.

Chairman ISAKSON. We will skip—I will let you look through——

Ms. FRANKLIN. OK.

Chairman ISAKSON. You are going to be up here for a while.

Ms. FRANKLIN. I have the figures with me.

Chairman ISAKSON. Well, the reason I was asking the question was that when I went out to the new one that was established in Atlanta, I guess it was over a year ago now, I was astounded how many calls were coming in and how rapidly they were coming in. I assume that has only gotten better. And, from everything I read about suicide and mental health issues, the quicker a person who is in trouble or at risk can make a direct contact with a trained or a professional individual, that is the best thing you can do to get somebody stabilized and not have the actual suicide take place before they get some help.

Secretary WILKIE. Mr. Chairman, while she is looking for the figures, I appreciate that comment. This Committee has been of great help in getting the message out. One of the myths that we had to combat was that when a veteran called the Veterans Crisis Line that that veteran would be thrown into voicemail. The system does not have a voicemail capability, and the average wait time for a live person on the other end to pick that phone up is 8 seconds. There are 1,700 calls a day, but 1,700 calls that require 200 acts of individual intervention, which is something that we are seeing play out on a daily and weekly basis; it is the front line in the fight.

Chairman ISAKSON. Well, the reason I brought it up is 2 years ago we had a problem with people getting referred to voicemail, or "call in after 10 tomorrow," responses that made no sense at all if, in fact, you are at your most risk when you have that time to call and know you are having a problem. So, I think the fact those things—using telemedicine to do that has been a big help.

Secretary WILKIE. I would also add, Senator Manchin is not here, but we are working with him to create a national three-code call-in to make the process even easier than it is now. We have turned over information to the FCC in response to what he has been trying to do, to make the system even easier.

Chairman ISAKSON. The same question I will ask again, with regard to suicide. What have the numbers looked like the last 2 years? Has it increased? Has it decreased? Is the rate about the same?

Secretary WILKIE. It has barely gone down. One of the problems we have is that this is a lagging indicator. We have to wait for reports from thousands of coroners across the country, in cities, towns, counties. So, the figure that we have fall back on 2016–2017. We know that 2 years prior to those figures the rate of suicide among veterans was about 22. It is down to 20.

The tragedy there is that 14 of those 20 have no contact with VA. Several are on active duty, several in the Guard and Reserve, as Senator Tester pointed out, and then another tranche, about 10 that we have never had contact with.

Chairman ISAKSON. Well, I am glad you answered the question that way because—and I will end my time by saying this—suicide is a terrible thing. I experienced it in my own family and it is a terrible thing to go through for a family; it is something you want to block out and not talk about. But, the most important thing you can do is talk about it.

I hope that we will understand that victories are not going to be fast or swift when you are dealing with something like suicide. The fact that the numbers have not moved that much, or they have moved down a little bit, that is good—it does not surprise me, because it is a very difficult situation to deal with. But, the better we do at making our services accessible and our people providing that service educated to deliver the service, the better we are going to be for our veterans, and the more, over time, we will address the subject, and we will reduce the rate of suicide.

Secretary WILKIE. Mr. Chairman, may I ask your indulgence. One note that I made in my opening remarks, and I would like to repeat it, is that this is a process for the military that really has to begin in basic training, making our troops aware of signs within themselves and within their comrades. That is something that was anathema in the military culture that I grew up around. It is changing.

Secretary Mattis was all behind that and I took his charge as the Under Secretary of Defense for Personnel to get that entrained, so that when they enter and they leave they are told that it is all right to come to others for help if they feel anxiety, if they feel depressed, and that is the first step in getting this right.

Chairman ISAKSON. Senator Murray.

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

Senator MURRAY. Mr. Chairman, thank you so much for having this hearing. I really appreciate it. Senator Tester, thank you for your courtesy, allowing me to go forward.

I heard Senator Tester's opening remarks. I could not concur more. Mr. Chairman, I did not hear yours, but I am sure you said all the right things too, so thank you.

Secretary Wilkie, undoubtedly, community mental health providers, social services, many others, have really a key role to play in establishing a comprehensive system of support for veterans to reduce the number of suicides. A 2014 Rand report found only 13 percent of community providers met readiness criteria to deliver mental health care to veterans, and last year Rand found just over 2 percent of community providers in New York meet all seven criteria for readiness to be able to treat veterans.

It seems like we have a long way to go in creating a highly effective network in our communities to address this crisis. I wanted to ask you, how will you oversee the quality of mental health care and services from our community providers and make sure care for veterans in need is seamlessly coordinated?

Secretary WILKIE. That is the key, and I think the goal—well, I know the goal of our task force is to make sure that we not only have the best standards when it comes to mental health care, but that we guarantee that those community providers meet those standards. Part of the task force is to create a national research

roadmap, and I think we will augment the standards that VA already has.

I see the grants, the research grants, the community grants that will come out of this—and Senator Boozman has introduced legislation today that will get us farther down that road—as being the key to making information more readily available to our community providers and make their care more robust. Dr. Franklin can give you more figures.

Ms. FRANKLIN. No, I definitely also appreciate the question. As a clinician myself, the importance of training providers on evidence-based practices and cultural competency or cultural humility, if you will, for the military sector and veteran is critical important.

We do have a partnership with an organization called PsychArmor that has also taken it on as their mission to train mental health providers across the Nation, not only mental health providers, but employers and a host of others on how to interact with veterans, what are the evidence-based protocols, and things like that. I think there is going to have to continue to be a push toward this, not only from our partners, but also from trade organizations like the National Association of Social Workers, APA, the Psychological Association, Psychiatry, and getting the standards into their credentialing and protocols, then continuing to hit it hard over time will be part of the way forward.

Senator MURRAY. OK. Thank you. A critical issue covered in the Department's National Strategy for Preventing Veteran Suicide, but was not touched on in your written testimony, is the issue of restricting access to lethal means. Even a few seconds that disrupts an individual's intent can end up saving their life. This is incredibly important, especially given the high proportion of veteran suicide by firearm. VA, I know, has taken some steps to restrict access to lethal means, like distributing gun locks, but to build on that work, how will your strategy expand these efforts to restrict access to lethal means?

Secretary WILKIE. Well, you are correct and it is key. Seventy percent of veterans who take their lives do so with firearms.

Senator MURRAY. Correct.

Secretary WILKIE. Now, we are dealing with a culture that has special familiarity with firearms. It has been part of their ethos. The goal here—and we have worked with the American Foundation for Suicide Prevention and groups like the American Shooting Sports Foundation—is to build into a veteran's life time and space between the impulsive thought and the final act. That comes with greater awareness in terms of us reaching out to veterans and educating them.

We have a comprehensive education program that we are now providing on gun safety. As you mentioned, we give gun locks out. "Lethal means safety" is something that we take very seriously and it is that psychological condition that we have to build in, that I think we are starting to do, to increase the likelihood that the impulse will not increase the last act.

But, to go further, the budget that I presented to this Committee has $9.5 billion for mental health services. I think the House will actually up that number when it finishes its work. Part of that will

be dedicated to outreach and education when it comes to the conditions that lead to a death by firearms.

Senator MURRAY. I am out of time. Mr. Chairman, I really appreciate it. I just want to make sure—I am going to submit some questions for the record. One is about our other-than-honorable discharge folks and how we can make sure they get better access, and also women veterans. I was alarmed that your testimony said the suicide rate among women veterans is nearly twice that of their civilian counterparts. I often hear from women that they do not get the care they need because they feel harassed or assume that when they are there they are waiting for their husbands. We need to do a better job there. So, I will be submitting questions and would like a response on those as well.

Chairman ISAKSON. I will leave the record open for 5 days for additional submissions should you want to.

Senator MURRAY. Thank you.

Chairman ISAKSON. Senator Boozman.

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

Senator BOOZMAN. Thank you, Mr. Chairman. I thank you and Senator Tester for having this very, very important hearing, leveraging the community to try and do a better job with suicides.

Secretary Wilkie, first I want to thank you for being so proactive in this area. We have had a lot of conversations over a long period of time, and I know that this concerns you as much or more than anyone. We do appreciate your leadership, and then also, Dr. Franklin, for the job that you are doing.

Let me congratulate you, too, on Community Care. We are probably not out of the woods yet. There are going to be some issues that crop up, but again, I know that you and your team have worked very, very hard to do the best you could on the rollout. So far, so good; that is very, very good.

As I mentioned, we have spent a lot of time talking about suicide. The problem is that we have the statistics. They do not seem to be changing very much. And, as you just pointed out, in 2010, the VA requested $62 million for suicide prevention outreach, and in 2020, that number nearly quadrupled to $222 million. In mental health funds, more generally, we gone from about $4.5 billion to almost $9.5 billion. So, we have spent a lot of money, and then again, despite this significant increase in funding, we have not done a good job of reducing our numbers.

Now, as you point out one of the major problems is most of these people are not within the VA system, so it is very difficult for you to be able to have a positive impact on that if you are not taking care of them. Yet, that is why this hearing is so important. What do we do? How do we use the community? How do we use all of the things that are out there to try to get people in the VA system?

I would even argue, you know, right now there are tremendous resources there but they are not coordinated. And, it might even be such that if you Google help, if you are somebody in need, you will get probably, I think it is 40,000 search returns. You know, that can almost be another stressor if you are in that problem.

Again, this is really what it is all about is trying to make it such that we can work together to reduce the risk.

So, I guess the question is, talk to us a little bit about kind of what is going on now. You mentioned that myself and Senator Warner drafted a bill. We worked very closely with you all to try to do things a little bit differently, where we can use the community to try to capture folks, you know, and also put the metrics in place. What we want to do is recognize programs that are working well, plus those up through grants and funding, as opposed to just throwing money at the problem.

Secretary WILKIE. Yes. So, I am going to tell you what the five lines of effort are that I have laid out for the suicide prevention task force and tell you how the ideas that you have put into legislation have actually worked in Little Rock for homelessness, and I use that as a guide for the national effort.

So, we will have five lines of effort. One is what you said, State and local grants, getting out to the people who are closest to those that we do not see in the Department of Veterans Affairs. A national research strategy that brings in NIH and the National Academy of Medicine. Workforce and professional development for our own people, to make them more cognizant of the signs that exist in our veterans who may be in danger. Then, better communication, and then cementing those partnerships that start with grants.

So, Little Rock has eliminated veteran homelessness. That is important because Little Rock has—I mean, Arkansas has one of the highest per capita levels of veterans in its State's population. What Little Rock went out and did, in coordination with the State, was bring in the churches, bring in the charities, create a city- and county-wide roadmap for them to go into areas where the Federal Government was not, bring people off of the streets, get them in transitional homes, and then give them to us to help with vocational rehabilitation and education.

I see that happening now with suicide. Senator Sullivan is walking in. In his State, 50 percent of the veterans are not in contact with VA. Alaska is a State where people can go and get lost on purpose. The Alaska Federation of Natives and I have had deep discussion about how to get into those remote areas and help us find those veterans. State and local grants, of the kind that you have laid out in your legislation, will make it easier for me to help his people, and then the charities in a State like Arkansas, to get out and find those folks. What you have is the key, I think, to unlock part of this crisis.

Senator BOOZMAN. Well, thank you. I really appreciate your support, and again, all your hard work.

Mr. Chairman, thank you.

[The prepared statement of Hon. John Boozman follows:]

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

Secretary Wilkie, thank you for being here and for bringing Dr. Franklin with you to talk about this important issue.

You and I have spent quite a bit of time talking about what we need to do differently in suicide prevention.

Congress has provided significant resources to the VA to decrease veteran suicides, yet the number of veterans who take their own lives everyday remains unchanged.

In 2010, the VA requested $62 million for suicide prevention outreach. In 2020, that number nearly quadrupled to $222 million. In mental health funds, more generally, we have gone from about $4.5 billion to almost $9.5 billion.

Despite the sharp increase in funding, the rate of veterans' suicide has remained roughly unchanged at 20 per day.

You have helped to highlight that many of those 20 per day do not have a connection to the VA. Only six of the 20 are receiving healthcare services at VA.

This points to a significant need to empower VA to work through community partners to expand outreach, so the topic of this hearing—leveraging community networks to reduce veterans' suicide—could not be more appropriate.

Earlier today, I introduced legislation with Senator Warner and some of my colleagues on this Committee to enable the VA to harness the potential in what is going on in the community.

The legislation, called the IMPROVE Wellbeing for Veterans Act, creates a new grant program at the VA to expand the reach of services aimed at preventing veterans' suicide.

As I was putting this bill together, I put myself in the shoes of a veteran who needs help. What I discovered was that there are really amazing services available, but they are hard to find and access.

As you all know, a veteran at risk of suicide may have multiple needs—housing, employment, help with a difficult relationship, medical care, counseling, and other things.

The veteran who has to search for help with every individual need, is a veteran unlikely to actually access and use the support. Rather than those services helping prevent a slide toward hopelessness and suicidal thoughts, the experience may be an added stressor that becomes another risk factor for suicide.

A quick search on GuideStar for the term "veteran suicide prevention" gets you results for almost 40,000 organizations. That tells me that the help is out there, it just needs to be coordinated.

I addressed this in my bill by requiring the VA to work with outside groups—before the first grant is awarded—to develop a framework for data collection and information sharing to make it easier for currently disparate organizations to coordinate. As we will hear in our next panel, there are groups that have already figured out what is needed to enable that broader coordination.

Another thing that I focused on as I drafted this bill was the need to measure more than just capacity. I am the chairman of the VA appropriations subcommittee, so I believe in capacity. I fund it in my bill, and as I said earlier, we have significantly increased funding to support capacity.

But, we need to get beyond measuring what we have the capacity to do and start measuring the impact of our efforts. As I have been around and talked to different groups operating in this space, I have become convinced that we can work together to create and use a standard measurement tool that helps us in this area. The bill also directs the VA to work with outside groups on that.

I have talked to mental health experts and read up on mental health measurement, and I think this is a gap in what is currently being done nationally.

VA has a real opportunity to work with its partners to develop a measurement tool that can be used to measure not just what services were made available to a veteran but the effects.

Did the services they received improve their mental outlook and mental resiliency? Are they less reactive to stress? Are they eating better and making healthier decisions? Are they more connected with family, friends, church, and community? Do they feel like their life has purpose?

This is an area where some organizations have already started to develop their own tools for measuring these types of outcomes. If we could have a common measuring tool, then we could really unleash the power of our collective efforts.

So, the bill will provide VA with the ability to reach far more veterans by tapping into what is going on within communities already and it provides a framework for better coordinating those community efforts and measuring the results.

Chairman ISAKSON. Senator Boozman, thank you, and thank you for your tireless effort throughout the last year. You have been a stalwart of this Committee with the work you have done on the MISSION Act, and we appreciate it very, very, very much.

Senator Brown.

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

Senator BROWN. Thanks, Mr. Chairman. Thank you, Mr. Secretary, and Dr. Franklin, thank you for joining us.

The last year we know, for sure, 245 Ohio veterans committed suicide, one just this spring while at Stokes Medical Center, as you know, the Stokes VA facility in Cleveland.

We know a number of things. We know that servicemembers face stresses that most of the rest of us do not have. It could be worry about the disruption when families move and are apart from each other. So often that can mean getting a VA debt letter because of an overpayment, and worrying about how you pay that back. That is why we changed that law. It can be—if the Department of Defense was at the table, we would talk about multiple deployments, as we do not have enough people volunteer for the military. I mean, you know all those things and I appreciate your comment that there is no single cause of suicide.

I have concerns. I appreciate the President's Executive order. I have concerns it is more of a strategic plan than it is an operational plan, and I would like to hear you talk about that, in terms of this. My understanding is for every 20 veteran suicides, 14 of those were veterans who did not receive VHA care. Some of them were active duty. That is another issue that tells me that the DOD should be at the table with you as you figure all this out and work to implement the Executive order and other things.

In some cases, my understanding is that we hear a story about veterans who had mental health and addiction issues who did not receive a so-called warm handoff when they left the service. So, talk to me about how you—if you look at all this you see that generally, if the VA has contact with this veteran, regular, medical, and psychiatric contact, the chance of suicide seems to be significantly less. Talk to me about how, when people leave with a less-than-honorable discharge, perhaps they did not serve the country as well as they should have. I guess it is implicit in that. But, they are still human beings. They are still Americans. They still wore the uniform, and we have got to find a way to reach them. Calling an 800 number or sending them a letter obviously is not enough.

So, what is the follow-up there on particularly those who the VHA has not connected with?

Secretary WILKIE. I am going to take a step back and answer your first observation by putting on my former military hat. We have not had a national strategy on suicide, both public and private, and in order to operationalize the efforts, if we do not have a national strategy we will not know where to go.

You mentioned Stokes. For the Committee's understanding of what happened in Stokes, this points to the great difficulty that we have had without a national strategy in getting our arms around it. That veteran took his life because he was facing life-altering surgery. He was going to lose an eye, his vocal cords, and his jaw. He did not want to live like that. He came to the VA in Cleveland because he knew the care was good. He took his life, leaving us a note saying, "Would you take care of my mother?" That points to the myriad of issues that we have.

The other-than-honorable—again, putting on my military hat—we have a lot of ground to make up. You and I talked about this in the week before my confirmation hearing. Other-than-honorable is an important tool in a commander's toolbox. However, in this country it has been abused in the past. Thousands of gay Americans were dismissed with an other-than-honorable discharge. That has to be rectified. Thousands of Americans were dismissed from the service because of injuries that nobody could diagnose, and those are the people that we have to reach out to.

Now, they do not represent the majority of those other-than-honorably discharged, and the reason it has been so hard to contact these people is many of them have a very dim view of government, because they were asked to leave the service. We have contacted, through letters, 500,000. We have followed up. 94,000 of those letters have been returned. We know that we have treated thousands who did respond. We will continue to work that.

You also rightly pointed out that it is not going to work unless DOD is at the table. We have to have more robust communication with them on getting their help in finding these people. But, I am not skirting the question. It is an incredibly difficult population to find because of the nature of that military judicial decision that was laid out.

Senator BROWN. In closing, Mr. Chairman, that really underscores the importance of it, because the VA has done, through all administrations, a reasonably good job of dealing with people once VA has them in their embrace, while those that you do not need special attention, which you have said, so thank you.

Chairman ISAKSON. Thank you, Senator Brown.

Senator Tillis.

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

Senator TILLIS. Thank you, Mr. Chairman and Senator Tester for holding this hearing. Secretary Wilkie, it is great to see you. Thank you for your generous time talking with me earlier this week as well.

First off, I want to thank Senator Boozman for the Improve Wellbeing for Veterans Act. I look forward to doing everything I can to help that be successful, and I expect that it is going to be very well-received on both sides of the aisle, on both sides of the Hill.

Going back to, I mentioned when we were on the phone call earlier this week, that I firmly believe that with the implementation of the new electronic health record and with the focus on the integration between DOD and the VA that we should be able to get to a point to where we could almost predict, at the point of transition, maybe at the point during service, of certain experiences that these men and women have had that could put them at risk, be a risk indicator for suicide.

So, as you are going through and implementing, you are going over a 10-year process of implementing the new system, I know we have work to do, but what are we thinking about now so that when we have these integrated system, could be much more helpful for

us to find somebody, perhaps even before they know they may have a challenge?

Secretary WILKIE. Well, the beauty, Senator, of the integrated electronic health record—and we are testing it out in the Pacific Northwest and Alaska—I am going to use my own father as an example. He was commissioned 2 months before Kennedy was inaugurated, 30 years of combat wounds, jumping out of airplanes, carried around a 800-page paper record, and it was the only record. Almost impossible for a medical provider to go through that and determine what the impact of his war wounds and the wear and tear of jumping out of airplanes.

This electronic record will have in it a catalogue of training injuries, combat injuries, battlefield exposure. That is a guide to any health care provider to divine what might be going wrong in that veteran's life and what will be needed to support that veteran. I hope it does not last 10 years to develop. It is moving forward.

I hope to have, for the Chairman and the Ranking Member, a name for the head of the Joint Program Office. I can tell you that Secretary Mattis and I were both committed, that this is the wave of the future, and if we can have a record of everyone who served in our system, and just punch in a few code words, we can make great strides in this.

You are correct. Right now we do not have those complete records.

Senator TILLIS. You actually did work, when I had the privilege of having you be the senior advisor in my office, and the Department has done great work on trying to extend mental health services to veterans. I think that is helpful. What data have we seen in terms of the response, to anyone, regardless of the status of their discharge, after these policies were implemented? What data suggests that we are actually making headway, Dr. Franklin?

Ms. FRANKLIN. Thank you so much. I have the numbers here in front of me. After we put the 500,000 letters out to the other-than-honorable, 3,520 came in for a visit or a hospital stay, an experience in the hospital system. Of those, 2,466 were actually treated with a mental health condition, and of those, there was follow-on treatment in the context of their diagnosis, with 1,413.

This is important as well, related to your prior question to the Secretary, with regard to the electronic health record in my sort of part of the world. In suicide prevention we have a tool that we often use called a Red Flag. It is a patient red flag sort of system, so that immediate when any provider gets onto a system they can see if they have a red flag, which means that they are at high risk for suicide. So, making sure that the same methodologies apply across DOD and VA with the red flag process is critically important, and we are eager to see it come to light.

Secretary WILKIE. I would also add, Senator Tillis, that this is interoperable, so that if I am treated by VA in Fayetteville and I go to my hometown doctor in Aberdeen, and he gives me something that VA did not want to give me, then that provider puts that into the record and the red flag goes up. It is very comprehensive.

Senator TILLIS. Just to dial in, I will just have the staff support it, maybe for the record, but I am glad that we are reaching out to people with other-than-honorable discharges. You mentioned a

whole class of people that probably never should have been given an other-than-honorable discharge. What work is the VA doing on a proactive basis to try to go back through that baseline and reach out to say we want to help reconsider this and potentially do what we should have done to begin with?

Ms. FRANKLIN. Yes, so the 500,000 letters that went out are for all other-than-honorable, not only recent ones. So, in some cases they may have gone out to a veteran that received an other-than-honorable in the '60s or '70s. The tough spot is that 90,000 or so that we are not able to reach. So, I know that there has been some conversation between the Department of Defense and the VA to try to improve any and all outreach measures so that we can reach them, maybe through social media or other types of outreach. I do not know if the Secretary might have something more.

Secretary WILKIE. Well, I would also add, as an answer to your question, that in my opening remarks I mentioned that in this fiscal year we have screened 900,000 veterans for mental health issues. We are following 3,000 more closely, who have given us indications that they might want to harm themselves. We have same-day mental health services. We have reached out and are reviewing the records of those who have suffered military sexual trauma, for instance. It does not matter what their status is as a veteran. Some might not be eligible for full VA care, but we are asking them to come in.

The transition that is now available for troops once they leave the service, whether or not they are going to be in VA for the rest of their lives, is there. We are not turning away anyone who has a mental health issue. That is the key to getting our arms around this.

Chairman ISAKSON. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I want to kind of follow on the less-than-honorable that Senator Brown and Senator Tillis brought up, as in the rules around it. They can come in now for up to 90 days.

I am hearing that many veterans are getting turned away because schedulers were not informed of the change. Have you heard that?

Secretary WILKIE. I have not.

Senator TESTER. It is unfortunate, because the truth is if you have not heard it, you cannot fix it.

Secretary WILKIE. Right.

Senator TESTER. But, the bottom line is I will probably have my staff talk with you guys, because that is the information we have been getting so there needs to be some information trickle down to you.

In December and January—and you talked about this for a second—the Department sent 400,000 letters—maybe it is 500,000 but 400,000 is what I wrote—to newly eligible veterans. These were not necessarily—well, from all types. Twenty percent were returned as undeliverable. Do you have a plan on how to deal with the 20 percent that never got to its ultimate destination, or intended destination?

Ms. FRANKLIN. I think we are just going to continue to do other methods through electronic means, pushing out information

through other portals, with our partners, The American Legion, the VFW, when they are pushing out their literature, and just trying to use a host of resources at our disposal.

Secretary WILKIE. I would say, Senator, again—and this is not a reason to slow down—but because of the nature of the population, there are many out there who do not want to be found, and that is something that I do not have an answer for.

Senator TESTER. Right. You are right; and as you pointed out, in Alaska you can get lost, and you can get lost in our State if you want to get lost. But, the bottom line is that I think we still need to try to do what we can do——

Ms. FRANKLIN. Absolutely.

Senator TESTER [continuing]. To reach out.

Last year's suicide data stated that the VA planned to expand suicide prevention activities to former members of the Guard and Reserve. So, what suicide prevention is the VA now offering to those folks? Dr. Franklin?

Ms. FRANKLIN. Yes. We have spent the last year building up increased robust services to the National Guard and the Reserve and it began with, like you said, a look at our data. The Secretary brought in the leadership of the Reserve and the Guard to come to the table on critical discussion. One of the first things out of the gate was a lash-up of our mobile Vet Centers to every drill weekend. So, we put pen to paper on this plan, and they are driving those Vet Centers out across America to these drill weekends, with the goal of executing the Secretary's vision for building trust and confidence with veterans as an organization. We hope to get with them early, while they are still serving in the National Guard and Reserve.

Also, we developed and published a toolkit that really speaks to the data, and went on a road show to educate others about it. The toolkit has practical application for making sure these folks know that they can get into care under something that we are calling humanitarian care, if it is emergent; and they always have access to our Veteran Crisis Line.

Senator TESTER. Yep.

Ms. FRANKLIN. Then, from there we have also been working with the Congress on a piece of legislation to look at access to care for this unique population. Hopefully that will come to bear in the coming year.

Senator TESTER. OK. Good. Do you have any metrics on what the use is for those mobile Vet Centers? If you do not, that is fine, but if you do, could you get that to us?

Ms. FRANKLIN. Sure. Absolutely. I appreciate also, because Chairman Isakson asked me in the opening and I was unable to find the numbers then. Forgive me, Chairman. But, it is actually astounding. In fiscal year 2018, in terms of access to care, with established patients we served over 694,000 veterans. Then, first-time patients that were just new to mental health, and this includes substance abuse as well, we served over 129,000. So this, to me, for a large health care organization, it is astounding in terms of access to care, such large numbers getting same-day appointments.

But, I will certainly pull the figures on the Vet Centers.

Senator TESTER. Very good.

Ms. FRANKLIN. Yes, Chairman.

Chairman ISAKSON. Thank you very much.

Senator TESTER. Yes. I think this question is for you, Mr. Secretary, but under the leadership of Dr. Stone I understand—well, maybe it is for Dr. Franklin—VHA is planning to sign a memorandum of agreement with the National Guard Bureau. What new services would the Guard members gain once that MOA is signed?

Secretary WILKIE. The Guard members will have access more readily to, as Dr. Franklin said, our mobile facilities.

Senator TESTER. Right.

Secretary WILKIE. We are enhancing the transition period that now exists for the Guard and Reserve when they leave, more robust services during that period.

Senator TESTER. Yep.

Secretary WILKIE. The same kinds of things that we offer to the active side when they come.

Senator TESTER. OK. When will it be signed?

Secretary WILKIE. We are starting that now.

Senator TESTER. So, is the MOA signed now?

Secretary WILKIE. I will have to check, but we have already put in train the plans for that.

Senator TESTER. OK. And, on the Guard weekends, are they serving all Guard members or just those that have been deployed?

Secretary WILKIE. Well, no. We are serving all Guard members. We go to their encampments. Obviously, we do not have trucks and centers for everybody, but it is important that we get out there.

Senator TESTER. I appreciate that. Thank you.

Chairman ISAKSON. Thank you, Senator Tester.

Senator Sullivan.

STATEMENT OF HON. DAN SULLIVAN,
U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and, Mr. Secretary, thanks again for being here. I appreciate the job you are doing. I think you are doing a really good job in a really hard position. Your visit to Alaska was very impactful. We look forward to having you up there soon. And, I think all of us and you agree that this is a hugely important issue. So many of us have been impacted by this issue. So, many of our constituents have been impacted by this issue of suicide.

You know, I lost a young Marine who was under my command to suicide many years ago, but I think most people in this position, whether in the military or otherwise, we are always asking, you know, what more could we have done? What more could we have done? So, I think this is why you are seeing this very bipartisan focus.

You already talked about Alaska, a great place to—I think you said it; I did not say it—to get lost. But, it is big and open wide and we are looking forward to, like I said, getting you up there. But, you know, the broader national metrics of the 20 suicides of veterans per day, my understanding is that 70 percent—I think you may have touched on this—are not using the VA services, nationally. In Alaska I think it is over 50 percent. Our VA, our Alas-

ka VA, is working on a big initiative to try to close that gap, get people in the system. And, as a critical first step your VBA has selected the State of Alaska as a case study and pilot initiative to look at broader components of a national outreach strategy.

What exactly are you looking at us—us, meaning my State—but others to try to do here, and how can we make sure that as we team up with the VA—we, Alaska—that the pilot study and initiative is best utilized?

Secretary WILKIE. Well, I think because of Alaska's unique relationships within the State, with tribal governments, with the Native Health System, and the ability of the State of Alaska that is unique to Alaska to have State resources get out into the most remote sections of this country, what we are looking at in Alaska is the ability to partner with all of those entities.

You know, when I addressed the Federation of Natives I asked them to double the number of tribal representatives that they have, to get out into the wilderness and help us. I mentioned Senator Boozman's legislation being a vehicle for us to give them the support that they need to do that. The beauty of Alaska is that the Tribal Health System is second to none, and we have an advantage there that we do not have in a lot of places.

Opening the aperture on grants, opening the aperture on Federal Government to State, local, and tribal governments is the key to getting our arms around this.

Senator SULLIVAN. Thank you. We look forward to working with you on this, and we appreciate being part of that initiative.

Let me kind of broaden it. You mentioned Alaska Natives and lower 48 Indians. The PREVENTS Task Force, which I certainly am supportive of what the President is doing, it has representatives from 10 separate executive agencies, but I do not think that IHS is part of that. And, as you know—and maybe I am wrong here—but as you know, in my State, and I think nationally, you have this incredible, what I call in Alaska, a special patriotism with regard to our Native community, that serves at higher rates than any other ethnic group in the country, lower 48 Native Americans as well, which is amazing, something that is wonderful. But, these communities often also have very high suicide rates.

So, is there any thought about getting IHS in there, because it seems like it is a natural that it should be part of this task force.

Secretary WILKIE. I will make a confession, and that is I will check. I had a whole panoply of Federal officials in front of me yesterday. I will say that we buy $1 billion a year worth of care from IHS. I was actually on Native American radio in 70 tribal areas yesterday, talking about this. You are absolutely right. If I find that they are not in the room I will get them in there.

Senator SULLIVAN. Yeah. I think they should not just be kind of asked on occasion. I think they should be permanently part of it.

Let me just ask one final question, Mr. Chairman, if it is all right. Can you speak, Mr. Secretary, very quickly, to the progress on the VA's Mental Health Hiring Initiative, which again, is another very important related topic?

Secretary WILKIE. The Mental Health Hiring Initiative started, in part, because of the efforts of this Committee in June 2017. The goal was to increase the population of mental health professionals

in VA by 1,000. Since that time, we have hired 3,900 mental health professionals, and there is a net gain in there of several hundred.

Where we have a palpable vacancy is among mental health nurses. We have about an 8.5 percent vacancy rate there, that we have to do better. Yet, we are actually ahead of the goal that the Committee wanted us to have when we started down this road back in June 2017.

Senator SULLIVAN. Thank you. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

If Senator Sinema would pause for 1 second before I recognize her.

We always talk about the quality of our recruits, to make our military the best it can be in the 21st century. We talk about the STEM subjects. We talk about the youth of our country. We talk about all the people we need to make our military strong. I noticed a couple of them happened to wander in the room a minute ago, and I think they ought to be introduced.

Senator Manchin, would you introduce these two suspects over here?

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

Senator MANCHIN. I would be delighted to introduce those two suspects. I am happy to have part of my family with me today. I have my brother-in-law, Manuel Llaneza, and his grandsons and my nephews, Domenic and Manny. They are right behind you. They are learning. [Applause.]

And, they understand the services that have been given to our veterans and the importance for us to serve them now, so I am very happy that they are here and enjoying this.

Chairman ISAKSON. Senator Sinema.

STATEMENT OF HON. KYRSTEN SINEMA,
U.S. SENATOR FROM ARIZONA

Senator SINEMA. Thank you so much, Mr. Chairman. I understand that Senator Manchin has to take these young men on a tour so they can get ready to take his job some day. If I might, could I——

Senator MANCHIN. Sooner than we think.

Senator CASSIDY. I am hoping they are Republicans, but that is OK.

Senator MANCHIN. Well, Manny is from Louisiana, Baton Rouge.

Senator SINEMA. He is coming for you.

Might I yield a moment of my time to Mr. Manchin so that he could ask his question and then take his nephews out? Would that be OK?

Chairman ISAKSON. That would be fine.

Senator SINEMA. Thank you so much.

Senator MANCHIN. Thank you, Senator Sinema. Let me just say that, first of all, Secretary Wilkie, I want to thank you because your office has been working with us on the three-digit hotline, which is so important.

So, for our audience and for the public, one of the first lines of defense that we have, all of us know, in times of emergency, and especially preventing a veteran suicide or the crisis line is the hot-

line that we have. The number is 800–273–8255. How many of us could remember that? I mean, right now we know 911 is ingrained in our minds.

So, we are going for that three digit. You all have been real receptive. I want to thank you. It is something that we need to do. We have that bill, and we will be introducing that bill shortly. I am asking all of my Senators to cosponsor, if you would. I think it is a great tool for our veterans, and hopefully we can help save some of our brave young men and women.

Next, I would like to talk to you about the gold standard for care integrated-coordinated services, which the VA does, I believe, better than anyone in the private sector. For many veterans in West Virginia and across the country, the VA is the best, most cost-effective care that they can get, and it is what they want. So, it is our duty to make sure that community care is as good or better than the VA and that it is as coordinated and integrated, especially with a whole set of veterans accessing community care now through the MISSION Act.

So, my question would be, Mr. Secretary, how has the VA determined how each community is prepared to coordinate with the VA when dealing with mental health and suicide prevention?

Secretary WILKIE. Well, first of all, I cannot thank you enough for your work that you are doing on those three numbers. We have turned over, at your request, our findings to the FCC and hope they turn those decisions around quickly in anticipation of introducing the legislation.

Our VISN directors across the country are responsible for making sure that those parts of the Community Care network, also in coordination with the system that provides for community care, meet the standards that we expect of those treating our veterans with mental health issues. I think you are right. Our care is second to none on mental health. I do not anticipate many veterans leaving our system to take advantage of community care, because you have said it in your presentations—it is the one place where they go and people understand the culture and speak the language.

The other thing that is important, particularly in a State like West Virginia, and also on the issue of mental health, is getting telehealth out into the counties, to the libraries, making it as easy as possible for people to access that.

Senator MANCHIN. Let me just tell you, the challenge we have there is called Rural Broadband Initiative. We have got so many people that are not connected in rural America, rural West Virginia, and that is something we have to do, and do immediately.

The other thing, just as I am finishing up, in the community, the network that will take care of these veterans, do you all vet them to make sure they are able to give the services at your standard and the standard we expect veterans to get?

Secretary WILKIE. Yes, sir. We are still actively vetting, so, yes, we do. We are not going to send a veteran out into the field without us knowing where he or she is going.

Senator MANCHIN. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Secretary WILKIE. Mr. Chairman, may I ask your indulgence?

Chairman ISAKSON. Absolutely.

Secretary WILKIE. The question was about the mental health providers, and the number that we have, in VA we have, right now, about 6,000 psychologists on the payroll, and 3,300 psychiatrists, in addition to that 500 mental health nurses. We are 8 percent vacant in that area and we are trying our best to engage in more nursing school relationships across the country to increase the flow of nurses into the system.

Chairman ISAKSON. Thank you very much.

Now did you yield some of your time to Mr. Manchin, or did you want me to go to you next?

Senator SINEMA. Mr. Chairman, I did, but he took it all, so——

[Laughter.]

Chairman ISAKSON. You actually have 1 minute and 38 seconds.

Senator SINEMA. How about we have another Member go and I will take my time later. Is that OK?

Chairman ISAKSON. OK.

Senator SINEMA. All right. Thanks.

Chairman ISAKSON. Without objection.

Senator Moran.

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

Senator MORAN. Thank you, Mr. Chairman. Thank you and Senator Tester for this hearing.

Secretary Wilkie, you perform some of your best work while wearing a boot. I have joined you, and I hope to do that as well.

You have—let me start with this. The grant-making working group that is proposed, how do you envision it? Do you envision that there will be community organization stakeholders to be members of that working group?

Secretary WILKIE. Absolutely.

Senator MORAN. Then, I think it makes sense to me and I may have some suggestions if you are willing to entertain those.

Your proposal that the Department is working on to connect community organizations and State and local governments, you mentioned Senator Boozman's efforts; Senator Tester and I are leading an effort in regard to suicide prevention called the Commander John Scott Hannon Veterans Mental Health Care Improvement Act.

Here is my question and/or request. Is there any reason your proposal could not be incorporated into the legislation that we are talking about, that a number of the Members on this Committee have introduced, and mark up in that fashion to move to the Senate floor? Here is a bit of a complaint. We are waiting on VA technical assistance on our bill, and we have been waiting a couple of months. As you do that VA technical assistance, perhaps you can incorporate your suggestions and improvements into the bill. I would encourage you, if you are interested in this, to visit with Senator Tester and me and other Members of the Committee to see if we can have a result that maybe is more-——

Secretary WILKIE. Yes. I will come visit you. I will be very candid. We are just starting down this road to develop a national strategy and then operationalize those efforts. I do think that having a list of things that we must do, without having that national

roadmap, may create a problem for us in terms of our capacity to carry out those programs.

We are very deep into alternative therapies on the opioid front and the pain management front. I do not know that we have the abilities to carry out many of the programs that are in the legislation. I will go back and take another look, but when I sit down and talk with you, that will be the premise that I start with, that if we are going to make these programs work we have to be able to carry them out, and right now, as the head of this task force, what I see as the most readily available means at our disposal to address veteran suicide will be that grant portion, where we can engage the local community.

Senator MORAN. That is useful and understandable. A significant portion of Senator Tester's and my bill is related to community organizations and their involvement in suicide prevention—you and I have had conversations. This Committee has worked on Community Care. How do we get things closer to where people live and more readily available. So, there is no question. I think that we are aligned and I would welcome that conversation.

Mr. Chairman, I know the vote has been called. I will not have a chance, I suppose, to—I want to hear the next panel's testimony, but in my absence I would like to highlight that we have a Kansan, Ms. Kavanagh, who is a panelist on that, and she has impressed me and my staff greatly; I am pleased that she is here today to testify. I encourage my colleagues on this Committee to pay specific attention to her and her story and her mission. Her daughters are with her as well, and we are delighted to have them here.

Mr. Chairman, I thank you for the opportunity to testify before I go vote.

Chairman ISAKSON. Senator Sinema.

Senator SINEMA. Thank you so much for your understanding and kindness, Mr. Chairman, and thanks to both of our witnesses for being here today. Secretary Wilkie, I look forward to meeting with you to discuss the priorities we have for Arizona for the VA, and I am really glad you are here before the Committee so we can hear about the VA's work to address veteran suicide.

As you know, the VA's national strategy for preventing veteran suicide states, "we must go beyond engaging mental health providers to involve the broader community and reach veterans where they live and thrive before they reach a crisis point." I could not agree more, which is why I authored the Sergeant Daniel Somers Network of Support Act.

Sergeant Daniel Somers was an Army veteran who completed two tours in Iraq, participated in over 400 combat missions as a machine gunner in the turret of a Humvee. Like many veterans, Daniel suffered from nightmares, depression, and symptoms of Post Traumatic Stress Disorder and Traumatic Brain Injury. Sadly, Daniel lost his life to suicide and he became part of the reason we are having this hearing today.

My bill, which was recently included in this year's National Defense Authorization Act, requires the Department of Defense to collect from new servicemembers the names and contact information of loved ones that they consider to be members of their own personal support network. Using this information, the Department of

Defense can provide information to those families and loved ones about available benefits and services. Members of this network of support are often the first in the line of defense to prevent suicide, and they are the best people to reach veterans where they live and where they thrive.

So, my first question for both of you is, is this something you believe the VA could benefit from, in incorporating this program into its unit, and if yes, can I get your commitment to work with my ops and my team to help develop this program for newly enrolled veterans after they disconnect from service?

Secretary WILKIE. I will; and I am going to now put on my old hat as the Under Secretary of Defense for Personnel.

I talk a lot about culture. What you are doing is part of that change. It is no longer the 1940s version of military service. There are not tens of thousands of draftees coming into the pipeline, so that people are more readily moved out. Family support is key. Having that information, I think, is vital, and I will do everything that I can to make that happen.

Ms. FRANKLIN. Yes. I also appreciate the question and I have also been working with the Somers for quite a few years. I worked on the DOD side and now on the VA side, and I am so pleased that you were able to push that through. Also, I am a bit embarrassed that it took a bit piece of congressional legislation to do it, because it is a very simple, common-sense approach. And despite the fact that it seems so simple, it is actually also life-saving.

And, just because a young man, a young soldier like Daniel Somers, was over the age of 18, and you might think that his parents might not know or need to know. It is absolutely not the case.

Your legislation that pushes out proactive education and content to loved ones and family members of people that have served and teaches them about signs and symptoms of suicide risk, Post Traumatic Stress, even just everyday coping skills, it is an important piece and I am very grateful that you did it, so thank you.

Senator SINEMA. We are really looking forward to expanding this through the VA, so that servicemembers, from the time they start to the end of their natural lives, will be able to have this network of support, and people who are ready and prepared to help them. Thank you.

All you all know, 14 of every 20 veterans who die at the hands of suicide are not being seen by VA providers today. As the national leader in suicide prevention, and the largest integrated health care system with experience in preventing veteran suicide, the VA has a lot to offer.

In 2014, when I was in the House, I cosponsored the Clay Hunt Act, the SAVE Act. We signed it into law in 2015, and it is was an important stepping stone. But, one piece of the bill requires the VA to annually evaluate its mental health and suicide prevention program. What are the things that you are learning from these assessments, and how are you using the information that you are learning to improve programs and community initiatives?

Ms. FRANKLIN. Yes. We are tracking quite closely on the Clay Hunt Act and appreciate the opportunity to provide you an update on that question. There has been a number of positive results that

have come about since the Clay Hunt Act was passed, and we have learned about those from the third-party evaluations.

We have learned that veterans that come in report that their health care has had a positive impact, that there has been an increase in psychological health care as a result of the Clay Hunt work. We also evaluate satisfaction, whether they have satisfaction reports related to their care, and all of those metrics are going in the right direction.

At the same time, we are learning that the veterans would like us to have more flexible work schedules, more flexible work structures. Also things like uncommon work schedules, nights, evenings, things that need to occur to improve employee retention and employee satisfaction.

We are also learning that we need to dedicate the peer support specialists that you authorized through the Clay Hunt Act. We, in some cases, have existing employees become collateral duty, if you will bear with that term, but additional duty as assigned, peer support specialists, which we learned fast and early that we had to shift from that model. We have now hired over 1,065 peer support specialists with a way-forward plan to hire even more.

Then, the other sort of big lesson that we have learned is we need to improve the connection between VA programming and non-VA programs. Sometimes the coordination was not there, and that is what our third-party evaluation highlighted. So, we have put a number of practices in place to improve that, encouraging our employees to join coalitions in their community and to engage and make sure that the programming outside the gates, if you will, is coordinated, targeted, and responsive and complementary, overlapping, and duplicative.

Senator SINEMA. Thank you. Thank you, Mr. Chairman.

Senator TESTER [presiding]. Senator Cassidy.

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

Senator CASSIDY. Thank you. Mr. Secretary, thank you for being here.

Just to set context, you and I previously discussed something which is not well understood, which is that the veteran who did not see combat is more likely to commit suicide than the veteran who did see combat.

Now, the fact that that veteran, while in the service, was not put into combat, suggests to me that the Department of Defense has a way of psychologically evaluating folks who would be able to handle the stress of combat and who are not; and those who can, are, and those who are not, not.

So, Senator Tester and I have a bill that we are going to submit for NDAA that would encourage—and you and I have spoken of this concept, but this is a bill that kind of codifies—that would have VA and DOD coordinate more closely so that if there has been an evaluation by DOD that someone is not emotionally resilient, therefore, should not go to combat, that that information would somehow be transmitted to VA. We know the transition points are most when someone is at risk—the first period of time, 6 months or so, after separation from active duty is the peak for suicide.

You and I have spoken of that, so I guess my first question is has any progress been made in terms of this coordination of information between the two, DOD and VA? We have spoken of that previously in terms of the integration of the electronic health record, which you had mentioned in the past would be a priority of yours, to make sure there was top-level accountability on that. Then, more broadly, the concept of how are we getting information from the DOD to VA, regarding the emotional resilience of someone when they separate from the service?

Secretary WILKIE. Based on your efforts, it is part of the discussion on the electronic health record. That has been the focus, because that is going to be the most readily available tool.

When I look at the combat statistics, the tooth-to-tail ratio in Vietnam was 1-to-17, meaning 17 people supporting the one person in combat. It is almost there this time. And, the more I look at it, wearing my Air Force officer hat, it is not, in most cases, an issue of psychological resiliency. In most cases it is just a question of need. There are very few units in the military where psychological testing is a be-all and end-all. The submarine service——

Senator CASSIDY. No, I am not—I am not—just because we have limited time, may I interrupt. I am not necessarily digressing as to what is the measure of resiliency or whether or not it takes place. The fact that if you are in combat you are less likely to commit suicide does tell me something. And what I am really concerned about, is there a communication of who would be at increased risk from DOD to VA?

Ms. FRANKLIN. Yes. If I—thank you, Mr. Secretary. We do have a program called In Transition, and this is a program that we put in place to help guide those that are at risk when they leave DOD into VA, and it ensures a very warm handoff from the agencies.

Senator CASSIDY. And how are you ascertaining who is, in particular, at risk?

Ms. FRANKLIN. These are from the medical officers on the active duty side. They are put on a high-risk sort of a list. The DOD flags them and they roll into this In Transition program. I should have also shared that they do not necessarily have to be at high risk to be put in the program. They could just be receiving ongoing mental health care. And we want to make sure that that——

Senator CASSIDY. So, let me ask, if you have the ability to compare, since that is a relatively new program, with the results of similar sort of folks from before that program was instituted, if you will, a historical control. Have we seen benefits of that warm handoff in terms of decrease in the suicide rate among those who are enrolled, and what is the comparative rate of those in that program, compared to those who are not enrolled in that program.

Ms. FRANKLIN. You know, that is a very good question and I do not have the data in front of me in terms of doing the analytics, but I think you are onto something. The point in time when the policy letter got written on the DOD side to implement In Transition and just do a basic pre/post and track those and run that. The death certificate data that we get that tells us whether someone has died from suicide is a 2-year lag. The implementation of In Transition was within the last year. So, it will catch up, and that is a very good analysis and potential study.

Senator CASSIDY. My only suggestion would be—and I am out of time almost—is that if somebody who is 35 or 25 who was healthy a year before——

Ms. FRANKLIN. Yes.

Senator CASSIDY [continuing]. Quite likely it is—more likely it is a suicide than it is anything else. And I know Social Security tracks that almost real-time, because they have to cutoff Social Security checks for those who died. So, because we would be very interested to know the effects of this program, maybe just kind of good enough for government work, just take death rates in general of those enrolled and those not enrolled. We would appreciate that, and I think we look forward to receiving that.

Ms. FRANKLIN. Tracking. Yes, sir.

Senator TESTER. Thank you, Senator Cassidy.

Senator Blumenthal.

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

Senator BLUMENTHAL. Thanks, Mr. Chairman. Since my time is limited before the vote expires I am going to be really quick. First, thank you for your work on veteran suicide. It is one of the most emotionally vexing for all of us who care about veterans, of all the problems that we deal with, because it is a preventable death.

There are two statistics I know you are aware of: 70 percent of veteran suicide deaths involve a firearm; and a veteran is three times as likely to die as a result of suicide if there is a firearm in the house.

So, I would like your commitment that you will form—call it whatever you want, a task force, a working group that will work with us on gun violence prevention causing suicide among veterans.

Secretary WILKIE. Yes, sir, that is a part of this task force.

Senator BLUMENTHAL. Well, I know it is a part of a task force, but I would like a working group or a task force whose mission it is to focus on this issue, and that reports back to us.

Secretary WILKIE. Yeah. I am happy to do that within the President's Executive order. And, I mentioned that the goal—and you have stated this in the past—is to build time and space between the impulse to harm oneself and——

Senator BLUMENTHAL. That is a theory that makes sense for all suicide, and that is the reason that guns cause more deaths by suicide, because the time and space, if somebody tries to commit suicide by taking overdoses of prescription drugs, you have got hours. In gun violence, you have no time.

Let me focus on two steps that can actually save lives—emergency risk protection orders. A number of States now have them. I am working on bipartisan legislation that will enable judges to take away firearms from people who are dangerous to themselves or others after a court due process that results in a warrant. Would you endorse that kind of legislation?

Secretary WILKIE. Not being a practicing lawyer I would be happy to take a look at it and give you my opinion.

Senator BLUMENTHAL. I would appreciate your opinion.

Secretary WILKIE. Yes, sir.

Senator BLUMENTHAL. Second, gun storage measures. I have introduced a measure called Ethan's Law. It is named for a young man who did not take his own life and is not a veteran, but as a result of an accident in the home, playing with a firearm, because there was no adequate storage. But, as you know, a gun in the home triples the risk of suicide, as I just mentioned, and if a caregiver can impose some discipline, as in gun storage, locks, and so forth—I know you hand out locks, but this takes it a step further. Would you endorse that kind of measure?

Secretary WILKIE. I will say educating family members is absolutely key in things as simple as gun storage, et cetera.

Senator BLUMENTHAL. Right. I appreciate that. I am sorry that I am going to have to leave to vote. I would just ask you, is the surgical processing trailers and other facilities still on track in West Haven?

Secretary WILKIE. Yes, sir.

Senator BLUMENTHAL. Thank you.

Senator TESTER. Thank you, Senator Blumenthal. You know, Secretary Wilkie and Dr. Franklin, you just had your best hour and 25 minutes of this week, and we appreciate you being here.

I only have one request. Senator Moran did some of my heavy lifting for me earlier, and I appreciate that. If you could get technical assistance for the John Scott Hannon Suicide Prevention Bill to us ASAP we can go to work, we can work together, and we can get something done.

Thank you for your service to this country. Thank you for being here today, and now we will go to the second panel. [Pause.]

Senator TESTER. While everybody is getting ready for the second panel I am going to introduce them, because we are in the middle of a series of five votes, so there is going to be a lot of folks here that get up and leave and come back.

The witnesses for our second panel include Col. Miguel Howe, U.S. Army, Retired, the April and Jay Graham Fellow for the Military Service Initiative, George W. Bush Institute. It is great to have you here, Colonel.

We have J. Michael Haynie, Ph.D., Executive Director of the Institute for Veterans and Military Families. Great to have you here, Michael.

We have Jessica Kavanagh, who is Founder and President of VetLinks. Jessica, good to have you here.

We have one of my favorite generals, Major General Matthew Quinn, Adjutant General, the great State of Montana National Guard. Good to have you here, Matt.

We have Lt. Col. James Lorraine, U.S. Air Force, Retired, President and Chief Executive Officer of America's Warrior Partnership. He is from the Chairman's home State of Georgia, Augusta specifically, and works extensively with the Atlanta veteran community.

The rules here, folks, are you get 5 minutes. Chairman Isakson will be back shortly. He is a lot meaner than I am so he will gavel you right down, so try to keep it to 5 minutes. Know that your entire statement will be put in the record.

I am going to start with you, Col. Howe, and let the fun begin.

I just want to say one other thing. I appreciate you all taking time out of what I know is a very busy schedule, to be in front of

this Committee. I apologize ahead of time. When votes happen this thing is all screwed up, but needless to say we appreciate you being here and we appreciate your testimony ahead of time.

Colonel, the floor is yours.

STATEMENT OF COL. MIGUEL HOWE, U.S. ARMY (RET.), THE APRIL AND JAY GRAHAM FELLOW FOR THE MILITARY SERVICE INITIATIVE, GEORGE W. BUSH INSTITUTE

Colonel HOWE. Senator Tester, Chairman Isakson, thank you for giving me the opportunity to testify this afternoon. I am Col. Miguel Howe. I served for 24 years in the Army as an infantry and special forces officer, deploying throughout Latin America, Iraq, and Afghanistan. My grandfather, father, and father-in-law served in World War II and Vietnam. My son is on his way to West Point and my daughter will soon be an Army ROTC cadet.

Six years ago I retired from the Army and was honored to join the George W. Bush Institute in Dallas, where I currently serve as the April and Jay Graham Fellow for the Military Service Initiative.

Since 2013, the Bush Institute has honored the service and sacrifice of post-9/11 veterans by fostering a successful transition from military service to civilian life. We believe our Nation has a duty to honor our warriors and empower them after that service.

I detailed four recommendations, based upon our work, in my submitted testimony, and I will highlight three of those recommendations now.

First, we advocate for an approach that integrates education, economic opportunity, and health and well-being, and sets the conditions for all veterans to thrive. We recommend more be done to establish a common vision and comprehensive framework for veteran services and outcomes. This new vision and framework must promote collaboration and instill a culture of accountability and measurement for outcome across all sectors, government and private.

Second, we recommend reducing barriers that veterans face in seeking and connecting to high-quality health care. Some of our war fighters return home with a visible injury; many come home with the invisible wounds of war, like Traumatic Brain Injury and Post Traumatic Stress. Our research shows that not enough veterans are seeking the care that they need. Eight out of 10 post-9/11 veterans say that embarrassment or shame is a barrier to seeking out care. Some simply do not believe that effective care exists, and others believe that asking for help will impact their future successes and careers.

But, of course, effective treatments are available. Public-private partnerships help to bridge this gap, and there are examples of these partnerships already at work. When the Bush Institute recognized the need to connect veteran peer networks, which instill purpose and belonging, with best-in-class clinical providers, we created the Warrior Wellness Alliance. I am glad that the VA is a partner with us on those efforts, because with peer connections, community collaborations and integration, and clearer data, we can better serve our veterans while maximizing national effort and resourcing.

Finally, we must improve access to and delivery of high-quality mental health care for all veterans and their families. The Administration, Congress, and the VA should focus the full weight of the Federal Government on enforcing consistent quality standards and partnering with the private and nonprofit sectors to identify comprehensive solutions for increasing the availability and the quality of effective care.

Like many of us here today, for me veteran suicide is not only very real it is also personal. When I was a young lieutenant, my communications section chief was Sergeant First Class Terry Dennis, a Panama Invasion and Gulf War veteran. We all widely considered him the strongest man in our unit. But, Terry also suffered from the invisible wounds, and, tragically, while still on active duty, Terry killed himself.

Sergeant Josh Burnette was one of my Green Berets. He was severely wounded in Afghanistan, leaving active duty as a double amputee. After struggling with both his visible and invisible wounds, and, frankly, with all aspects of his transition, Josh took his own life.

I will leave you with a more hopeful story. Corporate Dave Smith served in the Marine Corps, during two deployments to Iraq. Afterwards, when he came home, he experienced PTS. He came home drunk one night, stared down the barrel of a shotgun, and contemplated his own suicide.

Thankfully, Dave put that gun down. With support from family and friends, he sought professional counseling and treatment. He found new purpose, volunteering with Team Rubicon. He graduated from Cal Berkeley. He connected with other veterans while mountain bike riding with President Bush and our own Team 43. Dave is married now. He has a fulfilling career, and this year he welcomed a baby girl.

Dave is living proof that all veterans can live a meaningful life and thrive. I am encouraged by the work that all of you are taking on now to save lives and help us to ensure that Dave's story is the rule and not the exception.

Thank you again for this invitation, and I look forward to answering your questions.

[The prepared statement of Col. Howe follows:]

PREPARED STATEMENT OF COL. MIGUEL D. HOWE, USA (RET.), APRIL AND JAY GRAHAM FELLOW, THE GEORGE W BUSH INSTITUTE [1]

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, MEMBERS OF THE COMMITTEE, Thank you for the opportunity to testify today. I am Colonel Miguel Howe. I served for 24 years in the Army as an Infantry and Special Forces officer deployed throughout Latin America, Iraq, and Afghanistan. Military service has been my family legacy. My grandfather, father, and father-in-law served in World War II and Vietnam. My son is an Army ROTC Cadet on his way to West Point, and my daughter will soon be an Army ROTC Cadet. Six years ago, I retired from the Army and was honored to be asked by President Bush to lead his Military Service Initiative. Today I serve as the April and Jay Graham Fellow for the Military Service Initiative at the George. W. Bush Institute in Dallas, Texas.

Since 2013, the Military Service Initiative has honored the service and sacrifice of all post-9/11 veterans by fostering their successful transition and reintegration

[1] The George W. Bush Institute is a non-profit, nonpartisan organization advancing policy, programs and leadership development to address our Nation's most pressing challenges.

from military to civilian life. We believe our Nation has a duty to honor our warriors and empower them after their service.

For many veterans the transition process will be smooth, but still others face challenges finding new and meaningful education and employment opportunities. Some are adjusting to life with a wound, injury, or illness—either visible, invisible or both. Many face challenges re-establishing a sense of purpose, belonging, mission and identity. All of these factors are not only elements for ensuring successful transition, but they can also represent risk factors for veteran suicide.

While public awareness campaigns and acute crisis response are essential to a sustainable and comprehensive suicide prevention program, by themselves, they are not sufficient to address such a pervasive social, economic, and health challenge.

The PREVENTS Executive Order contains important elements to prioritize research, coordinate and align effort across the Federal Government, and to develop proposals to offer grants to state and local governments to support community level efforts toward a comprehensive approach to prevent veteran suicide. These mandates are key elements to a more expansive approach to suicide prevention while bringing to fruition several key goals and objectives of the VA's National Strategy to Prevent Veteran Suicide.

RECOMMENDATIONS

To address the systemic challenges associated with reducing suicide risk among veterans and to promote a life worth living among our Nation's veterans, I offer five recommendations designed to create more effective solutions for supporting veterans.

1. Establish Overarching Vision for Veteran Health and Wellbeing

At the Bush Institute, we advocate for an integrated and comprehensive approach focused on setting conditions for veterans to thrive by promoting overall wellbeing and a life worth living. This includes ensuring education, economic opportunity, and health and wellbeing—the three elements that are key to a successful transition. These three areas of transition success also incorporate key aspects of the social determinants of health that mitigate risk for not only suicide, but a host of other veteran outcomes. Our framework acknowledges those social determinants of health and applies a public health approach that simultaneously addresses the entire veteran population, those veterans at an elevated risk, and most critically veterans at highest risk, including those in acute crisis.

This focus on the full continuum of wellbeing drives our veteran transition work at the Bush Institute, and our work with other nonprofit organizations, businesses, government entities and partners to advance positive outcomes. We believe a common vision and comprehensive framework should be established that focuses specifically on veteran outcomes and aligns services and resources, especially across Federal agencies. This framework can be the basis of a national blueprint that promotes collaboration with private, non-profit, and philanthropic organizations that support veterans.

A comprehensive approach and holistic framework would empower veterans as leaders, provide them economic opportunities, ensure access to high quality health care for those in need, and guarantee needed social support and basic services for the most vulnerable. It would also more effectively leverage the full continuum of veteran services from the government and non-government sectors across the full continuum of transition issues. The primary goal should be to drive services for veterans that lead to positive outcomes.

The framework also should instill a culture of accountability and measurement for not only the government, but also for non-government entities and funders that serve veterans. It should include measurable goals and objectives for all spheres of veteran social, economic, and health and wellbeing outcomes. Federal resourcing should not only facilitate public-private partnerships at national, state, and local levels to deliver the full continuum of resources, services, and solutions to advance veteran outcomes, but also include resources to collect data and measure the effectiveness and impact of services.

In the non-governmental sector, educational institutions and employers each also have a role to play. In partnership with the Department of Defense (DOD), Department of Veterans Affairs (VA), and the Small Business Administration (SBA), corporate America should recommit and act to codify a new era in veteran and military spouse employment by improving recruiting, hiring, onboarding, integration, development and retention of veterans and their spouses. Leaders in higher education must foster a national effort for veteran recruiting, admissions, on-campus interaction, and education and career placement success. Both sectors must ensure men-

tal health resources, peer-to-peer networks and environments that leverage and values veterans while promoting treatment seeking behaviors for those in need.

By setting the conditions for veterans to thrive across and within all settings we promote holistic wellbeing and life of continued purpose, belonging, and identity. Developing and acting on a cohesive national blueprint would ensure successful transitions across the lifecycle, as well as promote more effective and sustainable crisis response efforts to not only suicide prevention but, homelessness, chronic unemployment, substance abuse, and other mental health conditions.

2. Reduce Barriers and Increase Access to Effective Mental Health Care

As you know, some of our warfighters return home or leave the military with a visible injury. Many come home with invisible wounds of war—both physical (Traumatic Brain Injury [TBI]) and psychological (Post Traumatic Stress [PTS]). Mental health conditions (inclusive of the invisible wounds), substance abuse, and access to lethal means are critical factors that contribute to veteran suicide.[2] While most servicemen and women return home without any injuries or recover successfully from these conditions, the number of post-9/11 veterans experiencing the invisible wounds has been high compared to historical rates. At any given time, as many as 10%–20% of servicemembers who have deployed to Iraq and Afghanistan experience symptoms consistent with PTSD.[3] Since 2001, more than 383,000 have been diagnosed with TBI.[4] Some veterans may also experience comorbid conditions like depression or anxiety.

Although evidence-based treatments exist for the invisible wounds of war, barriers to seeking or accessing high-quality care include: stigma about seeking help, difficulty navigating a confusing landscape, and limited capacity of effective mental health care.[5] Below, I outline two specific methods for reducing barriers and increasing access to mental health care:

2a. Improve Connections to Care through Peer Networks

Veteran and military culture and perceived societal stigmas still serve as significant barriers to care seeking behavior. We know from our research that 8 out of 10 post-9/11 veterans think that embarrassment or shame is an extreme or moderate barrier to seeking care for conditions such as PTS or TBI.[6] Less than 50% of those who need care seek care for their issues, and less than 50% of those receive an evidence-based care.[7] Our research also indicates that over 80% of veterans indicate concern of family, employer, or educator reaction as a barrier to seeking care.[8]

Veteran peer-based organizations can help to reduce these barriers to access and better connect veterans to care. As a promising practice, the Bush Institute established the Warrior Wellness Alliance to increase the number of Warriors seeking and accessing comprehensive and effective care, improve the delivery of effective high-quality care, and increase accurate awareness and understanding of invisible wounds and their impact. The Alliance links peer-to-peer veteran networks with effective clinical care providers so that ultimately more veterans get the care they need.[9]

In addition to serving as critical assets to facilitate connection to quality care, peer-based organizations can also serve to address other key aspects of suicide prevention. These veteran peer-based organizations can help to empower members pro-

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[2] Department of Veterans Affairs, National Strategy for Veteran Suicide Prevention, 2018

[3] Ramchand et al., Prevalence of, Risk Factors for, and Consequences of Posttraumatic Stress Disorder and Other Mental Health Problems in Military Populations Deployed to Iraq and Afghanistan; Curr Psychiatry Rep (2015) 17:37; DOI 10.1007/s11920–015–0575-z

[4] Department of Defense Worldwide Numbers for Traumatic Brain Injury, available at https://dvbic.dcoe.mil/dod-worldwide-numbers-tbi

[5] Matthew Amidon, Christopher Lu, Miguel Howe, Dr. James Kelly, Dr. Charles Marmar, and Terri Tanielian, *Addressing the Invisible Wounds of War: Creating a Collaborative Tomorrow*. Dallas TX: George W. Bush Institute http://gwbcenter.imgix.net/Resources/gwbi-addressing-invisible-wounds.pdf

[6] Confronting the Invisible Wounds of War: Barriers, Misunderstandings and a Divide. Dallas TX: George W. Bush Institute. https://gwbcenter.imgix.net/Resources/GWBI-invisiblewounds perceptionssurvey.pdf

[7] Tanielian, Terri and Lisa H. Jaycox, eds., Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery. Santa Monica, CA: RAND Corporation, 2008. https://www.rand.org/pubs/monographs/MG720.html

[8] Confronting the Invisible Wounds of War: Barriers, Misunderstandings and a Divide. Dallas TX: George W. Bush Institute. https://gwbcenter.imgix.net/Resources/GWBI-invisiblewounds perceptionssurvey.pdf

[9] Warrior Wellness Alliance: Connecting Best-In-Class Health care Providers and Peer Veteran Networks https://www.bushcenter.org/publications/resources-reports/reports/invisible-wounds.html Dallas TX. George W. Bush Institute

moting use of self-care skills, improving identification of individuals at risk, and promoting their member awareness of acute crisis response and intervention tools and resources. All of these efforts are part of comprehensive suicide programs.[10] Peer organizations can also help educate their members on the benefits of healthy lifestyles—better sleep, fitness and diet, and reduced alcohol use—to reduce suicide risk. Peer-based organizations can also raise awareness of the dangers of firearm access for those veterans at elevated risk and in acute crisis, and promote safe storage and removal when necessary.

To increase numbers of warriors seeking and accessing care, Federal, state, and community leaders should empower all veteran peer-based organizations and nonprofits, health care providers, and community organizations that foster effective connectivity and referrals. Congress should authorize and appropriate Federal grant funding to support infrastructure requirements for organizations conducting peer referrals to VA mental health care, and referrals back to peer-based organizations upon completion of clinical care.

To ensure effectiveness of services, accountability of outcomes, and better understand the veteran population and their needs, Congress should mandate the use of common data, measurement and evaluation elements for recipients of Federal aid. All recipients of Federal grants that support veterans in the community should be required to adhere to common data collection on individuals and population served-requirements that should be defined by and reported to the VA. Reporting should also include not only outputs of services provided, but impart of services provided, and most importantly outcomes for the population served. Federal grants should include resourcing that supports infrastructure required for data collection, storage and analysis, and Federal contracts must be awarded only to those entities who are able to commit to the common data elements established by the VA.

2b. Foster Meaningful Community Coordination and Partnerships

Connection to comprehensive services and solutions is most essential at the community level. Congress should provide additional resourcing and oversight to successful public-private partnership opportunities as a mechanism to connect veterans to high-quality health care and needed social support and basic services at the local level.[11] Congress should ensure adequate funding for infrastructure and connectivity to the full continuum of health and social services at the local level, inclusive of community, state, tribal, and Federal providers, as well as appropriate non-governmental entities. The VA, supported by other agencies, should provide appropriate infrastructure to facilitate meaningful partnerships and provide access to national level resources, services, and solutions, while improving integration and coordination of effort across all sectors, from the national to the community level. Such an effort can better facilitate local and state connectivity and coordination of Federal resources, programs, and services.

In order to maximize current grant funding in support of veteran services, Congress should consider repurposing Support Services for Veteran Families (SSVF) that focus primarily on ending homelessness, and consolidate that program with new community-based grants to more broadly support the full continuum of economic and health and human service needs in community-based networks that support My-VA communities.

Again, these recipients should be held to the standards of accountability as outlined above through the use of common data measurement and evaluation. Federal grants should include resourcing that supports infrastructure required for data collection, storage, and analysis.

3. Improve Access to and Delivery of High-Quality Mental Health Care for Veterans

Given that one of the most effective approaches to preventing suicide is the receipt of effective mental health care and substance abuse treatment, we must do more to ensure the delivery of high-quality mental health care in our Nation. Demand for effective mental health care exceeds capacity. Nationwide, there is a shortage of mental health providers. In the U.S., 60% of counties are without a psychia-

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[10] Ramchand Rajeev, Joie D. Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin. *The War Within: Preventing Suicide in the US Military*. https://www.rand.org/pubs/monographs/MG953.html CA: RAND Corporation, 2011

[11] Pedersen, Eric R., Nicole K. Eberhart, Kayla M. Williams, Terri Tanielian, Caroline Batka, and Deborah M. Scharf, Public-Private Partnerships for Providing Behavioral Health Care to Veterans and Their Families: What Do We Know, What Do We Need to Learn, and What Do We Need to Do? Santa Monica, CA: RAND Corporation, 2015. https://www.rand.org/pubs/research_reports/RR994.html.

trist.[12] And, we know very little about the quality of care provided by mental health professionals in the private sector. Only 13% of community-based mental health providers are ready to deliver culturally competent, evidence-based care to veterans confronting the invisible wounds.[13] Congress should continue to support programs that increase the number of clinicians in the community who can provide effective mental health care.[14] Education and training resources, many funded by the VA, Department of Defense, and the philanthropic sectors, are available to community providers, but are not frequently used. Incentive programs encouraging community providers to take advantage of these available training resources could help to improve the workforce capacity to deliver high-quality services to veterans with mental health conditions.

Public-private partnerships can help bridge the gap in access to high quality behavioral health care and connect more veterans to care.[15] These partnerships can also link veterans to effective social services wherever they exist, to both better treat veterans and their families, and address all of the social determinants of health that should be incorporated into a comprehensive strategy for suicide prevention. Health care providers, nonprofits, and community organizations all working to advance health and wellbeing must improve and streamline service delivery and improve integration and coordination effort across all sectors, from the national to the community level. The VA should set appropriate quality standards and apply them consistently across all care delivered and furnished by the VA and their funded community providers. Research indicates that veterans who receive evidence-based mental health care make fewer visits to the doctor in the next year.[16] This data indicates that veterans not only feel better, but it also saves money and reduces the overall cost to society.[17] Demanding consistently applied high-quality standards across the public and private sectors in order to receive Federal reimbursement would help to elevate the quality of mental health care available in this country.

Challenges exist in finding, connecting, and ensuring completion of high-quality mental health care for some segments of the veteran population. The VA should use existing data and innovation to develop a consumer driven approach to mental health care to increase engagement in treatment and improve outcomes for all veterans, not only those veterans who are engaged directly with the VHA, peer networks, or community-based efforts. While there are innovative predictive analytics efforts that are underway to identify veterans who may be at risk earlier and with greater precision than clinical assessment (such as VA's REACH VET program), these existing efforts are only using data available from within the health care system, which is limited. Meanwhile there is a burgeoning research base that provides great hope that nonclinical data, such as social media and fitness tracker data, can be leveraged to identify veterans who may be at risk for suicide and months in advance before a downward spiral ensues. Research projects that are currently underway such as Our Data Helps,[18] and our own Warriors Connect,[19] are examples of best practices in how this type of data can be leveraged ethically for mental health and suicide prevention research ethically. In addition, although 14 of the veterans who die by suicide every day are not engaged in VHA, there are significantly more veterans who are engaging with VBA, Department of Labor, and other non-health care sources of support across the Federal sector, and we recommend that innovative data science solutions that harness the power of existing available data be utilized.

Finally, Congress and the Administration must also work toward full parity in benefit coverage and reimbursement between physical and mental health care. The Mental Health Parity Act of 2008, which was signed by President George W. Bush, attempts to prevent health insurers from providing less favorable benefits for men-

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[12] American Medical Association, 2017

[13] Terri Tanielian, Coreen Farris, Caroline Batka, Carrie M. Farmer Eric Robinson, Charles C. Engel, Michael Robbins, and Lisa H. Jaycox, *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families*, Santa Monica Calif.; RAND Corporation, RR–806UNHF, 2014 (https://www.rand.org/pubs/research_reports/RR1542.html)

[14] Martsolf GR, Tomoaia-Cotisel A, Tanielian T. Behavioral Health Workforce and Private Sector Solutions to Addressing Veterans' Access to Care Issues. *JAMA Psychiatry*. 2016;73(12): 1213–1214. doi:10.1001/jamapsychiatry.2016.2456

[15] Terri Tanielian, Lisa S. Meredith, Caroline Batka, *Bridging Gaps in Mental Health Care, Lessons Learned From the Welcome Back Veterans Initiative*, Santa Monica Calif.; RAND Corporation, RR–2030-MTF, 2017 (https://www.rand.org/pubs/research_reports/RR2030.html)

[16] https://www.ncbi.nim.nih.gov/pubmed/23148769

[17] https://academic.oup.com/milmed/article/178/1/95/4210920

[18] https://OurDataHelps.org

[19] https://WarriorsConnect.OurDataHelps.org

tal health needs. Unfortunately, insurers have not been held accountable for successfully implementing mental health parity. Mental health care providers in the field indicate that over 10 years later, they continue to experience significant challenges with reimbursement for the quality care they deliver, and many ultimately resort to only accepting private pay.

CONCLUSION

An integrated approach to address all risk factors for a successful veteran transition—benefits, housing, education, economic opportunity, and quality health care -will not only better reduce risk for suicide, homelessness, substance abuse, and unemployment, it sets the conditions for veterans to thrive. To do so, and to maximize national resources, we recognize that more must be done to establish a common vision for veteran services, especially across Federal agencies and the full continuum of care, that promotes collaboration and instills a culture of accountability and measurement for not only the government, but for nonprofits and communities serving veterans.

We know that not enough veterans are seeking and accessing the care they need to treat the invisible wounds. Eight out of 10 post-9/11 warriors say that embarrassment or shame is a barrier to seeking out care. Some simply don't believe that effective care exists. And others believe that asking for help will impact their future successes, career and education opportunities, access to security clearances, or future deployments.

The reality is that most warriors will not seek care from the VA. Public-private partnerships help bridge the gap. And there are examples of these partnerships already at work. When the Bush Institute recognized the need to connect veteran peer networks, which instill purpose, camaraderie and reduce stigma, with best in class clinical care providers, we created the Warrior Wellness Alliance. I'm glad that the VA is a partner with us on those efforts. With community collaboration, clearer data, and a leading strategy, we can better serve our veterans, while maximizing national effort and resourcing.

We must improve access to, and delivery of quality mental health care for active duty servicemembers, veterans, and their families. The Administration, Congress, and the VA should focus the full weight of the Federal Government on enforcing quality standards, and partnering with private, nonprofit, and philanthropic sectors to identify thorough solutions for providing effective care. Community-based collaboratives, such as those piloted by America's Warrior Partnership, Combined Arms, America Serves, San Diego 211, and many others are promising practices for how to better connect our veterans and their family members to the full continuum of health and social services at the local level.

For us, this status quo is not acceptable. Effective treatments are available, and we must reduce the barriers that veterans face in seeking and receiving high-quality care. The risks otherwise are too great.

When I was a young Lieutenant, my communications section chief, Sergeant First Class Terry Dennis, a Gulf War and Panama Invasion veteran who was the strongest man in our unit, died by suicide. Two years ago, one of my 7th Special Forces Group Green Berets Sergeant First Class Josh Burnette, a double amputee who struggled with his visible and invisible wounds, and all aspects of his transition, died by suicide. So, for me, like many of us here today, veteran suicide is not only very real, but personal.

I'll leave you with Corporal David Smith's story. He served in the Marine Corps during two deployments to Iraq. Afterward, he experienced severe PTS. He came home drunk one night and stared down the barrel of a shotgun, contemplating his own suicide.

Thankfully Dave put the gun down. With support from family and friends, he sought professional counseling and treatment. He graduated from the University of California at Berkeley. He found new purpose volunteering with Team Rubicon and connecting with other veterans while mountain bike riding with President Bush and our own Team 43. Dave's married now, has a fulfilling career, and welcomed a baby girl last year.

Dave's experience is proof that all veterans can live a meaningful life and thrive. His story must be the rule and not an exception. I'm encouraged by the work you all are taking on now to help us ensure that and save lives.

Thank you again for inviting me to testify today. I look forward to your questions.

Senator TESTER. Thank you, Colonel.

Dr. Haynie.

STATEMENT OF J. MICHAEL HAYNIE, Ph.D., EXECUTIVE DIRECTOR, INSTITUTE FOR VETERANS AND MILITARY FAMILIES

Mr. HAYNIE. Thank you, Ranking Member Tester, Chairman Isakson, and the Members of the Committee. I would like to start by thanking you for your work on behalf of America's veterans and their families, and more immediately for the opportunity to be here today.

I am an Air Force veteran myself and I am here today representing Syracuse University's Institute for Veterans and Military Families (IVMF), the only academic institute of its kind in the Nation, focused exclusively on the post-service lives of our veterans and military-connected family members.

In addition to the Institute's research mission, we serve veterans through vocational and community coordination programs across the United States. This year alone, these programs will assist more than 25,000 servicemembers and veterans in the transition out of uniform, and toward civilian careers, schools, and communities.

Most simply, the point is that the transition experience for servicemembers and their families is the mission of our institute, and I emphasize that mission here to highlight that one of the most consistent findings stemming from our work and our scholarship is the powerful and enduring linkage between the lived transition experience of servicemembers and their families, and the overall well-being and mental health of our veterans. In other words, "getting transition right" is central to ensuring long-term wellness and mental health of our veterans.

Alternatively, a negative transition experience is highly likely to position a veteran—and, by extension, their family—on a trajectory of compromised wellness and mental health, from which our experience suggests it is difficult to recover.

Today, given this context, I would like to address efforts to meaningfully engage the communities where our veterans live, work, and raise their families, as partners in a national effort to address the compromised mental health and suicidal acts and ideations among our veterans.

Research conducted by the IVMF focused on the transition experience of more than 8,000 post-9/11 servicemembers, found that effective and efficient navigation of available services, resources, and benefits to be the most commonly cited challenge associated with the transition from military to civilian life. To be clear, that is saying it is not finding a job, it is not finding a school, it is not relocating. It is navigating the help they need, when they need it, in the communities in which they live, they cite as the most significant challenge they face in the context of transition.

There are several additional insights that we glean from that research, first that the mental health of our veterans is powerfully impacted, beyond clinical care, by the many social and economic determinants of well-being, including access to resources that help veterans meet basic human needs like food, safety, and shelter; pathways to vocational success and career fulfillment; and positive connections with family, friends, and the broader community they call home.

Second, that in the majority of communities across the U.S., the existing base of public and private-sector resources positioned to

provide social services to veterans is already well positioned. However, those resources are either unknown to veterans or the community-based providers lack the ability to offer culturally-competent care to veterans in their community.

Taken together, we recognized that creating an accessible and accountable means to navigate veterans to the help they need, when they need it, within their own communities, could serve to blunt those social and economic factors linked to compromised mental health. That single insight was the seminal motivation for the Institute for Veterans and Military Families to launch an innovative community care coordination program called AmericaServes.

The AmericaServes initiative is based on the simple idea that if existing community-connected social service providers were organized into an interconnected system of social service provision, a veteran accessing any individual resource would instead access a comprehensive continuum of resources and care.

Today I am proud to say that in 16 communities across the U.S., including New York City, Pittsburgh, San Antonio, Dallas, and across the entire State of North Carolina, the IVMF's AmericaServes provider networks represent the backbone infrastructure supporting community-care coordination, aligning almost 900 community providers to address what, over the course of the last 3 years, has now been 52,000 requests for support from veterans across the network.

AmericaServes community networks are launched in partnership with the communities that they serve and supported by local and national funders. In Pittsburgh, it is the Heinz Endowment. In North Carolina, it is Walmart and the North Carolina State Department of Health and Human Services. In New York City, early support came from the Robin Hood Foundation, and the success of that network generated funding from the city of New York.

The networks themselves are typically comprised of, on average, 40 to 50 local social and clinical service providers, that include the VA medical centers and Vet Centers in many cases. And, each of these networks, at its core, is a Care Coordination Center, which acts as the "Quarterback," navigating the veteran within the network and leveraging robust networks to provide performance accountability for providers in the network.

The networks use HIPAA-compliant care coordination technology to streamline referrals between providers in the network and connect veterans directly to in-network providers who are able to meet their needs. Providers are able to securely share protected client information and case referrals through the technology. The care coordination models solve the problem most commonly cited by veterans, which is navigation.

For time, Miguel told two very compelling stories. I am going to skip my stories for time. But, I do want to end with highlighting that in this era of all-volunteer military, it is, in my experience, a false and too-closely-held assumption that it is the VA's responsibility alone to serve and support the post-service lives of our veterans and their families.

One real consequence of that assumption is the significant social and cultural divide present between those who have served and those who have not, and that divide really does serve to foster,

among some veterans, a feeling of social isolation and disconnectedness, which, in turn, is directly linked to the mental health challenges and the suicide numbers that have been cited throughout this hearing.

It is my hope that we engage comprehensively local community-connected providers, nonprofits, local government, cities, and counties in a national effort to address this crisis.

Thank you very much.

[The prepared statement of Mr. Haynie follows:]

PREPARED STATEMENT OF J. MICHAEL HAYNIE, PH.D., VICE CHANCELLOR FOR STRATEGIC INITIATIVES AND INNOVATION, FOUNDER AND EXECUTIVE DIRECTOR, INSTITUTE FOR VETERANS & MILITARY FAMILIES, SYRACUSE UNIVERSITY, SYRACUSE, NY

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND THE MEMBERS OF THE COMMITTEE, I'd like to start by thanking you for your work on behalf of America's veterans and their families, and more immediately for the opportunity to address you today on the subject of "Harnessing the Power of Community: Leveraging Veteran Networks to Tackle Suicide."

I'm here today representing Syracuse University's Institute for Veterans and Military Families, the only academic institute of its kind in the Nation, focused exclusively on the post-service lives of our veterans and military-connected families. In addition to our research mission, the IVMF serves veterans through vocational and community coordination programs across the United States. This year alone, these programs will assist more than 25,000 servicemembers and veterans in the transition out of uniform, and toward civilian careers, schools, and communities.

Most simply, improving the transition experience for servicemembers and their families *is the mission* of the IVMF. I emphasize that mission here, as a means to highlight that one of the most consistent findings stemming from our work and scholarship, is the powerful and enduring linkage between the lived transition experience of servicemembers and their families, and the overall wellbeing and mental health of our veterans.

'Getting transition right' is central to ensuring long-term wellness and mental health. Alternatively, a negative transition experience is highly likely to position a veteran—and by extension, the veteran's family—on a trajectory of compromised wellness and mental health, from which our experience suggests it is often exceedingly difficult to recover.

Today, given this context, I'd like to address the efforts to meaningfully engage the communities where our veterans live, work, and raise their families, as partners in a national effort to address compromised mental health, and suicidal acts and ideations, among our veterans.

Research conducted by the IVMF, focused on the transition experience of more than 8,000 post-9/11 servicemembers, found that effective and efficient navigation of available services, resources, and benefits to be the most commonly cited challenge associated with the transition from military to civilian life. In addition, this early research also opened the door to two additional and less understood truths informing the relationship between transition, community, and mental health.

First, that the mental health of our veterans is powerfully impacted by the many social and economic determinants of well-being, including access to resources that help veterans meet basic human needs like food, safety, and shelter; pathways to vocational success and fulfillment; and positive connections with family, friends, and the broader community they call home.

Second, that in the majority of communities across the U.S., the existing base of public and private-sector social service providers is already well-positioned to improve the mental well-being for our veterans. However, often those resources are either unknown or inaccessible to veterans, or the community-based providers lack the ability to offer culturally competent care to veterans in their community.

Taken together, we recognized that creating an accessible and accountable means to navigate veterans to the help and support they need, when they need it, within their own community, could serve to blunt those social and economic factors linked to compromised mental health. This single insight was the seminal motivation for the IVMF team to launch an innovative community care coordination program called AmericaServes.

The AmericaServes initiative is based on the simple idea that if existing community-connected social service providers were organized into an inter-connected system of social service provision, a veteran accessing any individual resource would

instead access a comprehensive continuum of resources and care. Today, I'm proud to say that in 16 communities across the U.S.—including New York City, Pittsburgh, San Antonio, Dallas, and across the entire state of North Carolina—the IVMF's AmericaServes provider networks represent the backbone infrastructure supporting community-level care coordination, aligning almost 900 individual providers to address what more than 52,000 requests for support from veterans across the network.

AmericaServes community networks are launched in partnership with the communities they serve, and supported by local and national funders. In Pittsburg, it's the Heinz Endowment. In North Carolina, it's Walmart, and the State Department of Health and Human Services. In New York City, early support came from the Robin Hood Foundation, and the success of the network generated funding from the City.

The networks themselves are typically comprised of, on average, 40–50 local social and clinical service providers, to include VA medical centers and Vet Centers in many cases. At the center of each AmericaServes network is a Coordination Center, which acts as the network's "Quarterback"—navigating the veteran within the network, and leveraging robust network performance data to hold providers accountable on behalf of the veteran.

AmericaServes utilizes a HIPAA-compliant care coordination technology platform to streamline referrals between participating providers, and to connect veterans directly to in-network providers who are able to meet their unique needs. Providers are able to securely share protected client information through case referrals, enabling an integrated and transparent system of local support and care. The care coordination center model solves the veteran's most compelling problem: navigation. The most powerful way to make that point, is through the voice of a veteran.

Nathan transitioned from the U.S. Army with significant disabilities stemming from service in both Afghanistan and Iraq. Not long after his transition, Nathan found himself in need of immediate assistance that the VA was unable to provide. At the time Nathan contacted the TXServes care coordination center, he was a single father, homeless, and unemployed. Because of his homelessness, Nathan's young son had recently been placed into state-sponsored care. The TXServes care coordination center conducted a holistic assessment of Nathan's situation, and shared a detailed accounting of Nathan's co-occurring needs across the North Texas provider network. The immediate task was to stabilize Nathan's situation. Nathan was connected to a provider able to secure him temporary housing, and referred to another who found Nathan a temporary, living wage job. At the same time, other TXServes providers began working with Nathan to access and secure his VA benefits, and to engage local workforce development programs on Nathan's behalf. Through this continuum of coordinated care, Nathan was able to secure permanent housing, and receive training that landed him a job at Dell Computer in Austin, TX—and most importantly, as a result, reunite with his son. Nathan says that TXServes literally saved his life, in part because he only had to tell his story one time—to the TXServes care coordination center—and that initial storytelling engaged a network of more than 50 local providers, each working in concert on Nathan's behalf.

Nathan's story—unfortunately—is not unique. In fact, Nathan's story represents one of the most persistent and compelling challenges facing our veterans; that is, inadequate coordination and insufficient collective purpose among public, private, and social sector organizations that purport to serve this community.

In the era of an all-volunteer military, it is a false but too closely held assumption that it is the VA's responsibility alone to serve and support the post-service lives of our veterans and their families. One consequence of that assumption is a real and significant social and cultural divide, present between those who have served, and those who have not—a divide that serves to foster among some veterans a feeling of social isolation and disconnectedness. Social disconnectedness, in turn, is directly linked to compromised mental health and suicide among veterans. Too often, well-intentioned policy fails to leverage opportunities to purposefully engage the community of non-public sector providers, for the specific purpose of 'building community' in a way that fosters social and community connectedness among veterans. Importantly, engaging the veteran-serving community, by itself, is not enough. While it is true that there are more than 40,000 nonprofit service providers in the military-connected space, many have evolved to become narrowly focused and increasingly siloed. Consequently, many of these organizations fail to purposefully engage the broader community of human service providers, in a way that fosters social and community connectedness among veterans.

It is my view that any holistic strategy positioned to support the overall mental wellbeing of our veterans, must include engaging the communities where our veterans live, as partners and stakeholders in our effort. To "Harness the Power of

Community" as a strategy to tackle veteran suicide requires that government, industry, and non-profit partners act together to create accessible pathways connecting veterans and their families to community-connected services and support representing the full continuum of social and economic determinants of wellbeing. Acting on this opportunity need not be exceedingly complicated, or costly. Examples of how this engagement could proceed include specific grant funding to support care coordination and navigation services in local communities; enhanced opportunity for community organizations and non-profit providers to access military cultural competency training; and support for community-level resource mapping, aligned with the objective of enhancing information available to veterans related to providers of social and human services within a given community. Investments like these will enhance and extend the impact of funds this Committee has already directed toward clinical interventions and, most importantly, best serve the enduring mental health concerns of our veterans and their families.

On behalf of the veterans and military-connected families the IVMF serves in partnership with this Committee, thank you for the opportunity to provide testimony today.

Senator TESTER. Thank you, Dr. Haynie.

Jessica Kavanagh.

STATEMENT OF JESSICA KAVANAGH, FOUNDER AND PRESIDENT, VETLINKS

Ms. KAVANAGH. Good afternoon Chairman, Ranking Member, and Members of the Committee. Thank you so much for having me here today. I am grateful for the opportunity to speak on behalf of my late husband, Major Brian Kavanagh, our two young children, Meryn and Evie, who are 7 and 5, and the millions of veterans and families who deserve access to care and benefits. In addition, I am pleased to be here to represent VetLinks.org and the many community-based organizations, particularly those in rural communities, that support veterans trying to navigate the VA system, and who need our advice and resources to get that help.

Brian was diagnosed with Post Traumatic Stress in December 2011. In May 2014, we realized that he needed serious help for his Post Traumatic Stress and substance abuse. We went to our VA doctor and to our VA social worker, who both had no recommendations of where to send him for inpatient treatment.

So, I looked on the Internet, scouring it for hours and hours, and all I could find were places that were private for $30,000 to $50,000—nothing that we could afford—until I found a place locally here, the Washington Institute of Psychiatric Care, where I sent my husband, who was an infantry officer, to a psych unit for 2 weeks, with 14 other women who were raped and sexually assaulted as children. Obviously, I knew that was not the right place to go but we were desperate and needed help.

Fast forward to July 2015. He was not getting any better. We were paying for private care at that point, for a full year. I called the VA and they put him on a six-week—late time for a mental health care appointment, which ironically fell on September 11, 2015. We went and saw our social worker. We explained the situation again, how his substance abuse and Post Traumatic Stress was not getting any better. We were in dire need. He was not working at that point. All she could offer was the psych unit at the Baltimore VA.

I went home. We were both just very defeated, very frustrated with the system. I started making phone calls to VAs across the country to see what other specialized programs they had, and not

one VA called me back. I was calling vet advocates, until someone called me from Houston and said, "I have heard your story from multiple people. There is a VA Committee hearing on October 7, 2015. Secretary Bob McDonald, at the time, was going to be there. You should go."

I went. I went up and introduced myself to Mr. McDonald, and he helped me get Brian into the Martinsburg VA inpatient unit.

While Brian was there he was coming across other veterans who were not getting the benefits they were entitled to. That is where the idea of VetLinks.org was created, to help other veterans navigate through the system to get the help that they needed and deserved.

When he was discharged he was sent to a Vet Center that could help him with one trauma appointment once every 3 to 4 weeks. We went back to private care for Brian, paying for someone to help him twice a week, along with myself, paying for care once a week. We were turned down for caregiver support multiple times.

Then, on June 28, 2016, Brian ultimately lost his battle to Post Traumatic Stress, and it was then, during the eulogy, that I vowed to carry on his mission for VetLinks.org to help. Even if it was just one family to not have to live through the hell that we did, we were going to do it.

So, we started VetLinks.org, and now we help not just the veteran but the caregiver and the family, and we get them the immediate help that they may need for post-traumatic stress, substance abuse, or TBI, in the immediate fashion, and we pay for those services as well. We have partnered with Code of Support. They are a great organization as well, locally. With their peer navigators we are able to help the veteran and the family members walk through the entire process, from A to Z, whatever help they might need, and again, while paying for those services.

So, we still have a lot of work to do. I think we all have a lot of work to do. We are sending these men and women to war, they are doing their jobs, and we need to do ours to help them in an immediate fashion for mental health care. We all know there are still 20 suicides a day, and we are not even counting the statistics for caregivers or children who are also committing suicide.

So, as we have all sat here today there has been one more family affected and now is going through pure hell, just like our family.

[The prepared statement of Ms. Kavanagh follows:]

PREPARED STATEMENT OF JESSICA KAVANAGH, FOUNDER & PRESIDENT, VETLINKS

TO THE COMMITTEE ON VETERANS' AFFAIRS, I'm writing to you today on behalf of my late husband, MAJ Brian Kavanagh. Brian was commissioned through the Reserve Officer Training Corps as a Second Lieutenant in the Infantry branch of the Army. As a 2nd LT, Brian completed the Ranger School and was assigned to Bravo Company, 1/8 Infantry, 3rd Brigade, 4th Infantry Division. As a Platoon Leader, Brian led in garrison and combat, receiving two Bronze Stars for actions during his first deployment in Iraq. During his time with 1/8 Infantry, he was promoted to 1st Lieutenant and then Captain. CPT Kavanagh transitioned to the Military Intelligence Branch and served as an Intelligence Advisor to the Afghanistan Army where he received another Bronze Star for actions in combat. Brian finished his Active Duty career as the Company Commander for Alpha Company, 308th Military Intelligence Battalion, 902nd Military Intelligence Group where he earned the Meritorious Service Medal for his service to both Alpha Company and the Aberdeen Proving Ground Military Intelligence Detachment. Brian transitioned to the US Army Reserves and was promoted to the rank of Major. He was activated to serve

as the Chief of Joint Operations for the Joint Reserve Intelligence Support Element to the United Stated Africa Command J2—Intelligence Directorate.

I met Brian in August 2009 after he started command of Alpha Company at Aberdeen Proving Ground. Roughly two years later we got married in June 2011. In December 2011, Brian was diagnosed with PTS and was placed on medications for depression, anxiety, and sleep problems including a particularly disturbing pattern of nightmares. After Brian's initial diagnosis and treatment for PTS while on Active Duty, his symptoms steadily worsened. When Brian transitioned from active service into Federal Government service we sought treatment with a Psychiatrist within the Maryland VA system. We were assigned a social worker at a local Veteran Center where Brian had regular sessions along with couple's therapy. Despite what we thought were our best efforts to manage Brian's symptoms for PTS, they continued to worsen.

In May 2014, Brian acknowledged that he needed something more intensive as his symptoms were getting worse. We asked our VA counselor for recommendations, and they were unaware of where to direct Brian for inpatient help. I called the Veterans' crisis hotline, but they said that if he was not suicidal, they were unable to assist. As I researched for an inpatient unit that would be able to help Veterans' with PTS and substance abuse, I found that nothing seemed to exist. Every Google search came back to "VA Health System," except our social worker at the VA was not even able to provide a location. I ended up finding a place in Washington DC, the Psychiatric Institute. It did not seem to be the right fit for Brian, but we were desperate in our efforts to find anything to help his symptoms ease. For two weeks, Brian stayed at this location with 14 women who suffered PTS from sexual assault. Upon discharge, Brian started with a private practice for further therapy hoping different professionals would be able to help. Our family paid out of pocket for this private treatment.

Fast forward to July 2015, Brian was unable to continue working. He was severely depressed, would lay in bed for days if not weeks, and his symptoms were becoming unmanageable. We saw his primary care doctor at the VA, and with the request to see a mental health professional to discuss further options, we were given a 6 week wait time.

Meantime, I continued my research to find inpatient units that specialized in PTS and substance abuse, specifically for Veterans. Little came to fruition except for a few private locations around the country that all required cash payments.

On September 11th, when we finally had our highly anticipated appointment with the VA social worker, I told her of these private practice locations that might be able to help. She said that she would have no way of getting Brian a referral to any of those facilities, but could get him a consult so that he could go into the Psych Unit at the Baltimore VA. We felt very defeated and left feeling as if we were back at square one.

By this time, I made it my full-time job to start calling Veterans' advocates and anyone who would listen to me to try to get Brian the help he needed. I started calling VA Centers across the United States to see what specific programs they had for PTS and substance abuse disorder. Not ONE VA center returned my call. I spoke with one veteran advocate who let me know about a new program called the Choice program. I called the number they provided me, and they let me know that Brian was not eligible. I called the Baltimore VA multiple times until I finally spoke with someone, and they let me know that the Choice program did not cover inpatient facilities, only doctor's appointments that had a 30 day wait time or had a distance further than 40 miles from the closest VA.

At this point, Brian was still not back to work, and we were both feeling hopeless. I received a phone call mid-September from a woman in Houston who had heard about our struggles from one of the many phone calls I had made. She let me know that there was going to be a VA Congressional Hearing and the former VA Secretary Bob McDonald was going to be there. She was flying in for the hearing and suggested that I go to try to meet him and ask for assistance. So, on October 7th, of 2015, that's exactly what I did. I introduced myself to Bob McDonald and told him our story along with the battles we were facing. He said "give me three days, and I will help you." Sure enough, a couple of days later, the Martinsburg VA called me and said they could get my husband into their program in 2–4 weeks. Needless to say, I called Mr. McDonald's cell phone after this and let him know their status after he promised me he could help immediately. The VA then called me back a couple of hours later that Friday, and on Monday I was able to get Brian enrolled into their program. I will pause to publicly thank Mr. McDonald for taking the time to personally help Brian.

The program itself lasted 90 days. It consisted of all group sessions and classes, no individualized care. Brian seemed to be doing well while he was there, and

seemed to enjoy being around other Veterans. While he was there, he realized that many of his fellow Veterans were not receiving a lot of the benefits that they had earned or were entitled to. Brian started holding classes there showing them with his laptop how to get set up for their benefits until he was told that he was not able to do this being a patient himself. He continued to do so anyhow. Over Thanksgiving, three weeks before his anticipated discharge, Brian was able to come home for the holiday. He had a complete relapse, and he did not do well being home with myself and our two girls (Meryn and Evie), 3 and 1 at the time. Our family priest had to take him back to Martinsburg early, and I was left with severe angst about his discharge in three weeks. When I spoke with the social worker after the holiday and expressed my concerns, she said there really wasn't anything more they could do, and that he had already almost competed all of the group sessions. We had an emergency family meeting, and his program lead ensured me that we would have a thorough discharge plan to help continue his progress.

On December 21st, Brian was discharged, and we were to start one-on-one trauma therapy sessions at the local Veteran Center. After starting in January, he was able to see the social worker there once every 3 to 4 weeks. The social worker explained that there were not enough resources, and that was all he could do for Brian. Brian also decided that he could no longer go back to work doing Counter Intelligence and officially resigned from his position. He decided based on what he experienced during his stay at Martinsburg that he wanted to start a Non-Profit and help Veterans find the immediate resources they might need and get them the benefits they may be entitled to. I thought that this was a great idea and stated that this should be for caregivers and the family as well, considering my own difficulties trying to find Brian help.

Brian's struggles continued. Seeing the social worker at the Veteran Center was not productive with the amount of time we were allotted. Through my own private therapist, I found Brian a trauma therapist who was a Vietnam Vet and had previously worked at the VA. We were paying for two sessions a week for Brian and one session a week for myself. And couples therapy when we could afford it. I applied for Caregivers support and was turned down. We were applying for increased disability for Brian and also turned down. Being able to "prove PTS" proved difficult. I reapplied for Caregivers support and was turned down again. I felt like I was fighting a war on the inside of our household and a war on the outside against the VA, all while working a full-time job and caring for our two young daughters.

On June 28th, 2016 Brian ultimately lost his battle to PTS. I received the phone call from the Baltimore police while driving down 95, and it was the worst moment of my entire life. My entire soul was shattered in the matter of an instance. Never once did I feel that it would have ended like this, we were always just going to continue our fight. While his life did not end with suicide, it was directly related to his PTS and substance abuse disorder.

During my eulogy, I vowed to continue the fight even if it simply meant saving just one family from the hell that we had to experience. The day after his funeral, I sat around with his best friends and told them of his desire to start a Non-Profit, and then and there in my living room VetLinks.org was created. I threw my grief into VetLinks.org, and we officially became a 501(c)3 on December 20th, 2016. A Christmas present from Brian.

VetLinks.org assists with helping the Veteran, the Caregiver, and family members get the immediate resources they might need, specifically for PTS, TBI, and Substance Abuse disorder while also paying for those services. We have partnered with Code of Support who offers Peer Navigators to each Veteran or Caregiver who calls in to walk them through the entire process and finding them their immediate resources they may need. VetLinks.org then pays for those services so the process is seamless and helps the Veteran and their family not incur any costs to getting the care they deserve.

To date, we have helped almost 30 families in need. One Veteran worked for the VA himself, was suicidal and suffered from PTS and alcoholism. The VA gave him a 6-week lead time, and we were able to get him into a private inpatient unit and pay for the treatment in two days.

I believe that I met Brian for a bigger purpose. But in a perfect world, VetLinks.org along with the thousands of other non-profits wouldn't have to exist if our government did their job taking care of our Veterans and Caregivers. I don't understand when less than 1% of our Nation selflessly serve our military why the rest of the 99% can't take care of these men and women. If we as a country are going to decide to send our men and women to WAR, we have got to do a better job taking care of them when they come home.

As I now close my remarks, I urge you with every fiber of my being to use your positions of influence within our government to allocate significant resources to help

our veterans, caregivers, and family members fight against the effects of PTS, TBI, and substance abuse disorder. Without your help, thousands of veterans and their families will continue to struggle. Please help me honor my late husband—MAJ Brian Kavanagh—and decide to take action—now.

Senator TESTER. Thank you for your testimony. I am sorry, but I actually have to go vote, General Quinn. Otherwise I will get shut out on this, so we have got to recess for a second. And, Chairman Isakson should be back here shortly.

We are in recess. Smoke them if you have got them. [Laughter.]

[Recess.]

Chairman ISAKSON. We are going to go ahead and start. I will bring us back to where we were. Jon will be here in just a second. Thank you for your patience. We are sorry, we had to vote, but we got them all done. There are no more votes tonight, so we are all yours for the rest of the night, if you want us, but I know you do not want us for the rest of the night, so we will get right to our business now.

Maj. Gen. Matthew Quinn, Adjutant General of the Montana National Guard.

General Quinn?

STATEMENT OF MAJ. GEN. MATTHEW T. QUINN, ADJUTANT GENERAL, MONTANA NATIONAL GUARD

Maj. Gen. QUINN. Good afternoon Mr. Chairman. I am Maj. Gen. Matt Quinn, Adjutant General and CDR of the Montana National Guard. I am here today to testify on actions the State of Montana has taken to protect our National Guard servicemembers, our Montana veterans, and their family members.

I have been the Adjutant General for just over 7 years and in that time we have lost 11 soldiers. We did not lose soldiers to combat. Rather, every tragic loss was due to death by suicide. Over half of our losses to suicide had never deployed, nor did they have the qualifying amount of active duty service for veteran eligibility. Only 33 percent of our current National Guard servicemembers qualify for VA care, so this was and continues to be a challenge that we had to solve as a State.

At the direction of Governor Bullock, Montana Departments of Military Affairs and Administration joined forces to determine potential resources available within Montana State government that could be used to support the National Guard women and men who serve our State and Nation. We have a servicemember living in every one of our 404 ZIP codes of Montana and we needed a benefit that would be convenient and accessible by any servicemember across the State.

Each employee of the State of Montana, through our State health insurance plan, is a participant in an employee assistance program designed to provide counseling services to the employees and their families or household members. The Department of Administration, working with employee assistant provider, EAP for short, determined that the benefit could be expanded to include every National Guard servicemembers.

In the fall of 2016, the State of Montana enrolled every member of the Montana National Guard in Montana's Employee Assistance Program. This benefit allows for in-person counseling services

across the State for any issue the servicemember or family member is facing, from alcohol, to job, family, financial, or deployment stressors, any issue which can be helped with counseling.

These visits are totally confidential; Montana National Guard leadership will not know who has sought counseling. I am encouraged by the number of Montana National Guard men and women taking advantage of the benefit, but additionally encouraged by the number of spouses and children of servicemembers seeking care.

After deploying the benefit, the first call received was from a former National Guard member who had served 30 years in the National Guard but did not have veteran eligibility. So, another call was made to the EAP provider, and shortly thereafter we rolled out the Veteran Assistance Program, or VAP.

VAP provides free counseling to any former servicemember or veteran within the State of Montana. Montana has the second highest per-capita percentage of veterans, and we are looking to not only provide support to those who had previously served our State in the National Guard, but also to augment the services provided by the Veterans Administration. Although the usage by former servicemembers is not great, several did utilize the benefit expressing an intent for self-harm. If one veteran or former servicemember is helped in a time of need and is stopped from making a final, fateful decision through this program, I will continue the advocacy, in spite of limited usage.

As a result of our work and the work of the cities of Helena and Billings in a VA Health and Human Services program titled The Mayors Challenge, Montana has been selected as one of seven States to participate in The Governor's Challenge. The Governor's Challenge is a collective effort with the Veterans Administration and Health and Human Services Administration's SAMHSA group to combat the loss to suicide of our veterans, servicemembers, and family members.

The effort in Montana has three primary objectives: (1) identify those citizens who have served or have family members who have served, (2) Provide universal screening to those individuals; and (3) connect veterans through a peer-to-peer support network. This effort is in its early stages but we are encouraged by the progress made so far to bring all of Montana's communities together to better support our veterans, our current servicemembers, and their families.

I will conclude with a thank you to Senator Tester and this Committee's work to allow for readjustment counseling services to our National Guard servicemembers at the Vet Centers across the Nation. Although a National Guard servicemember may not have served in a combat theater, many may be suffering from the traumatic stress of recovering neighbors from hurricanes, tornados, fires, floods, and landslides. When they leave a drill location at the conclusion of a weekend or an annual training period, they return to their communities potentially without the blanket of care provided by our Veterans Administration. I would encourage this Committee to recognize the service provided to our States and nation by our National Guard and continue to seek ways to care for those who serve.

Mr. Chairman, that concludes my testimony.

[The prepared statement of Major General Quinn follows:]

PREPARED STATEMENT OF MAJ. GEN. MATTHEW T. QUINN, ADJUTANT GENERAL AND COMMANDER, MONTANA NATIONAL GUARD

Good afternoon Mr. Chairman and Members of the Senate Veterans Affair Committee. I am Major General Matt Quinn, Adjutant General and commander of the Montana National Guard. I am here today to testify on actions the State of Montana has taken to protect our National Guard servicemembers, their family members, and Montana Veterans.

I have been the Adjutant General for just over seven years and in that time, we have lost 11 Soldiers. We did not lose Soldiers to combat, rather every tragic loss was due to death by suicide. After each death we looked at the possible mitigating factors leading to the suicide and in nearly every case there was a concern by the Soldier that if they sought help for depression or emotional issues they were dealing with, they would either not be allowed to deploy, or worse yet, would be removed from the Guard. Over half of our losses to suicide had never deployed, nor did they have the qualifying amount of active duty service for Veteran eligibility. Only 33% of our current National Guard servicemembers qualify for VA care, so this was and continues to be a challenge that we had to solve as a state.

At the direction of Governor Bullock, Montana military affairs and Department of Administration joined forces to determine potential resources available within Montana state government that could be used to support the National Guard women and men who serve our state and Nation. We have a servicemember living in every one of the 404 zip codes of Montana and we needed a benefit that would be convenient and accessible by any servicemember across the state. Each employee of the State of Montana, through our state health insurance plan, is a participant in an employee assistance program designed to provide counseling services to the employees and their families or household members. The Department of Administration, working with our EAP provider, determined that the benefit could be expanded to include our National Guard servicemembers. In the fall of 2016, the State of Montana enrolled every member of the Montana National Guard in Montana's Employee Assistance Program, or EAP for short. This benefit allows for in-person counseling services across the state for any issue the servicemember or family member is facing, from alcohol, to job, family, financial, or deployment stressors, any issue which can be helped with counseling. These visits are totally confidential; Montana National Guard leadership will not know who has sought counseling. I am encouraged by the number of Montana Guard men and women taking advantage of the benefit, but additionally encouraged by the number of spouses and children of servicemembers seeking care.

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As a result of our work and the work of the Cities of Helena and Billings in a VA/DPHHS program titled the Mayors Challenge, Montana has been selected as one of seven state to participate in the Governor's Challenge. The Governor's Challenge is a collective effort with the Veterans Administration and the Department of Public Health and Human Services Administration's Substance Abuse and Mental Health Services Administration to combat the loss to suicide of our Veterans, Servicemembers and Family members. The effort in Montana has three primary objectives: 1) Identify those citizens who have served or have family members who have served; 2) Provide Universal Screening to those individuals; and 3) Connect Veterans through a peer-to-peer support network. This effort is in its early stages but we are encouraged by the progress made so far to bring all of Montana's communities together to better support our Veterans and their servicemembers.

I will conclude with a thank you to Senator Tester and this Committee's work to allow for readjustment counseling services to our National Guard servicemembers at the Vet Centers across the Nation. Although a National Guard servicemember may not have served in a combat theater, many may be suffering from the trau-

matic stress of recovering neighbors from hurricanes, tornados, fires, floods, and landslides. When they leave a drill location at the conclusion of a weekend or annual training period, they return to their communities potentially without the blanket of care provided by our Veterans Administration. I would encourage this Committee to recognize the service provided to our states and nation by your National Guard and continue to seek ways to care for those who serve.

Mr. Chairman that concludes my testimony.

Chairman ISAKSON. Well, General, thank you very much. Jon did not get here. I guess he is still——

Anyway, I am sure you are proud of Senator Tester. He is a great Member of the Senate, does a great job and has worked a lot, tirelessly on the suicide program. And, many of the things you told me meant a lot and I am glad you are doing them, particularly involving the National Guard. I was a guardsman myself. Georgia is in that situation. We have a lot of National Guardsmen who have deployed many times, but some of them have not been deployed.

When Rumsfeld reformed the military, in the first couple of years under George W. Bush, he basically equalized benefits for Guard and Reserve units that were called up, which they were then repositioned to come up for the first time. In fact, the first people in Afghanistan and in Iraq, almost all the first people in there were Guardsmen, either for the fire, people at the airport, people of that nature.

The fact that you have tried to reach out to those who were not eligible, per se, but were serving the country is a tremendous testimony to you but also a testimony to what we all need to do to make sure that kind of information is accessible and available to all of our veterans in the United States. I commend you for what you have done, very much.

And our next—who has been left out? It surely was not Jessica. OK.

Lt. Col. James Lorraine, you are recognized.

STATEMENT OF LT. COL. JAMES LORRAINE, U.S. AIR FORCE (RET.), PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICA'S WARRIOR PARTNERSHIP

Lt. Col. LORRAINE. Thank you, Sir. Chairman Isakson, Ranking Member Tester, and Members of the Committee, thank you for the invitation to testify on the implementation of the community-based strategy to eliminate veteran suicide.

Mr. Chairman, in September 2017, you said "suicide is a terrible, terrible, terrible loss, and a wasteful loss of life, and a preventable loss of life." No truer words could be spoken. In those 22 months, our Nation has spent millions to prevent veteran suicide and still an estimated 13,000 veterans took their lives, and we continue down the same path.

Mr. Chairman, in 2016, you and Senator Tester said we needed to find unique ways to provide services that benefit veterans. You were on target with your vision. We need to get moving, as veteran suicide has become a public health crisis.

I have been a critical care nurse for more than 35 years. I have cared for thousands of wounded, ill, or injured, on the battlefield and in the clinical environment. The greatest care I can provide is to give hope.

In 2009, a fellow soldier and friend took his life in the parking lot of an Army medical center because he could no longer endure the pain caused by 13 blasts that he had been exposed to during his combat tours. He left me a note saying that he had lost hope and he was sorry for giving up. Ten years later, we still have veterans taking their lives because they have lost hope.

A renowned University of Kansas researcher, C.R. Snyder, studied not only the measurement of hope but also the correlation to post-traumatic stress, wellness, and suicide. Dr. Snyder identified a direct correlation between hopelessness and suicide. Hope is a powerful determinant in the person's quality-of-life.

In our annual survey that America's Warrior Partnership conducts, we find that 80 percent of the veterans are hopeful and are seeking connection to other veterans, volunteer opportunities, and recreational opportunities. Word is the less-hopeful veterans sought improved transportation, spiritual and emergency financial assistance.

America's Warrior Partnership's proven scalable community approach supports 48,000 veterans in communities of New York, South Carolina, our great State of Georgia, Florida, the tribal areas of Arizona, and Southern California, with measurable increase in hope. Our model seeks to proactively build relationships with all veterans before the crisis occurs, especially those not enrolled in the VA, in order to provide veterans hope by knowing the community has their back.

The PREVENTS Executive order is a unique, game-changing approach to ending veteran suicide. As Congress determines how to operationalize this order, I would like to offer some joint recommendations developed with our partners at Combined Arms in Houston and the Institute for Military Veterans and Families at my alma mater of Syracuse University.

We strongly recommend the proposed veteran suicide prevention effort be implemented through community-focused grants similar to the VA's Supportive Services for Veterans and Families Program. This effort must require grantees to outreach to all veterans while facilitating collaboration between local and national service organizations in a coordinated effort to holistically serve the veterans.

It is important to highlight that mental health access is a critical element in preventing suicide. However, it is one element of the solution. Community programs must provide access to holistic resources such as employment, health care, housing, benefits, education, personal and professional networking, and much more, to improve the hopefulness of the veteran and their family.

To better understand veteran suicide there must be greater collaborative research and data-sharing between academic institutions, the Department of Veterans Affairs, and Department of Defense, as well as with local coroners and medical examiners. Today we are using incomplete veteran suicide data to develop programs for a problem that we do not fully understand.

In December 2017, America's Warrior Partnership joined with the University of Alabama and the Bristol-Myers Squibb Foundation to launch Operation Deep Dive, a 4-year, 14-community national research study that is the first of its kind, to examine the community-level factors involved in veteran suicide.

We have developed a socio-cultural investigation tool and utilize a cutting-edge technology to better understand how the communities can combat veteran suicide. We believe granted communities should use this methodology to establish a baseline of veteran suicide and annually assess the rate as a measure of the program's success. With Operation Deep Dive we are moving from net fishing to hunting for veterans who are about to take their life.

In summary, as Congress decides the best path forward, I urge this Committee to consider the successful precedent of the SSVF program as a template to end veteran suicide. And last, we must understand more about veteran suicide to include the impacted from the military service experience, community influence, and the service provided by Veterans Affairs.

I am hopeful. I am hopeful for our military, I am hopeful for our veterans, and I am hopeful for our success in ending veteran suicide. Thank you for the opportunity to present recommendations to the Committee.

[The prepared statement of Lt. Col. Lorraine follows:]

PREPARED STATEMENT OF LT. COL. JAMES LORRAINE, USAF (RET.), PRESIDENT & CEO, AMERICA'S WARRIOR PARTNERSHIP, AUGUSTA, GA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE: Thank you for the invitation to testify today on the implementation of a community-based strategy to eliminate suicide among our Nation's military veterans. My name is Jim Lorraine, and I am the president and CEO of America's Warrior Partnership. I served as an Air Force Officer and Flight Nurse for 22 years. I was the founding director of the United States Special Operations Command Care Coalition; a Department of Defense wounded warrior advocacy organization that has been recognized as the gold standard in supporting wounded, ill or injured warriors along with their families. I also served as Special Assistant for Warrior and Family Support to the Chairman, Joint Chiefs of Staff, where I helped to transform the Chairman's "Sea of Goodwill" concept into a strategy. America's Warrior Partnership is a national nonprofit organization dedicated to empowering communities to empower veterans, their families and caregivers. Our organization intimately understands the importance of building collaborative partnerships between national resources and the local community groups who interact with veterans on a daily basis.

Empowering communities is a proven approach, and I have seen for myself what coordinated networks of veteran-serving organizations can accomplish and how our approach of developing a relationship with veterans before the crisis occurs has paid dividends on improving the quality of life for veterans, their families and their communities. This has been the core of our work at America's Warrior Partnership since we launched our Community Integration service model in June 2012. Our service model is currently active in six affiliate communities and has positively impacted the lives of more than 48,000 warriors in the last seven years.

We are not alone in emphasizing the role of communities in serving veterans. Groups such as Combined Arms in Houston and the AmericaServes programs of the Institute for Veterans and Military Families (IVMF) at Syracuse University have built local collaboratives that bridge the gaps between disconnected service providers.

The VA has documented the impact that suicide is having on veteran communities across the country. The latest report from 2018 found that, on average, 20 veterans die by suicide every day, 6 of whom are under Veteran Health Administration care and 14 who are not. These numbers may speak for themselves, but for many of us in the veteran-serving community, suicide prevention has become a personal mission. Ask any veteran and you will likely hear stories similar to the ones I have to share. Stories of fellow servicemembers who died even after we begged them to reach out for assistance. Stories of trying to comfort the friends and family members who are left wondering if there was more they could have done. Stories of close friends leaving behind notes asking for our forgiveness.

It cannot be overstated how dire of a public health crisis that veteran suicide has become.

The PREVENTS Executive Order signed by the President in March of this year provides the Nation the greatest opportunity to change how our whole nation ends

veteran suicide. Mr. Chairman, I know you understand this because in 2016 you made it your top priority to change the paradigm at the Department of Veterans Affairs in delivery of quality services in unique ways that benefit veterans. Both you and the Ranking Member, Senator Tester, have recognized in words and legislation that communities where veterans live provide the greatest opportunity for positive, sustained, collaborative impact toward ending veteran suicide. Harnessing the services and compassion that exist in our Nation's communities to end veteran suicide is both unique and revolutionary.

The PREVENTS Executive Order established a Department of Veterans Affairs Task Force to develop a roadmap to help veterans achieve an improved quality of life while strengthening community-based programs to prevent suicide among veterans. I strongly encourage the Department to not only begin the Task Force's work, but also look beyond government membership and include national leaders in community integration programs to play an active role in implementing the PREVENTS Executive Order.

As Congress determines how to operationalize this initiative, I would like to offer a joint recommendation developed by three of the leading authorities in community-based services for veterans: Combined Arms, IVMF and our own team at America's Warrior Partnership. We developed this recommendation based on our organizations' combined history of developing and operating veteran community integration programs with more than 1,000 partners in 26 rural and urban communities representing 18 states. Our programs have collectively impacted more than 70,000 veterans, military families and caregivers across the country.

We strongly recommend that the PREVENTS Executive Order be implemented through a community-focused grant program that requires grantees to facilitate collaboration between national and local veteran-serving organizations in a coordinated effort to serve veterans holistically. The support provided by grantees should be delivered proactively to addresses both the mental health and social determinants affecting veterans' outlook on life.

Along with our collective experience, we have based our recommendation on the successful roadmap established by the Supportive Services for Veterans and Families Program (SSVF). In 2008, Public Law 110–387, Section 604 of the Veterans' Mental Health and Other Care Improvements Act, authorized the VA to develop the SSVF program, which awards grants to select private non-profits and consumer cooperatives that assist low income veteran families who are residing in or transitioning to permanent housing. These grants continue to enable communities to reduce veteran homelessness through integrated networks of government and non-government resources, which empower veterans to thrive even after they secure stable housing. The community-based approach of the SSVF program was a great success, and we strongly believe it should serve as the foundation of the mission to end veteran suicide.

Eliminating suicide is the mandate of the PREVENTS Executive Order, so it is also essential to consider how grantees can improve the quality of life and hopefulness of veterans in a holistic manner. Every veteran is different, which means every veteran will be affected differently by the varying geographical and cultural characteristics of the community in which they live. That is why it is also critical that grantees should be required to coordinate programs and services that not only track and support the mental health of veterans, but also the wide range of social factors that can impact their outlook on life. Holistic resources should be available to support veterans with employment, healthcare, housing, benefits, education, personal and professional networking, and much more.

It is important to highlight that we believe access to mental health treatment is a critical element of preventing suicide, but it is only one element of the solution. In our annual survey, America's Warrior Partnership uses a validated measure of hope in the surveying of veterans across the Nation. Using Dr. C. R. Snyder's Adult Hope Scale, we correlate hopefulness or hopelessness to what veterans are seeking within their community. We measure hope because it provides for the veteran's future perspective and correlates well to suicide. In our studies, we find that veterans with the greatest hope are seeking connection with other veterans, volunteer opportunities and recreational opportunities, whereas veterans with the lowest hope sought improved transportation, spiritual assistance and emergency financial assistance. We believe proactively developing a relationship with veterans ahead of the crisis and connecting them to a wide range of community services that not only provide support, but also provide purpose has increased veterans' hopefulness for the future. In the end, veterans know that someone in the community cares, can help them navigate barriers, and has their back.

With such a broad range of areas to support, grantees must balance the unique services that their community will prioritize with a systemic approach to tracking

progress and monitoring results. This should all start with communities using established research methods, such as those endorsed by IVMF and other veteran-focused researchers, to form a baseline that indicates the current outlook of local veterans and the specific factors that are affecting those at greatest risk for suicide.

Registering a baseline of veteran suicide within the community and annually measuring the change as a result of the grant, planning appropriate measures to improve veterans' lives and establishing metrics to holistically track progress should all be monitored using a comprehensive information management system, such as America's Warrior Partnership's WarriorServe® system, throughout the duration of the grant. This information management system should also serve as a tool for grantees to coordinate outreach to veterans between various service providers and programs.

Last, to better understand veteran suicide there must be greater collaborative research and data sharing between academic institutions, the Departments of Veterans Affairs and Defense, and local coroner and medical examiner offices. In December 2017, America's Warrior Partnership joined the University of Alabama and the Bristol-Myers Squibb Foundation to launch Operation Deep Dive, a four-year research study that is the first of its kind to examine the community-level risk factors involved in suicides and early mortality due to self-harm among veterans. The project is currently active in 14 communities across the country, with locally based Community Action Teams directing the study under the guidance of a national research team in order to coordinate prevention and postvention techniques on a community level that can adjust in real-time as data is collected and analyzed. When Operation Deep Dive concludes, we expect to understand the community-level factors contributing to veteran suicide, as well as have a methodology that any community can implement locally to identify the unique risk factors affecting their veterans, along with guidelines on how they can address these issues through proactive, holistic outreach programs. For Operation Deep Dive to succeed, both local, state and Federal Government in conjunction with non-government data must be available to researchers to understand the veteran most at risk, in a specific community to take their life.

In summary, as Congress decides on the best path forward to operationalize the PREVENTS Executive Order, I join the leaders of our country's largest veteran community collaboratives in urging this Committee to consider the successful precedent of the SSVF program. We recommend a grant program adopt the community focus of the SSVF initiative and complement it with an emphasis on holistic measures that are inclusive of both the mental health and social factors that affect veterans at risk for suicide. A community's progress in coordinating services and bringing positive change to local veterans should be monitored using established research methods and a comprehensive information management system.

One final point I will add is that all grantees should authentically represent the communities in which they serve. This means that each organization actually resides within their community and has documented agreements in place that show they have the support of local government and non-government leaders. The goal of this initiative, after all, is not to supplant the hard work that community organizations have done to help their veterans, but to empower them to take it to the next level.

Thank you for the opportunity to present this recommendation to the Committee. As Chairman Isakson has said, "Suicide is a terrible, terrible, terrible loss, and a wasteful loss of life and a preventable loss of life." Veteran suicide is an undisputed public health crisis, and it will take a highly coordinated level of collaboration between local community groups and national veteran-serving organizations to end it. Our country's legislators have already taken the first steps toward providing communities the support they need. I speak for my fellow leaders within the veteran-serving community when I say that we are all here to offer our continuing help and support to complete this mission.

Chairman ISAKSON. Well, Colonel, thank you very much. Are you a resident of Augusta, GA, or were you from Augusta, GA?

Lt. Col. LORRAINE. I work out of Augusta, GA, but I am a resident of Aiken, SC, sir.

Chairman ISAKSON. Well, that is a good place, too. It is almost as good as Augusta.

Lt. Col. LORRAINE. Almost as good, sir. Not quite as good, but almost as good.

Chairman ISAKSON. We have got a lot of soldiers at Fort Gordon. We have got a lot of military personnel there. In particular, the NSA has built a huge, modern intelligence facility there that is second to none in the world, and certainly our military. That is the home base of many people that have a lot of conditions or opportunities for conditions we talk about.

I appreciate so much your focus on getting over the hump, thinking about what the problems are and finding out what the problems are, because sometimes they are not what you think, and sometimes they are things we overlook without intention to do so. I enjoyed your testimony tremendously.

Paige Thornton—Paige?

Ms. THORNTON. Yes, sir?

Chairman ISAKSON. Donna Stitcher. These two beautiful women flew up on here on Delta Airlines from Georgia just to visit today, because of their interest in this particular issue, particularly PTSD and some of the other problems we face.

Have you all enjoyed the day and picked up something?

Ms. THORNTON. We sure did.

Ms. STITCHER. Yes, sir. It is a delight to be here and to see people that have common situations, that I have personally lost a loved one due to combat, a veteran, Desert Storm. So, thank you so much for having this hearing.

Chairman ISAKSON. We know we are going to be altogether better if we are always all together, and sharing is critically important. The sharing of information, the willingness to share the information, and the ability to seek out that information can make all the difference in the world. You do not need a situation of stigmas and stereotypes. What you need is opportunity and hope. That is the way I try and always—just give me a chance to get your question answered and I will give you a chance to get to somebody who can give you help.

Thank you for what you are doing. I appreciate you all coming up, and I will turn it over to the Ranking Member.

Senator TESTER. Thank you, Mr. Chairman, and thank you all once again for your testimony. I will apologize. Normally this Committee is here to grill you guys, and I know you were looking forward to that grilling, but unfortunately it is just me and Johnny, so it is my turn first.

General Quinn, thanks for being here. Thanks for representing Montana and the views of the National Guard in Montana. In your testimony you highlighted the importance of a state-run program like the Montana Employees Assistance and Veterans Assistance Program, that provides mental health services for State employees and for members of the Guard. Why was it important for the State of Montana to get involved?

Maj. Gen. QUINN. Thanks, Senator, for that question, and thanks for your support.

It was important because of those servicemembers serving in the National Guard, and that was the initial focus, for those that do not have veteran eligibility. We were not trying to take away from the veterans program. If we have National Guard members who are veterans then we would like to augment the Veterans Administration and the program that they have.

When the statistics showed that over half of those individuals that lost their life to suicide were not veterans, did not have eligibility for veteran care, then there needed to be something that we should do in order to provide them the services they need.

The numbers are looking good. The number of soldiers and airmen who are seeking counseling services is encouraging to us. The number of family members who are seeking counseling services are encouraging to us. I do not want to know who those individuals are. I want them to seek the help and not be worried about what the military will do if we find out that they are seeking help.

So, it was important to have an outside program that they can turn to. Military OneSource is out there, but servicemembers are seeing that as related to the military and they do not want to seek that help. That is why we went to an outside agency. That is why we went through the State and provided or offered those benefits to the soldiers and airmen that serve our National Guard.

Senator TESTER. What impact do you think guardsmen's access to Vet Centers will have?

Maj. Gen. QUINN. I think, Senator, the access to Vet Centers is critical. I often use as an example military sexual trauma, and servicemembers that are in our National Guard that have suffered military sexual trauma, or sexual trauma outside the military. But, they are a member of our force. They are currently serving our State and our Nation. Their ability to seek help through the Vet Centers, if they do not have veteran eligibility is important to them. They are looking for that care. They are looking to continue to serve but they just need the care that will allow them to continue to serve.

The ability to have veterans—we opened the one in Helena maybe, what, 2 years ago. That is important, and I have a lot of servicemembers willing to go to a Vet Center and look for that care, even if they are not VA eligible.

Senator TESTER. Last question for you. Are there any gaps that you see out there that we should be looking at?

Maj. Gen. QUINN. Senator, I still worry about those who are not seeking the care that they need to serve, and the transition services that have been talked about today—you have mentioned it, Secretary Wilkie mentioned it—that transition care, I think is very important. If I have a Guard member who departs after 20 years or 30 years, who is not veteran eligible, who does not have that care, I think we need to look harder at that transition care, and how can they continue to be able to rely, either on the Vet Center or on the Veterans Administration, if that is possible. I think that transition is critical, Senator.

Senator TESTER. Thank you, and thank you for being here.

Dr. Haynie, in your testimony—I have got it written down in my notes—getting the transition right is critical. You talked about, in that transition—and do not let me put words in your mouth, but navigating and getting the help they need, navigating through the jungle of issues that you are dealing with when you are a veteran.

Could you, number 1, flesh that out a little bit more for me, talk with some more specifics, and then what do we need to do, or better yet, if, in fact, it is not just the VA but the DOD, because I

think you might have mentioned that too, or somebody up there did. What do we need the DOD to do to make the transition right?

Mr. HAYNIE. Thank you for the question, Senator. I think what I highlighted in my testimony was sort of the learned experience now, over 10 years of developing programs to support the transition, and, more importantly, hearing directly from servicemembers and their families about their barriers at the point of transition. You know, it was unexpected, even for us, to learn that among all of the challenges servicemembers and their families face when they make that transition from military to civilian life, the most significant challenge they cite is simply understanding—I think the way I put it is—how to get the help they need, when they need it, and, importantly, in their own communities. We tend to think that we transition veterans to national programs. At the end of the day, our servicemembers are transitioning to towns, villages, cities, and the extent to which those towns, villages, and cities are resource and culturally competent to accept them and welcome them into their communities I think makes all the difference.

There is also an economic argument here. The work that we have done in communities around the United States, we have not come to a single one where we have identified a gap in resourcing as it relates to boots on the ground, nonprofit, community-connected providers, clinical health care providers, et cetera, the stock of resources that exists to actually address the needs of our veterans. I guess what I am say is we do not need to build more things. What we really need to do is create a system that connects all of those resources, at a community level, and then shepherds the veteran and their family to those resources when they need those resources.

To your point about transition, our other big insight, all of the conversation that we have had today related to mental health, et cetera, you know, we are essentially working behind the curve. The consequence that is the subject of this hearing is really a function of our ability to effectively manage the transition of a military-connected family to civilian life.

And, as Jim pointed out and others have spoken to, we have not had the discussion about the social and economic determinants of health and well-being. It is the case that jobs, careers, connections to community, stable families, all of that plays into the compromised-or-not mental health situation of our veterans, and all of that is aligned with a healthy and robust transition.

So, from my perspective, if we get the transition right, that is the most powerful way to blunt some of the unfortunate consequences that we see down the road as it relates to suicide.

Senator TESTER. Last question, if I might, Mr. Chairman.

Chairman ISAKSON. Certainly.

Senator TESTER. Jessica, as I listened to your statement—first of all, thanks for being here and for sharing your story, and Brian's story. As I listened to your statement I was hoping that it ended up better than it ended up. I had read about your story and I just want to thank you for making a negative situation into a positive situation, and I just cannot thank you enough. Little did I know that you happened to be FROM my friend, Jerry Moran, of Kansas.

He has a note here that says Pittsburg, KS, which is a bit confusing to a guy from Montana.

Nonetheless, I think that through your statement you have shown that VetLinks has the ability to make personal connections——

Ms. KAVANAGH. Correct.

Senator TESTER [continuing]. With the veteran, their caregivers, their family. It would be my hope that the VA would work closely with you. I would like you to comment on if they have been. I would also like you to comment on if there are areas that they can improve in making it more seamless and more effective, things that you would like to see them do.

Ms. KAVANAGH. Yes. Thank you, Senator. I have not reached out to the VA as of yet to partner with them to help. We worked directly with Code of Support. They are also a local nonprofit. And together we just—they have people who hear of Code of Support and they send them in our direction, where we are able to provide the finances for them, whether they are in need of something for substance abuse or Post Traumatic Stress or Traumatic Brain Injury, for the veteran, for the child who might need any sort of therapy, for the caregiver.

It is very situational. I mean, I think it is all individualized care, and everybody has a different need. Which is what is so great about our partnership: we can take their individual need, run them through A to Z, see what they specifically need, just not for the veteran but for the entire family, and then we are able to provide the resources and pay for what they are in need of.

Senator TESTER. Thank you, and thank you all. Hopefully we did not screw up your life by this hearing going until 5:30 when it probably should have ended an hour ago. The bottom line is we appreciate your input. It will make a difference in the decisions we are able to make because of the expertise that all of you offered up, either in your statements or in your answers to the questions. Thank you.

Ms. KAVANAGH. Thank you.

Chairman ISAKSON. I, too, want to thank you and I apologize that you got caught in the crossfire of Committee and votes. But, I do not think I have ever had a situation as Chairman where everybody wanted our guests to stay until we came back, because they want them to go. But, they did not want you all to go anywhere; and after hearing your testimony, we know why.

I want to add one thing for Mr. Haynie. The handoff from the Department of Defense to the Veterans Administration is horrible. There is a black hole out there somewhere that every active duty military person falls into when they leave DOD health care, and each does not come out of it until after they should have already been in the VA health care for a year or so.

We are addressing that. One of the ways we are doing it is DOD's software and computer systems and the Veterans, they are not interoperable. So, the first thing we have to do is—we have got two important sources of information that do not talk to each other. Senator Tester and I, along with the leadership of the VA, signed the largest contract in the history of the VA with Cerner to get an

interoperable information system for medical IT with DOD and VA systems together, and that is going to make a big difference.

Because more of these causes or contributors to the psychological and mental problems that are associated with suicide are health related and not necessarily narcotics related or heritage related or anything else, and sometimes that information does not flow with veterans as easy as it should. Something is missed for a time while the veteran is getting used to talking about the problem they have. That absence of information available to the professional could hurt them a lot.

So, I want to thank you for your testimony. We know we are short on that. We know we need to do better, and we are doing better, everything we can. Secretary Wilkie is a great Secretary. He is doing a wonderful job, and I think his service is going to be great to this country and great to the veterans of our country. And we are going to do everything, our Committee together, to keep working to make the veteran system and the benefits to a veteran's service to his country, or her country, they get every benefit they are supposed to get, and they get it the way they need to get it, and that we are helping people and saving their lives, that we are not hurting people and keeping them away from the health care they need.

Thank you for coming. Thank you for your testimony. We are going to leave the record open for 5 days, for any additional questions, and we will get them to you if they are for you specifically, or anything you might want to add to the testimony that you gave.

Unless there is any further information, I will call the meeting adjourned.

[Whereupon, at 5:30 p.m., the Committee was adjourned.]

PREPARED STATEMENT FROM HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS FOR PANEL II

I know you all were here for the first panel and heard my description of the bill that my colleagues and I introduced today.

I won't rehash the whole thing, but as a recap, the legislation will accomplish three broad objectives:

1. It will enable the VA to directly or indirectly reach more veterans;
2. It will increase coordination among currently disparate organizations that all play a part in reducing the purposelessness that ends in suicide; and
3. It will drive adoption of a standard measurement tool that will help us determine the effects and outcomes of our services.

I would emphasize that we believe organizations like those on this panel have already figured out how to do some of the work that needs to be done.

It's simply a matter of taking the best of what works, sharing ideas, and working together within a shared framework.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Do you have any metrics on what the use is for those mobile Vet Centers? If you do not, that is fine, but if you do, could you get that to us?

Response. Readjustment Counseling Service (RCS) maintains a fleet of 80 Mobile Vet Centers (MVC) to extend focused-outreach, direct services, and referral services to Veterans, as well as to serve as a resource for VA's emergency response mission. In FY 2018, MVCs were present at 4,880 events where staff engaged in over 49,000 encounters (outreach and direct counseling) with Veterans, active duty Servicemembers, and their families. In addition, in FY 2018, MVCs were deployed in response to 11 emergency situations including shootings in Las Vegas, Yountville, Santa Fe, and Parkland; the Hawaii Big Island Volcano; the Northern California,

Carr, and Mendocino Fires; and Hurricanes Florence, Maria, and Harvey. During these deployments, Vet Center staff provided services to over 13,125 individuals during these events.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. What kind of meaningful outreach is VA doing to ensure veterans with Other Than Honorable discharges are aware of the care available to them and how to access that care?

Response. VA coordinated and conducted focused outreach to former Servicemembers with OTH discharges twice over the past 18 months. This included joint outreach efforts in support of the President's January 9, 2018, EO 13822 which focuses on mental health and suicide prevention support for newly separated Servicemembers in the first 12 months after separation. The joint efforts with the DOD and DHS included outreach materials that focused on recently separated Servicemembers with OTH discharges. This occurred from March 2018 to December 2018. More recently, VA conducted internal and external digital media engagement, to augment the January notification by mail to OTH former Servicemembers. This effort included a blog at https://www.blogs.va.gov/VAntage/60349/other-than-honorable-discharge/; posts on VA's Facebook page (1.19 million followers); and a Twitter feed (624,000 followers). This information was also distributed by email to over one million subscribers to VA's *This Week* newsletter.

Question 2. What specifically is VA doing to remove barriers for women to access mental health care?

Response. The Women's Mental Health Section of the Office of Mental Health and Suicide Prevention (OMHSP) has recently developed an infrastructure and strong clinical trainings initiatives to support the availability of gender-sensitive mental health care for women Veterans.

As part of this infrastructure, OMHSP has established a national network of Women's Mental Health Champions. Each VA medical center has appointed at least one clinician to this role. Women's Mental Health Champions disseminate information; facilitate consultations; develop resources that increase the visibility and accessibility of gender-sensitive women's mental health care; and contribute to a welcoming care environment.

VA has also developed specialized training initiatives to advance the clinical competency of mental health providers who care for women Veterans, including those at risk for suicide. These training efforts contribute to a welcoming treatment environment for women Veterans by improving access to gender-sensitive Veteran-centered care. Examples of innovative clinical training initiatives include the following:

- The Women's Mental Health Mini-Residency which is a 3-day training that covers a broad range of topics related to the treatment of women Veterans, such as understanding suicide risks in female patients and working with women whose mental health problems are influenced by hormonal changes.
- The STAIR (Skills Training in Affective and Interpersonal Regulation) training teaches clinicians to deliver a trauma treatment that focuses on strengthening emotion regulation and relationship skills. These areas of functioning are often disrupted in women who have experienced severe interpersonal traumas, such as sexual assault. Research suggests that emotion dysregulation is associated with suicidal ideation and behaviors.
- Parenting STAIR training teaches therapists to deliver a component of the STAIR treatment that is designed to help Veterans who have persistent trauma-related reactions that negatively impact their parenting and parent-child relationships.
- The Multidisciplinary Eating Disorder Treatment Team training aligns with the Joint Commission's rigorous standards for the outpatient treatment of eating disorders. Eating disorders are associated with increased risk for suicide attempts and death by suicide.
- The National Women's Mental Health Monthly Teleconference Series is a monthly clinical training designed to enhance knowledge of gender-tailored treatment approaches, including prescribing practices. Physiological changes across women's reproductive lifecycles can affect their mental health and suicide risk. For example, women who have premenstrual dysphoric disorder (PMDD) have a greater likelihood of having suicidal thoughts, plans, and attempts. Treating PMDD is different than treating depression. Only some antidepressants are effective for PMDD, and dosing only during the luteal phase (2nd half, after ovulation) of the menstrual

cycle is effective. Proper recognition, diagnosis, and treatment of PMDD can substantially reduce suicide risk for this subset of women Veterans.

Question 3. How will VA identify these veterans who have experienced military sexual trauma especially when some of these veterans are reluctant to identify themselves this way and help get them into care?

Response. Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all Veterans seen for health care are screened for military sexual trauma (MST). This is an important way to ensure that Veterans are aware of and offered the free MST-related care available through the VHA. For Veterans who experienced MST, it also helps ensure that their trauma history is considered in the provision of their care.

All Veterans seen in VA's health care facilities must be screened at least once using the MST clinical reminder in the Computerized Patient Record System. However, since some Veterans may not feel comfortable disclosing an MST experience when first screened, national educational resources highlight the importance of creating multiple opportunities for disclosure of MST experiences. For example, VA encourages additional MST screening for any Veteran receiving mental health care. Veterans who decline to respond to the MST screen are automatically re-screened after 1 year. Veterans who respond "yes" to either of the screening questions (indicating the Veteran did experience sexual assault/harassment during military service) are offered a referral for mental health services via an automated question in the MST clinical reminder. This referral question standardizes the referral process system-wide and helps streamline access to mental health care for Veterans who express interest in MST-related mental health treatment.

For Veterans, services for any mental and physical health condition related to MST are available for free at every VA medical center, and eligibility is expansive: Veterans do not need to have reported their experiences at the time or have any documentation that they occurred and may be able to receive free MST-related care even if they are not eligible for other VA care. Under its new treatment authority (38 U.S.C. § 1720I), VHA is now offering mental health care free-of-charge to former Servicemembers with an OTH discharge who experienced MST. VHA has several initiatives to help ensure that targeted, specialized services are available and that Veterans and former Servicemembers are aware of these services. Every VA health care system also has a designated MST Coordinator who serves as the local point person for MST-related issues and can help Veterans and eligible former Servicemembers access MST-related services and programs.

Question 4. What is known about the prevalence or causes of suicide among dependents and family members of veterans?

Response. Research is needed about the prevalence of suicides among Veterans' dependents and family members. Even more so than just understanding the prevalence of suicide, it is important to understand why this subgroup may have elevated suicide rates. Research has shown that suicide bereavement in the general population is often accompanied by experiences of trauma, guilt, anger, shame, stigma, perceived preventability, social isolation, family relational disturbance, and perceived rejection that can increase vulnerability to persistent distress, psychiatric disorders, and a survivor's own suicide risk. There are additional complexities faced by survivors of military suicide, including challenges around the shame and stigma of a "dishonorable" death, the violence of the death, lengthy investigations to determine benefits, and the culture around remaining strong and self-reliant at all costs. Researchers have called for more research and resources into the impact of suicide on military suicide loss survivors and culturally sensitive postvention supports needed for their care.

Question 4a. Is VA doing anything to better integrate families into the suicide prevention process?

Response. Although family conflict and social isolation are risk factors for suicide, at this point there are no published evidence-based interventions to engage relatives and loved ones to address suicide risk in adults. Therefore, OMHSP Family Services Section (FSS) is developing best practices that can be used by mental health providers who interact with Veterans at risk for suicide and their loved ones, while waiting for stronger empirical data to be available. FSS has three initiatives in this regard.

First, over the past 2 years, FSS co-developed and sponsored two system wide webinars for VA mental health providers to educate them about family issues and suicide. The webinars provide information on the Interpersonal-Psychological l Theory of Suicide, which emphasizes: 1) the importance of feeling like a burden to others; 2) feeling alienated from others; 3) the capacity for suicide (knowing how to use a weapon, not fearing death, high pain tolerance) in increasing suicide risk in

adults; and 4) ways to interact with Veterans and relatives and alert them to these issues and proactive in addressing them. FSS developed these webinars with the VA Suicide Prevention Coordinator Leadership and the leadership of the VA Coaching into Care Program and they have been well-received.

Second, FSS has integrated training into the intensive evidence-based training programs on Integrative Behavioral Couples Therapy for Marital Distress and Cognitive-Behavioral Conjoint Therapy for PTSD for VA mental Health for engaging relatives and Veterans to promote dialog about suicidal ideation and develop conjoint safety planning. Clinicians are provided with empirical information on family factors that have been identified as helpful and harmful by adults at risk for suicide, and recommendations about effective ways they can interact with Veterans and loved ones to reduce suicide risk. Clinicians are also given ample time to consult with project staff about these issues during these training as well.

Finally, FSS is collaborating on two VA research pilot trials to better understand family factors in Veteran suicide and to develop effective family interventions. The most developed of these projects is being led by Dr. Marianne Goodman at the Bronx, New York (NY) VA, who is testing a family-based intervention to address Veteran suicide risk in a feasibility trial. It should be noted that one of the important findings from this trial is the wide variability in Veterans' and loved ones' interest and comfort in family interventions addressing suicide. One size does not fit all. Many Veterans appear ashamed of their suicidal feelings, and do not wish to share them with their relatives, and a subset of relatives are either incredulous at the idea that their Veteran loved one is suicidal or are angry/dismissive about it. Clinicians need thoughtful and effective strategies to address these barriers. This is a small pilot, but it is clear there is much work to be done in this area.

A second project for which a grant proposal is just being written is building from a study on Cognitive-behavioral Conjoint Therapy for PTSD, led by Dr. Leslie Morland at the San Diego, California (CA) VA. Given the prevalence of suicidal ideation observed in Veteran couples in this study, Doctors Chandra Khalifian and Morland are collecting data on couples' interest and willingness to address suicide conjointly. This study just received Institutional Review Board approval to pilot a novel couples-based suicide intervention with Veterans, called Treatment for Relationships and Safety Together in collaboration with Doctors Craig Bryan and Feea Lefiker.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. How is VA working with DOD to ensure servicemembers who suffer from addiction and mental health receive a warm hand off once separated from service?

Response. VA and the Department of Defense (DOD) collaborate closely to provide a single system experience of lifetime services for the men and women who volunteer to serve in our military services. VA and DOD collaboration includes programs to facilitate the transition to including help with enrollment, to VA health care for eligible Veterans; increase availability and access to mental health resources; and decrease negative perceptions of mental health problems and treatment among Servicemembers, Veterans, and providers. The following is a summary of VA policies and programs that support continuity of care for Servicemembers as they separate from service.

- *Coaching into Care:* VA provides a national telephone service for Veterans, their family members, and other loved ones seeking services at local VA facilities and in the community. Coaching is provided free-of-charge by licensed psychologists or social workers to family members and friends who are seeking care or services for a Veteran family (https://www.mirecc.va.gov/coaching).
- *Community Provider Toolkit:* Launched in March 2016, the Community Provider Toolkit is a one-stop web-based interagency repository of resources and tools that support the behavioral health and wellness of Veterans receiving care from community providers. The Toolkit was developed with input from VA, DOD, and the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA). The repository provides a single point of access to resources including the National Resource Directory, the SAMHSA Treatment Locator, Military OneSource, and the Military Families Learning Network (https://www.mentalhealth.va.gov/communityproviders).
- *Community Resource and Referral Centers:* These Centers provide Veterans who are homeless or at risk of homelessness with one-stop access to community-based multiagency services to secure permanent housing, health and mental health care,

career development, and access to VA and non-VA benefits (https://www.va.gov/homeless/Crrc.asp).

• *Concierge for Care:* Former Servicemembers are called within 30 days of separation by VA staff who can answer questions; process the VA health care enrollment application over the phone; and assist eligible Veterans with setting up their first VA medical appointment.

• *MakeTheConnection.net:* A one-stop web resource where Veterans, families, and friends can privately explore information on mental health issues; listen to fellow Veterans and their families share their stories of resilience; and easily find and access support and resources. In May 2019, for Mental Health Awareness Month, VA launched The Moment When campaign to highlight the many positive moments or steps in one's recovery process. The overarching goals of the campaign were to improve access to mental health care and encourage Veterans to reach out for support at http://maketheconnection.net/.

• *Mobile Applications (Apps):* VA has a suite of award-winning mobile apps to support Veterans and their families with tools to help them manage emotional and behavioral concerns. In addition, VA actively and routinely coordinates with DOD's Defense Health Agency to: 1) ensure that Servicemembers are aware of VA mobile apps during their service and in their transition out of service; 2) ensure that DOD and VA mobile technologies are coordinated and aligned in the types of content and services they provide; and 3) share best practices for delivering mobile health to Veterans and Servicemembers. Available mobile apps include those for use by Veterans (self-help) to support their ability to cope with a range of issues (e.g., Post Traumatic Stress Disorder (PTSD) symptoms, alcohol use, or smoking cessation) as well as mobile apps designed as an adjunct to psychotherapy and used with a mental health provider to support Veterans' engagement in care and their use of skills learned in therapy. VA's mobile apps enable Veterans to engage in self-help before their problems reach a level of needing professional assistance and aim to promote active engagement when they are in care. The goals are to empower Veterans and their families and support VA's efforts to improve access to care (https://mobile.va.gov/appstore/).

• *Peer Specialists:* VA continues to expand access to Peer Specialists who are VA employees in recovery from mental illnesses and substance abuse disorders that help other Veterans to successfully engage in mental health and substance use treatment. Consistent with the Clay Hunt Suicide Prevention for American Veterans Act, community-oriented peer support programs have been developed in 9 networks at 21 VA sites to assist Servicemembers transitioning from military service and to improve access to mental health services. These collaborative outreach events in the community are bringing in many more Veterans for care. In addition, in implementing section 506 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VA has added 30 peer specialists to work in Patient Aligned Care Teams (PACT) in 15 VA facilities this year and will expand to an additional 15 VA facilities next year to further increase Veterans' access to mental health care through primary care.

• *Same-day Services for Urgent Primary and Mental Health Care Needs:* In addition to the Emergency Department/Urgent Care Centers available at all VA medical centers, VHA offers Same Day Services in Mental Health for Veterans and eligible former Servicemembers. Same-day services may include: a face-to-face visit with a clinician; advice provided during a call with a nurse; a telehealth or video care visit; an appointment made with a specialist; or a prescription filled the same day, depending upon what best meets the needs of the Veteran.

• *Transition Assistance Program (TAP):* TAP provides information, tools, and training to ensure Servicemembers and their spouses are prepared for the next step in civilian life, whether pursuing additional education, finding a job in the public or private sector, or starting their own business. As part of TAP, Servicemembers learn about VA benefits and health care and start the 10–10 EZ health care enrollment application during the weeklong course that occurs prior to separation from the military. The recently redesigned TAP is the result of an interagency collaboration, including work by VA, to offer separating Servicemembers and their spouses better, more easily accessible resources and information to make their transitions more successful. Site: https://www.benefits.va.gov/tap/tap-index.asp

• *Transition and Care Management (TCM) Services:* Every VA medical center has a TCM Team that provides case management to Post-9/11 Combat and Non-Combat Veterans who are eligible for VA care and elect to enroll in TCM. Case Managers, who are either nurses or social workers, are available to help newly enrolled Veterans navigate the VA system and to coordinate all patient care activities and needs. All recently separated Veterans who are eligible for VA care can use this program.

• *VA/DOD Joint Executive Committee (JEC) and Work Group Activities:* The JEC provides senior leadership a forum for collaboration and resource sharing between VA and DOD. By statute, the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness co-chair the JEC. The JEC consists of the leaders of the Health Executive Committee (HEC), the Benefits Executive Committee, the Interagency Program Office (IPO), additional Independent Work Groups, and other senior leaders designated by each Department. The JEC works to remove barriers and challenges that impede collaborative efforts; assert and support mutually beneficial opportunities to improve business practices; ensure high-quality cost-effective services for VA and DOD beneficiaries; and facilitate opportunities to improve resource utilization. Other specific JEC work group activities are as follows:

(1) *HEC Psychological Health Work Group (PHWG):* The HEC PHWG actively collaborates on several initiatives, including:

– *The inTransition Program:* A voluntary, confidential telephonic coaching program that provides continuity of care (i.e., warm hand-off) within and between VA and DOD health care systems as Servicemembers and Veterans with psychological health needs transition between duty stations and from active duty service to civilian life. The program was created to bridge that gap by supporting Servicemembers as they transition between health care systems to facilitate connecting to and engaging with a new provider. VA is working with DOD to promote self-referral to inTransition among Veterans with any category of discharge and to strengthen referrals from in Transition to VA health care and Vet Centers.

– *Separation Mental Health Assessment:* In accordance with the National Defense Authorization Act for FY 2018, section 706, DOD and VA are standardizing practices in support of separation mental health screenings that are part of the Separation Health Assessment process for all separating Servicemembers within 180 days prior to discharge. The VA/DOD Joint Action Plan for Suicide Prevention, mandated by EO 13822, Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life, includes the requirement to offer mental health screening to 100 percent of transitioning Servicemembers. Once implemented, the separation mental health assessments will ensure that separating Servicemembers with mental health needs are appropriately referred for transition services.

(2) *HEC Care Coordination Business Line (CCBL):* CCBL provides joint leadership to drive continuous integration of care, benefits, and services provided to Servicemembers, Veterans, and their families. Current priorities include: evaluating and refining transition processes for all recovering SMs, to include those with complex care needs and improving Interagency Comprehensive Plan interoperability.

(3) *HEC Pain Management Work Group (PMWG):* While primarily focused on assessment and management of pain conditions, HEC PMWG works collaboratively with VA and DOD leaders to synchronize pain management and opioid safety education and training of DOD and VA providers and patients. By coordinating DOD and VA patient and provider education, HEC PMWG strives to provide a similar approach to pain management and opioid safety across the two Departments; thus, making the transition smoother for those suffering from pain-related conditions. HEC PMWG developed and continues to update a basic pain curriculum for primary care providers (Joint Pain Education Program) which includes training on opioid use disorder. The HEC PMWG is also working on the alignment of pain/opioid safety metrics and outcomes collection to maximize the value of DOD-collected data after transition to VA.

(4) *JEC Separation Health Work Group (SHAWG):* The JEC SHAWG coordinates VA and DOD responsibilities to perform separation and disability exams to meet requirements and enable the delivery of VA benefits at discharge in a way that avoids duplication of effort and minimizes burden on the separating Servicemember. Effective coordination also ensures completeness of the Service Treatment Record so that it will efficiently support any future claims by the Veteran. In FY 2018, the SHAWG developed and tested a common workflow to enable VA and DOD electronic systems to interface. Once implemented, this interface will eliminate the need for Servicemembers to courier a copy of the Service Treatment Record to VA and for VA claims processor to manually return the VA Disability Benefit Questionnaire to DOD.

(5) *Integrated Disability Evaluation System—Disability Evaluation System Improvement Work Group (DES WG):* The DES WG supports process improvements to make the Integrated Disability Evaluation System (IDES) process faster and more efficient. On July 30, 2018, DOD published policy reducing the timeliness goal for the Integrated Disability Evaluation System (IDES) from 295 days to 230 days. This

change impacts ill and injured Servicemembers who are no longer medically fit for continued military service. VA benefits from increased efficiencies by reducing the time to evaluate and award VA disability benefits to former Servicemembers.

(6) *VA/DOD Interagency Program Office (DOD/VA IPO)—Health Data Sharing:* The purpose of the DOD/VA IPO is to jointly oversee and monitor the efforts of the DOD and VA in implementing national health data standards for interoperability and act as the single point of accountability for identifying, monitoring, and approving the clinical and technical data standards and profiles to ensure seamless integration of health data between the two Departments and private health care providers. DOD/VA IPO activities include:

– *Data Mapping:* To maintain and enhance interoperability, the Departments and IPO continued regular mapping updates for data quality assurance. Throughout FY 2018, the IPO's Interoperability Standards and Documentation Change Control Board reviewed, analyzed, and approved a total of 8 DOD clinical data maps. VA continues to advance its data mapping capabilities as it proceeds with additional electronic health record enhancements. Moving forward, the IPO will continue working with VA and DOD to provide data quality assurance and explore opportunities to refine the process for reviewing and deploying data mapping updates.

– *Joint Legacy Viewer (JLV):* VA and DOD continue deployment and infrastructure improvements of JLV. At the end of FY 2018, there were 422,370 total JLV users (96,187 at DOD; 308,529 at VHA; and 17,654 at VBA). To further enhance data sharing, DOD and the U.S. Coast Guard signed a Memorandum of Agreement to expand the use of JLV.

– *Interoperability Metrics:* To measure the impact of interoperability, the IPO works with the Departments, academia, and other subject matter experts to develop and monitor Transactional and Outcome-Oriented Metrics to assess interoperability's impact on the health care received by our Servicemembers, Veterans, and their families (SMVF) through the DOD, VA, and their private partners. With this information, the IPO will be able to demonstrate the amount of data being exchanged (transactional metrics) and further improve the quality of care our beneficiaries receive (Outcome Oriented Metrics). Results from these metrics will ultimately determine interoperability's progress and its impact on our wounded warriors, our men and women in uniform separating from service, as well as the general population's health.

– *VA/DOD Electronic Health Record (EHR) Modernization Efforts:* The IPO supports the EHR modernization efforts of VA and DOD, encouraging and enabling collaboration by serving as an interagency resource for EHR modernization and supporting system information technology (IT) governance and health data interoperability. As the Departments continue their efforts to implement Cerner EHR products, the IPO will continue to support interoperability and modernization goals of the Departments to ensure our Veterans and transitioning Servicemembers receive seamless health care.

(7) *Federal Electronic Health Record Modernization:* DOD and VA are developing a Federal Electronic Health Record Modernization (FEHRM) joint governance strategy to further promote rapid and agile decisionmaking. This structure will maximize DOD and VA resources, minimize EHR deployment and change management risks, and promote interoperability through coordinated clinical and business workflows, data management, and technology solutions while ensuring patient safety. The FEHRM program office will be responsible for effectively adjudicating functional, technical, and programmatic decisions in support of DOD and VA's integrated EHR solutions. DOD and VA will jointly present the final construct of the plan to Congress, including our implementation, phase execution, and leadership plans.

• *VA Liaisons for Health Care:* VA has liaisons stationed at military medical treatment facilities and Army Warrior Transitions Units to support the transfer of severely wounded Servicemembers. They coordinate care and provide consultation on VA resources and treatment options. Liaisons contact the Servicemember's local VA medical center and Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Care Management Team to ensure that appointments and care plans are in place before the Servicemember leaves the military medical treatment facilities.

• *VA Mental Health Services website for Transitioning Servicemembers:* This new site provides simple guidance and direct links on how to access VA mental health services for Post Traumatic Stress Disorder, psychological effects of military sexual trauma, depression, grief, anxiety, and other needs. This site makes clear that some of these services are available to former Servicemembers even if they are not en-

rolled in VA health care (https://www.va.gov/health-care/health-needs-conditions/mental-health/).

• *Veterans Benefits Administration (VBA) Call Center:* VBA is expanding an existing call center to call Veterans at least three times during the first year after separation. The call center will provide information about the variety of VA benefits and health care resources available, including mental health care services, as well as create a caring contact with each Veteran.

• *Vet Centers:* Vet Centers are community-based counseling centers that provide a wide range of social and psychological services including professional readjustment counseling to certain Veterans and active duty Servicemembers, to include members of the National Guard and Reserve components. All Vet Centers maintain regularly scheduled nontraditional hours, including evenings and weekends, to ensure that Veterans and Servicemembers can access these services. There are 300 total Vet Centers with locations in every state, the District of Columbia, Puerto Rico, American Samoa, and Guam (https://www.vetcenter.va.gov).

• *VHA Directive 2014–02:* VHA Directive 2014–02, Continuation of Mental Health Medications Initiated by Department of Defense Authorized Providers, allows VA providers to continue mental health medications initiated by DOD authorized providers for recently discharged Servicemembers, even when the medication is not included in the VA National Formulary (VANF). In the interest of Veteran-centered care principles, VA medical facilities must streamline local processes to ensure prompt access to DOD-prescribed VANF non-formulary or restricted mental health medications for recently discharged Servicemembers.

• *VHA Health Eligibility Center:* In addition to starting the VA Form 10–10EZ during TAP, separating Servicemembers can start the VA application in person at any VA Medical Center, by phone at 1-(877) 222-VETS, online at https://www.va.gov/health-care/how-to-apply, or by sending the application to Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329.

• *Web-Based Self-Help Tools:* VA launched an online portal in 2014 for Web-based self-help resources to provide one-stop shopping for Veterans and their families. Award-winning courses available at https://www.veterantraining.va.gov/index.asp include:

(1) PATH TO BETTER SLEEP—an online tool to support cognitive behavioral therapy for insomnia;

(2) MOVING FORWARD—an educational and life-coaching program that teaches problem-solving skills to help Veterans better handle life's challenges; Anger and Irritability;

(3) MANAGEMENT SKILLS—offers a wide range of practical skills and tools to manage anger and develop self-control over thoughts and actions; and

(4) PTSD COACH ONLINE—a Web-based version of the award-winning PTSD Coach for trauma survivors, their families, or anyone coping with stress.

• *Whole Health Orientation Groups:* Veterans may attend Whole Health Orientation groups that give them the opportunity to connect with VHA and, if needed, receive a referral for VA mental health care. The Whole Health model is a holistic look at the many areas of life that can affect Veteran health from work environments, relationships, diet, sleep patterns, and more. The Components of Proactive Health and Well-Being helps illustrate how these areas are all interconnected (https://www.va.gov/patientcenteredcare/explore/about-whole-health.asp).

• *VA/DOD Identity Repository (VADIR):* VADIR makes DOD service record information available to VA. Among regular operational uses, VA utilizes information from VADIR to identify at risk groups who may benefit from further care enhancement and engagement.

Question 1a. Which Department is required to inform the individual about services and benefits?

Response. VBA provides mandatory training to Transitioning Servicemembers (TSM), their families, and caregivers at over 300 military installations worldwide, with information about services and benefits available to them in their communities. Training is mandated through the Interagency Transition Assistance Program where the Department of Labor, DOD, and VA are required to provide information in a cohesive, modular, outcome-based program that bolsters and standardizes the opportunities, services, and training that Servicemembers receive.

TSMs participate in these training courses through a varied approach that includes in-class instruction, Joint Knowledge Online, Military Life Cycles, installation engagements (which are tailored to the audience such as military spouses), and one-on-one counseling sessions where TSMs can approach a Benefits Advisor to inquire about additional services and opportunities available in a private setting at the installation.

VA is committed to providing the most up-to-date information on VA benefits and services to foster TSMs opportunities to achieve economic success and total well-being from Military service through civilian life.

Question 1b. How do the two Departments work together to ensure that veterans don't fall through the cracks?

Response. The joint VA/DOD efforts associated with Executive Order (EO) 13822 (EO) on transitioning Servicemember mental health have resulted in improved transition, access, outreach, and monitoring of TSMs and Veterans. Sixteen lines of action were developed, 10 of which are now in a steady operational state. In December 2018, DOD and VA began conducting mental health screening on all TSMs prior to separation. VA will reach out to all TSMs within 90 days of separation and again at 180 days and for a third time before the end of the first year of separation. VA, DOD, and the Department of Homeland Security (DHS) collaborated to develop a "one team" messaging campaign, disseminated to all VA facilities to ensure that transitioning Servicemembers, Veterans, family members, providers, and staff are aware of the impact and benefits resulting from the EO. Specific products developed included frequently asked questions resources, a placemat with EO benefits, brochures, social media posts, blogs, and an EO specific Web site that has been widely circulated.

Question 2. Veterans who receive care with VA are less likely than those who don't to commit suicide. What is the detailed plan for the two EOs to improve mental health and suicide prevention programs to benefit veterans?

Response. Suicide is a complex issue with no single cause. It is a national public health issue that affects people from all walks of life—not just Veterans—and for a variety of reasons. VA, alone, cannot end Veteran suicide. We know that some Veterans may not receive any or all their health care services from VA, and we want to be respectful and cognizant of a Veteran's choice to obtain care elsewhere. This means using prevention approaches that cut across all sectors in which Veterans may interact and collaborate with Veteran Service Organizations, state and local leaders, medical professionals, criminal justice officials, private employers, and many other stakeholders.

The Joint Action Plan for EO 13822, Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life, outlines the detailed plan for implementation, and 10 of 16 of these tasks are already complete. The Roadmap for EO 13861, National Roadmap to Empower Veterans and End Suicide, will outline the plan for implementation and enhancement to improve mental health and suicide prevention programs across Federal agencies, states, and communities to improve Veteran care.

Question 2a. What steps is VA taking to reach veterans who may have an OTH discharge, or who might not be associated with the broader veterans' community or a VSO?

Response. Former Servicemembers with OTH discharges can be difficult to locate. However, in January 2019, VA mailed 477,404 letters to OTH former Servicemembers' last-known addresses, as part of our public outreach efforts.

Question 2b. What are the metrics VA is using to see if the programs are working?

Response. Because no one strategy is effective in isolation, the public health model advocates for bundled approaches that reach all Veterans, selected subgroups of some Veterans that may be at increased risk, and the relatively few indicated Veterans at high risk. We have developed measurement strategies for each line of effort in our program to track and measure impact of activities on suicide reduction. VA tracks and assess numerous metrics associated with suicide prevention priorities, activities and efforts aligned with the 2018–2028 National Strategy for Preventing Veteran Suicide.

This list focuses on some of the metrics associated with the VA's suicide prevention priorities that are regularly tracked to monitor trends to include our enhanced care delivery, education and training, and outreach and awareness interventions:

- Lethal Means and Safety Planning which encompasses the following:
  - Suicide Risk Identification using a three-step approach to ensure universal suicide risk screening for all Veterans seen in clinics throughout VHA;
  - High Risk for Suicide and Enhanced Care (HRF) patient record flag for patients assessed to be at high risk for suicide. VA tracks numerous metrics tied to the HRF program to ensure compliance and appropriate follow up for these vulnerable Veterans;
  - Number of gunlocks we deliver;
  - Pounds of medication disposed;

– Suicide safety planning throughout VHA;
– Suicide Awareness Voices of Education (SAVE) training compliance among VA staff;
– SAVE trainings provided externally in the community; and
– VCL use and metrics associated with efficient and effective crisis line efforts.

- Partnerships, Outreach, and Awareness which includes the following:
  – Awareness campaigns—Online interaction with our campaign materials to gauge how effectively we are reaching the right people with the right information: site usage patterns, traffic to site, time on site, number of pages visited, public service announcement views, impressions and distribution, broadcast and billboard efforts (for more information on paid media see response to question 5);
  – Engagements with other key resources such as downloads of campaign materials, uses of SAVE training, views of our educational videos and public service announcements;
  – Outreach events completed by VHA staff within their communities and number of participants in attendance;
  – The number of community partners and an assessment of the gaps in sectors to ensure VA is developing partnerships across all areas that intersect with suicide; and
  – Action plans and efforts from Mayor's and Governor's Challenge partners.
- Enhanced Health Care Services such as the following:
  – Mental Health and Suicide Prevention Coordinator staffing metrics;
  – Number of Veterans identified by predictive analytics that receive the recommended interventions;
  – New mental health appointments within 30 days;
  – Same day access to mental health appointments;
  – Mental Health appointments delivered by telehealth; and
  – Post discharge follow up from inpatient care, emergency department, residential facilities, substance abuse, etc. to engagement in outpatient care.

Metrics related to our enhanced care delivery interventions have been developed through several automated dashboards to identify Veterans at highest risk for suicide to aid providers in improved decisionmaking and safety planning. Examples of these tools include the following:

- Suicide Prevention Quarterly Dashboard—reports quarterly metrics on core suicide prevention priorities, tracking trends, needs, and gaps for quality improvement, and is adaptable to track new priorities. Specifically, the dashboard maps out Veterans who have recently been identified as high risk for suicide and placed on our HRF. This dashboard marks the percentage Veterans that:
  – Have a Safety Plan documented within 7 days before or after flag initiation, or on or before discharge;
  – Received at least 4 mental health encounters within 30 days of flag initiation;
  – Have a new assignment, reactivated, or continued HRF who received a case review within 100 days after flag initiation.
- Recovery Engagement and Coordination for Health—Veterans (REACH VET): is Enhanced Treatment, which identifies patients at statistical risk of death by suicide in the next month.
- The Stratification Tool for Opioid Risk Mitigation (STORM): identifies patients at statistical risk of overdose or suicide-related health care events or death in the next year.
- The Suicide Prevention Population Risk Identification and Tracking for Exigencies unifies information from the following: HRF, STORM, REACH VET, post-discharge engagement, positive secondary suicide risk screens and intermediate or above risk levels captured by the comprehensive suicide risk evaluation to identify and reduce care gaps and ensure high levels of care for patients identified at high risk for suicide.
- Suicide Prevention Application Network (SPAN): a database that allows Suicide Prevention Coordinators to report suicides and suicide attempts; manage treatment plans; follow patient progress; and provide outreach. SPAN is designed to capture the number of suicides and non-fatal suicide attempts among the Veteran population. This information is calculated monthly and continuously updated.

VA developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to measure, evaluate, and benchmark quality and efficiency at medical centers to promote high quality, safety, and value-based health care. SAIL assesses

25 Quality measures including specific metrics assessing mental health care. These metrics are reviewed and utilized for decisionmaking and technical assistance to close gaps to offering the best care. These reports are publicly available on the VA website: https://www.va.gov/qualityofcare/measureup/strategic_analytics_for_improvement_and_learning_sail.asp.

FYQ	Number of OTH Veterans seen in VHA in the last 4 quarters	Number of OTH Veterans who received VHA specialty MH treatment in the last 4 quarters	Percentage of OTH Veterans seen in VHA who received care in specialty MH settings
FY 2017 Q4	426	301	70.65%
FY 2018 Q1	912	641	70.28%
FY 2018 Q2	1388	980	70.60%
FY 2018 Q3	1957	1393	71.18%
FY 2018 Q4	2350	1651	70.25%
FY 2019 Q1	2580	1818	70.46%
FY 2019 Q2	3130	2227	71.15%

In the 4th quarter, ending March 31, 2019, VHA treated 3130 OTH Veterans, with 2227 receiving care in a specialty mental health program.

Question 2c. Will the Department require additional funding from Congress to implement the EOs?

Response. Executive Order (EO) 13822, is well underway, and additional funding is not required. Funding requirements for EO 13861 are currently being assessed for FY 2020 and the Department will execute these requirements within its FY 2020 budget request.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Can you please describe the training provided to VA personnel following enactment of the Honor Our Commitment Act?

Response. VA conducted multiple trainings, including sessions for executive leaders, clinical providers, and administrative staff on the new 38 United States Code (U.S.C.) § 1720I, which authorizes VA to provide mental and behavioral health care to certain former Servicemembers with other-than-honorable discharges (OTH). The training included information about the changes made to the Veterans Health Administration's (VHA) policy governing eligibility determinations to implement section 1720I.

Question 1a. What actions has VA taken to ensure personnel are aware of the eligibility changes for other than honorable veterans so that they know not to deny these veterans mental health and behavioral care?

Response. VA enrollment staff recently completed updated training provided by VA's Health Eligibility Center. In addition, VA has established training plans for all employees who process compensation claims for former Servicemembers with OTH discharges, in the Veterans Benefits Administration's Veterans Service Centers.

Question 2. Can you please provide an update on VA's progress implementing GAO's recommendations outlined in their report Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation?

Response. We have implemented the recommendations of the Government Accountability Office (GAO). Recommendation 1 was to establish an approach for oversight of Suicide Prevention media outreach, including a clear delineation of roles and responsibilities and periods of staff turnover or program changes. This recommendation has been implemented and is closed. In April 2019, VA provided a new oversight plan that indicated leadership and contract oversight roles. The plan specified reporting structure and identified positions that can serve in acting capacities during periods of turnover. GAO closed the recommendation.

Recommendation 2 was for VA to establish targets for the metrics the office uses to evaluate the effectiveness of its suicide prevention media outreach campaign. VA is looking at metrics related to the following areas:

- *Awareness:* Reaching people, getting content and messaging in front of people;
- *Education:* Interaction with informational materials like data sheets or views of educational videos; and

• *Engagement:* People using Veterans Crisis Line (VCL) call, chat, text. Downloads and usage of products, resources and tools, link-outs to trusted resources like Make the Connection or self-check quiz. Deepest level of engagement.

Question 2a. How is VA evaluating the data it collects on its suicide prevention media outreach campaigns?

Response. In addition to the metrics presented in response to 2b below, the following are outcomes of the Crisis Intervention campaign and special activations:

• A paid media campaign started on March 12, 2019. Since the campaign launched:

– Monthly site visits to VCL.net increased from roughly 44,000 to over 90,000.

– Increase of 103.2 percent, with 48 percent of all site traffic arriving from paid advertisements.

– Monthly increases in the amount of calls, texts, and chats because of our ads:

– Monthly calls increased by 64.7 percent since launch. In February2019, before the launch, calls averaged around 4,500; by April, calls averaged around 7,500.

– Monthly chats increased by 124.6 percent since launch. In February, chats averaged around 1,500; by April, chats averaged around 3,300 in April.

– Monthly texts increased by 290 percent since launch. In February, texts averaged around 900; by April, texts surged to 3,800.

• Billboards: March 1-April 30

– 682 billboards disseminated in each of 100 largest markets in the United States;

– Estimated 440 million impressions, donated value of $2.5 million;

– Monitored web traffic in 17 markets that first confirmed placements; and Traffic increased by 248.7 percent, from 201 visits in February to 701 visits in April, average 41 visits per month per market.

• Major League Baseball Ads: Gameday programs estimated to gain 18.6 million impressions;

• Times Square: Drove 6 percent of traffic for the week (about 31 visits).

Question 2b. What targets is VA using to determine if a campaign is effective in reaching its intended audience?

Response. The paid media strategy is composed of the following three primary components that are monitored monthly:

Campaign 1: Crisis Intervention

• Campaign success will be gauged by actions taken on VCL.net as a direct result of the marketing campaign, measuring key performance indicators (KPI) such as paid traffic, calls, chats, and texts against baselines established in past years' campaigns.

Keyword Search Metrics	Fiscal Year (FY) 2019 Targets	Monthly Targets
Impressions	5,200,000	740,000
Calls	14,000	2,000
Texts	14,000	2,000
Chats	14,000	2,000
Self-check Quiz Link-outs	7,000	1,000

Campaign 2: National At-Risk

• In order to assess the immediate efficacy of this campaign, we will measure web KPIs and engagement with display and video content.

• Over a longer period of time, we will conduct search and brand lift studies on campaign YouTube content—examining lifts in awareness, as measured by organic search activity.

Top-line Metrics

FY 2019 Display Targets:	FY 2019 Video Targets:
• Impressions: 132,000,000 • Traffic to site: 520,000 • Site-specific conversion TBD	• Impressions: 19,000,000 • Traffic to site: 40,000 • Video views: 7,000,000 • Site-specific conversion TBD

Campaign 3: High-Burden Communities

• In order to assess the immediate efficacy of this campaign, we will measure web KPIs and engagement with display and video content.

• Over a longer period, we will conduct search and brand lift studies on campaign YouTube content—examining lifts in awareness, as measured by organic search activity.

Top-line Metrics

FY 2019 Display Targets:	FY 2019 Video Targets:
• Impressions: 132,000,000 • Traffic to site: 520,000 • Site-specific conversion TBD	• Impressions: 19,000,000 • Traffic to site: 40,000 • Video views: 7,000,000 • Site-specific conversion TBD

Question 2c. What action has VA taken to ensure its outreach content reaches veterans and others in the community to raise awareness of VA's suicide prevention services?

Response. Additional detail is presented in the response to question 2b above, but in general terms, the campaign can be outlined as follows:

• Awareness: promote VA suicide prevention resources and the #BeThere campaign to increase awareness among Veterans and their supporters through:
  – Impressions from ads, videos, out-of-home placements; and
  – Site visits to VeteransCrisisLine.net, BeThereForVeterans.com, VA.gov/BeThere.

• Education: increase familiarity with suicide prevention information to equip audience with skills to apply at an individual and systemic level through:
  – Time on site;
  – Pages visited; and
  – Interaction with informational resources (clicks to State data sheets, views of educational videos).

• Engagement: increase interaction with campaign and external resources that align with public health approach to suicide prevention through:
  – Downloads or use of actionable campaign resources (VCL chat, social media toolkits, clinical guides) and
  – Link-outs to other trusted partner and VA sites (self-check quiz, Make the Connection).

Question 3. Can you please provide an update on VA's progress implementing 14 of the remaining 16 recommendations outlined in GAO's July 2018 report, Actions Needed to Address Employee Misconduct Process and Ensure Accountability?

Response. A summary update on VA's progress toward implementing each of GAO's 16 recommendations set forth below:

• Recommendations 2, 3, 5 and 11 are closed.

• The VA Office of Inspector General (OIG) will respond separately to the Senate Committee on Veterans' Affairs for Recommendations 6 and 13.

• In response to recommendation 1, the VA Office of Human Resources and Administration (HRA) is defining requirements for one or more information systems that will collect misconduct and associated disciplinary action data Department-wide. Upon system implementation, a policy will be created that directs procedures on addressing blank data fields; lack of personnel identifiers and standardization among fields; and accessibility. The target date for system implementation, which is dependent on approved funding and acquisition related requirements, is January 1, 2020.

• Regarding recommendation 4, since November 1, 2018, the Oversight and Effectiveness (OE) Service assessed misconduct related files and documents at 14 VHA facilities in conjunction with scheduled human capital management assessments. OE will review any additional five VHA facilities during the 4th quarter of FY 2019. To ensure files are consistent with statute, regulation, and VA policy, to include VA Handbook 5021, OE uses checklists provided by the Employee Relations and Performance Management Service (ERPMS) to verify required documents and notices are maintained in the case files. Disciplinary actions that have a related processed Standard Form 50, Notification of Personnel Action are reviewed. OE identifies actions and requires human resources management offices to provide proposed and decision disciplinary letters and related case files. At the end of the assessment, OE provides feedback to the facility and human resources office. OE's findings and completed checklists are shared with ERPMS. VA has requested that recommendation 4 be closed.

• To address recommendation 7, non-criminal matters involving allegations of misconduct by senior officials that are referred to Office of Accountability and Whistleblower Protection (OAWP) by OIG, OAWP ensures that responses submitted back to the OIG address the six elements required in VA Directive 0701: (1) evidence of an independent review by an official separate from and at a higher grade than the subject/alleged wrongdoer; (2) specific review of all allegations; (3) findings of each allegation, which are clearly identified as either substantiated ("founded") or unsubstantiated ("unfounded"); (4) description of any corrective action taken or proposed as a result of a substantiated allegation, (e.g., change in procedures, disciplinary or adverse action taken, etc.); (5) Supporting documentation for the review, such as copies of pertinent documents, a summary report of the board of investigations, etc.; and (6) designation of a point of contact for additional information.

– OAWP is working with other offices in the Department to understand VA's current processes for receiving and tracking recommendations from OIG, the U.S. Office of Special Counsel (OSC), VA's Office of the Office of Medical Inspector (OMI), and GAO. OAWP is establishing a new VA compliance and oversight directive to cover the requirements under 38 U.S.C. § 323(c)(1)(F) to record, track, review, and confirm implementation of recommendations from audits and investigations carried out by OIG, OMI, OSC, and GAO. The target date for staffing the team to track the requirements under 38 U.S.C. § 323(c)(1)(F) and finalize the OAWP directive on these requirements is fall 2019.

– Per 38 U.S.C. § 323(c)(1)(F), OAWP is responsible for "[r]ecording, tracking, reviewing, and confirming implementation of recommendations from audits and investigations carried out by the Inspector General of the Department, the Medical Inspector of the Department, the Special Counsel, and the Comptroller General of the United States, including the imposition of disciplinary actions and other corrective actions contained in such recommendations."

– Consequently, the process described in GAO's report to respond to OIG findings or results will be changed to require all such reports be submitted to OAWP, which will record, track, review, and confirm implementation of the recommendations. As part of this oversight process, OAWP will also be responsible for reviewing responses to recommendations from facilities or program offices to ensure that they address the six elements identified in VA Directive 0701. The publication of guidance is expected by fall 2019.

• To address recommendation 8, OAWP is establishing a new VA investigations directive, which will cover the investigation of senior leader misconduct, poor performance or whistleblower retaliation by OAWP, and OAWP's referral of whistleblower disclosures to the appropriate investigative entities. The directive will include provisions for tracking the implementation of any recommended action. The directive is currently undergoing review within the Department and OAWP anticipates that will be formerly issued before October 2019.

– All misconduct by senior leaders in VA is handled by OAWP from intake, through investigation to working with the proposing and deciding officials (including preparing the proposal and decision letters). The Proposing and Deciding Officials have independent authority to determine whether an action should be proposed or taken and the appropriate levels of discipline, if any, to impose. OAWP then works with the appropriate servicing personnel office to ensure the action decided upon is implemented. The publication of written guidance is expected by fall 2019.

• In response to recommendation 9, OAWP is working closely with HRA, which owns the primary human resources system of records for VA, to ensure that disciplinary actions taken in response to findings of misconduct are recorded within this official system of records.

OAWP maintains an internal management information system to record all phases of work processes and the outcomes for all disclosures of wrongdoing received by OAWP. Information regarding senior leader cases is maintained in greater detail. Both results (those from all disclosures and those specifically focused on senior leaders) are routinely used to inform VA leadership regarding accountability efforts involving senior leaders throughout the Department.

– The ad-hoc VA-wide discipline tracking system using de-identified data was created in response to a specific request from the Congressional Oversight Committees and was never designed as a robust management information system. It will be phased out once the Human Resources Information System (HRSmart) can capture and record similar data. OAWP is working with HRA to refine VA's HRSmart to capture all types of disciplinary information.

• Regarding recommendation 10, all allegations of misconduct by senior leaders within the Department are resolved by OAWP. An investigative report or summary generally will not include a recommendation for any specific penalty. All investigative reports or executive summaries involving senior leaders, regardless of origin (e.g., OAWP Investigations Division, OIG, OSC), are reviewed by OAWP's Advisory and Analysis Division to determine the appropriate accountability actions to recommend to the proposing official. The Advisory and Analysis Division then prepares a draft proposed action, which is submitted for legal review to the Office of General Counsel (OGC) and shared with the proposing official, the management official responsible for proposing disciplinary action, for consideration. OAWP then works with the proposing officials as they consider whether to propose an action and determine the level of penalty to propose.

– When OAWP began operations, it started with a legacy caseload of 116 cases, involving 216 persons of interest (POI). Since June 23, 2017, through June 1, 2018, OAWP has received an additional 261 cases for investigation, involving 482 POIs. From June 23, 2017, through June 1, 2018, OAWP completed 128 cases involving 236 POIs. From June 23, 2017, through June 1, 2018, 39 cases, involving 65 POIs, were received from other investigatory efforts and sent directly by the OAWP Advisory and Analysis Division for review and disposition. The release of written guidance is expected by fall 2019.

– See, also, update on the response to recommendation 8.

• Regarding recommendation 12, per 38 U.S.C. § 323(c)(1)(F) OAWP is responsible for "[r]ecording, tracking, reviewing, and confirming implementation of recommendations from audits and investigations carried out by the Inspector General of the Department, the Medical Inspector of the Department, the Special Counsel, and the Comptroller General of the United States, including the imposition of disciplinary actions and other corrective actions contained in such recommendations."

– See also the update for recommendation 8.

• In response to recommendation 14, the internal VA policy (an interim policy step via memorandum) is expected to be published by fall 2019. The subsequent Directive and Handbook will be published as rapidly as staff coordination permits.

• As for recommendation 15, VA is committed to ensuring that employees who report wrongdoing are treated fairly and are protected against retaliation. VA was one of the first cabinet-level agencies to be certified by OSC's 2302(c) Whistleblower Protection Certification Program in October 2014. Under the program, VA:

(1) places informational posters regarding prohibited personnel practices (PPP), whistleblowing, and whistleblower retaliation in a public setting at VA facilities and VA personnel and equal employment opportunity offices;

(2) provides new hires with written materials on PPP, whistleblowing, and whistleblower retaliation;

(3) establishes a website on PPP and whistleblower rights and protections; and

(4) developed, in cooperation with the OSC, supervisory training on PPP and whistleblower rights and protections. VA executives, managers, and supervisors must complete this training on a biennial basis.

– Regarding the training discussed above, OAWP is working with OSC to revise the training to comply with the requirements of 38 U.S.C. § 733 and anticipates issuance of that training by fall 2019.

– Regarding whistleblower protection, since the appointment of OAWP's first Assistant Secretary, Dr. Tamara Bonzanto, OAWP has completely stopped referring disclosures alleging whistleblower retaliation by senior leaders or supervisors to other VA entities for investigation. Instead, those allegations of retaliation are investigated directly by OAWP staff to mitigate the potential of a conflict of interest or further retaliatory acts against the whistleblower.

– OAWP also works closely with OSC and OGC to implement the whistleblower protections codified under 38 U.S.C. § 714(e). Under that subsection, VA cannot take a 38 U.S.C. § 714 disciplinary action if an individual has a pending complaint with OSC (unless OSC allows VA to proceed) or has an open disclosure with OAWP.

– The process and procedures for making a whistleblower disclosure and reporting PPPs, including retaliation, to OSC are posted at every VA facility. OAWP is also responsible for receiving and, in certain instances, investigating allegations of whistleblower retaliation.

– Additionally, whistleblower protections are written into 38 U.S.C. § 714, one of the authorities that VA uses to discipline employees. OAWP and OSC have developed a functional process to ensure those protections are implemented. Section 714(e) prohibits VA from effecting an action under that section when the employee against whom the action is proposed has alleged that they either: (1) are seeking corrective action with OSC for an alleged prohibited personnel practice or (2) have a disclosure pending with OAWP.

– From June 23, 2017, through June 1, 2018, OAWP, in cooperation with OSC, has resolved 73 matters and has 90 open cases involving the whistleblower protections under 38 U.S.C. § 714(e).

– The Secretary of VA has delegated authority to the Executive Director, OAWP, to hold individual personnel actions if the action appears motivated by whistleblower retaliation. OAWP has hired two Whistleblower Program Specialists, specifically to increase awareness of whistleblower protections and work with individual disclosing employees to ensure they are treated fairly and protected from retaliation for their disclosures.

• For recommendation 16, OAWP is finalizing training required under 38 U.S.C. § 733, which includes:

(1) an explanation of each method established by law in which an employee may file a whistleblower disclosure;

(2) the right of an employee to petition Congress regarding a whistleblower disclosure in accordance with 5 U.S.C. § 7211;

(3) protections against being prosecuted or reprised against for lawfully disclosing information to Congress, OIG, OAWP, OSC, or another investigatory agency;

(4) an explanation of the language required in non-disclosure agreements and policies to ensure wrongdoing may still be reported;

(5) the right of contractors to be protected from reprisal by their employer for disclosing substantial violations of contracting law; and

(6) An explanation of the prohibited personnel practices and the rights of employees when reporting wrongdoing.

– As part of Public Law 115–41, the VA Accountability and Whistleblower Protection Act of 2017, the Department is required to provide whistleblower training to all employees on a biennial basis (codified in 38 U.S.C. § 733). The training will include the reporting lines for disclosures of wrongdoing, the manner in which disclosures flow once they are made, how information is shared among the whistleblower entities and what protections exist for those who disclose wrongdoing. The required training is expected to be released by fall 2019.

Question 3a. Would VA support increasing the independence of the Office of Accountability and Whistleblower Protection? If so, what action would VA take to increase independence, and what, if any, resources or authorities would VA need from Congress?

Response. OAWP is an integral part of VA. As required by law, the Secretary of Veterans Affairs provides OAWP with the staff, resources, and access to information as is necessary to carry out its statutory functions. As with other VA offices, except OIG which, by law has its own counsel, OAWP relies on OGC legal guidance as it pertains to the execution of its statutory functions.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. KIRSTEN SINEMA TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Has the VA discovered what could be the main reasons or trends that veterans have for discontinuing mental health treatment so early on?

Response. VA is learning that the reasons Veterans may discontinue mental health treatment early vary based on age, gender, race, and mental health condition. However, there are several cross-cutting factors such as competing demands from work, school, and family responsibilities. We also know from studies with Ac-

tive Duty Servicemembers that, as a group, they value self-reliance and tend to believe they can handle mental health problems without professional intervention. Other factors associated with lack of ongoing engagement with mental health treatment include lack of trust in mental health professionals; concerns about confidentiality; and general issues with the procedures of treatment, such as the length of a course of treatment, frequency of appointments, and taking medications. Additionally, several studies have found that the stigma associated with mental health treatment is also a major factor in a Veteran's choice to leave treatment.

It is worth noting that discontinuing mental health treatment earlier than expected may not always be associated with negative outcomes. Recent research suggests a significant portion of Veterans who discontinued evidence-based treatment demonstrated significant clinical benefit. This was true for an estimated 50 percent of Veterans treated for PTSD; 65 percent of those treated for Alcohol Use Disorder; and 68 percent of those treated for depression.

Annually, VA contacts a random sample of Veterans to inquire about their experience with mental health care. The Veterans Outcome Assessment Survey is administered by telephone to approximately 10,000 Veterans each year at the time when they are beginning treatment in a mental health program and again after 3 months. In 2017, approximately 11 percent of Veterans reported that they had not received mental health services between the baseline and follow-up interviews. Approximately 5 percent reported that they discontinued because they did not want or need services, while 8 percent reported that they had experienced problems that led to their dropping out. Three percent reported both types of reasons.

An example of the reasons provided by the 11 percent of the Veterans who agreed to participate and subsequently dropped out of the survey is as follows:

- "Specific services or programs I wanted weren't available" (2.1 percent);
- "It was too difficult to travel to appointments" (2.7 percent);"
- "Services were available but not at times that were convenient for me" (2.9 percent);
- "Services were available, but I didn't like my options" (2.0 percent);
- "I started to get services and didn't like them" (1.7 percent);,
- "I wasn't able to see the provider I wanted" (1.2 percent); and,
- "There were problems with eligibility or insurance" (0.6 percent).

VA has since used this data to consider strategies needed to improve Veteran satisfaction.

Question 1a. What is the VA doing to encourage veterans to reengage with mental health if they quit treatment early?

Response. VA is attempting to decrease the number of Veterans who unexpectedly or prematurely leave treatment. For example, when Veterans are engaged in a shared decisionmaking conversation with a mental health care provider to help them adequately understand their mental health conditions and problems and then provided sufficient and understandable information about appropriate treatment alternatives, they are more likely to develop an informed treatment preference. Research indicates when Veterans are offered the treatment they prefer, they are more likely to engage in treatment, complete the course of care, and receive increased benefit from treatment. Several shared decisionmaking training resources have been developed for use by VA mental health providers. Additionally, standardized tools for use in the shared decisionmaking conversation to ensure quality of information provided have been developed for depression, PTSD, insomnia, Substance Use Disorder treatment, and pain.

When Veterans discontinue treatment unexpectedly, policy guides providers to make multiple attempts to contact the Veteran to discuss the situation and encourage treatment engagement. If Veterans cannot be reached by telephone, they receive a letter from the provider encouraging contact. VA has also attempted to remove any process barriers to Veterans returning to care. For example, Veterans can use appointments to meet with a mental health provider when they desire (rather than having to wait for an appointment) and all VA facilities offer evening appointments. If the Veteran has been identified as being at risk for suicide, the facility-based Suicide Prevention Coordinator activates additional means of contacting the Veteran and ensure his or her safety and advocating for re-engaging with treatment.

Veterans with serious mental illnesses (SMI) constitute a highly vulnerable population. Studies have shown that individuals with SMI have a higher rate of mortality compared to patients without SMI. In VHA, the SMI Re-Engage Program identifies Veterans with SMI who have been lost to follow-up care for at least a year; attempts to locate and contact them; and invites them to return to VA for the mental health and physical health services they need. Through this program, 42 percent of Veterans who were contacted returned to care within 18 months of being

contacted, significantly more than the percentage of Veterans who were not able to be contacted (27 percent).

VA's Primary Care Mental Health Integration (PCMHI) initiative provides mental health care in the primary care clinic. For many Veterans, receiving mental health care within primary care reduces the stigma associated with mental disorders. PCMHI has developed brief versions of some evidence-based therapies that are often more acceptable for Veterans who are unable or unwilling to engage in the usual mental health services. PCMHI clinicians are part of the primary care PACT and serve as resources for patients who have discontinued mental health treatment but continue enrollment in PACT.

Question 2. Can the VA explain the lack of reporting?

Response. VA was one of the first institutions in the United States (U.S.) to implement comprehensive suicide surveillance and has continuously improved data surveillance related to Veteran suicide. VA and DOD collaborate to search the National Death Index (NDI) of the Centers for Disease Control and Prevention (CDC) to assess vital status and cause of death for Veterans and other Servicemembers. CDC compiles NDI data from data from State vital statistics offices. These are provided to the CDC's National Center for Health Statistics through agreements with the States. NDI data are considered the gold standard of mortality data. They include indicators of date, State, and cause of death.

NDI releases death records for request approximately 11 months after the end of the calendar year. At this time, a coordinated VA/DOD search of millions of records is completed, leading to the identification of the matching death records and cause of death for Veteran decedents, followed by analyses and reporting of this information. This synchronized, multiagency process leverages the best available data to report and track Veteran mortality.

The most recent national-level Veteran suicide data was released in September 2018, (reflecting data through 2016), and is available in the VA National Suicide Data Report, 2005–2016. The 2017 data are scheduled to be released later this summer. Recent additional reporting has included State-level longitudinal data and information on former Servicemembers who never were activated by the Federal Government as National Guard and Reserve members.

A limitation of the CDC's National Death Index is that it does not include additional fields that are captured in death certificates (e.g., district and county of death, occupation, and detail regarding manner of death). This limitation constrains ongoing VA suicide surveillance, including county-level assessments.

VA recommends enhancement of the CDC's National Death Index, at least for the purposes of Federal mortality surveillance, to enable collection of these important measures.

Question 2a. How many researchers are actively working in this database and does the VA have a plan to expand its research team, and does the VA have a plan to create sharing access to these databases with academics?

Response. In addition to the annual Veteran suicide statistics reported in VA's 2005–2016 National Suicide Data Report, and accompanying State-level analyses, VA provides Suicide Data Repository NDI mortality data, by request, to approved VA researchers with an Internal Review Board-approved research project or VA program-office sponsored non-research operations project. From 2014 through June 2019, VA provided mortality data to more than 110 VA research and operations projects, including 22 specifically focused on examining suicide mortality in the Veteran population. VA's provision of these data to these researchers led to the development of at least 16 peer-reviewed publications specifically in the area of suicide prevention, contributing to a greater understanding of suicide mortality among the Veteran population.

Through VA's agreement with NDI, these data are only available to VA researchers, and must be maintained within the VA IT environment. Should non-VA affiliated researchers be interested in mortality information, they should work directly with NDI to receive mortality data.

Question 2b. How are you using these databases to inform how you resource suicide prevention programs and efforts on the ground?

Response. Ongoing collection, analysis, and dissemination of suicide-related data is crucial for understanding Veteran suicide and informing suicide prevention initiatives. Data drives the public health approach. VA analyzes and reports on suicide data to gain insight into high-risk populations.

VA is using data to tailor the best possible targeted prevention strategies to reach all Veterans—not just those who are identified as being at risk. Universal strategies reach all Veterans in the U.S. (e.g., the #BeThere campaign). Selective strategies are intended for some Veterans in subgroups that may be at increased risk for suici-

dal behavior, such as women Veterans or Veterans with substance use challenges (e.g., mental health care for OTH discharged Veterans, the Mayor's Challenge, and the Executive Order). Indicated strategies are designed for the relatively few individual Veterans identified as having a high risk for suicidal behaviors (e.g., REACH VET; the expansion of VCL; and discharge planning and follow-up enhancements).

VA uses, and will continue to use, data to improve its strategies, programs, and resources. Additionally, we will share data with community-based health care providers and partners to help them support Veterans in their communities.

Question 3. Are you looking at how the states with higher rates are resourced versus states with lower rates and using that to inform your prevention work moving forward?

Response. Disparities in suicide rates exist between states and, in some cases, regions. Numerous factors that contribute to suicide risk and incidence must be considered when examining a state's suicide data. Some states have relatively large Veteran populations or overall populations, which can affect suicide rates. While there is no single reason why one state has higher suicide rates than others, factors such as access to health care; rural versus urban settings; and access to lethal means are relevant considerations when examining differences in rates.

In March 2018, VA and SAMHSA launched a partnership to give 24 cities the tools and technical assistance needed to address Veteran suicide at the local level. The program began with seven cities—Albuquerque, New Mexico (NM); Billings, Montana (MT); Helena, MT; Houston, Texas (TX); Las Vegas, Nevada (NV); Phoenix, Arizona (AZ); and Richmond, (VA)—participating in a policy academy process that had previously only been available to States and territories. The cities were invited based on Veteran population data, suicide prevalence rates, and the capacity to lead the way in this first phase of the Mayor's Challenge. The teams developed an understanding that a multi-stage, multi-faceted approach will likely yield the greatest long-term impact on Veteran suicide. Ongoing engagement and support for teams at the local level is critical for success in not just one but all seven areas of the CDC identified strategies.

One year after the launch of the Mayor's Challenge, building on the aforementioned successes, the program is now expanding to 24 sites nationwide: Albuquerque, NM; Atlanta, GA; Austin, TX; Billings, MT; Charlotte, NC; Clarksville, TN; Columbus, OH; Detroit, Michigan; Helena, MT; Hillsborough County, FL; Houston, TX; Jacksonville, FL; Kansas City, MI; Las Vegas, NV; Los Angeles, CA; Manchester, NH; Oklahoma City, OK; Phoenix, AZ; Reno, NV; Richmond, VA; Suffolk County, NY; Topeka, KS; Tulsa, OK; Warwick, RI.

The Mayor's Challenge served as a model for the State-based Governor's Challenge, which launched February 2019, in Alexandria, VA. State leaders from Arizona, Colorado, Kansas, Montana, New Hampshire, Texas, and Virginia are creating plans to implement the National Strategy for Preventing Veteran Suicide to provide a framework for identifying priorities, organizing efforts and contributing to a national focus on Veteran suicide prevention in their states. VA and SAMHSA will ensure the work is, evaluated for effectiveness, and shared with communities to help optimize the efforts of all partners and stakeholders committed to preventing suicide across the SMVF demographic group.

To reach all 20 million Veterans in the U.S., including those who do not—and may never—seek care within our system, VA has launched a community-based public health approach to effectively implement multiple target goals outlined in the National Strategy for Preventing Veteran Suicide. Veteran Integrated Service Network (VISN) 23, which includes Iowa, Minnesota, Nebraska, North Dakota, South Dakota and portions of Illinois, Kansas, Missouri, Wisconsin, and Wyoming, provided the innovative first step of creating roles in its facility suicide prevention programs dedicated to expanding education and outreach for suicide prevention across the network. VISN 23 then partnered with VA OMHSP to initiate a pilot program within VISN 23 to improve the effectiveness of its localized public health approach by reaching Veterans through proactive, community-based measures.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO LT. COL. JIM LORRAINE

Question 1. Your testimony also notes the need for a greater collaborative research and data sharing relationship between the Federal, state, and local governments as well as academic institutions. This is why your organization launched Operation Deep Dive which is currently active in 14 communities across the country.

Question 1a. Can you discuss in greater detail the mechanism you have in place to assess and analyze data in real-time?

Response. Operation Deep Dive has two phases of data collection and analysis:

• Phase 1 is a retrospective study designed to more accurately understand the veteran suicide crisis at the community level. This phase will obtain all non-natural death records from coroner/medical examiners offices in 14 communities across the United States for those who have died by suicide or accidental death (i.e. single car accident, overdose, accidental death by fire arm) between 2014–2018. There is no standard across states or counties for identifying if the deceased is a former servicemember. Therefore, all names are provided to the University of Alabama's secure database. Once the Department of Defense's Institutional Review Board (IRB) has approved our protocol, these records will be shared with the DOD to identify who in our database was a former servicemember and who was not. The former servicemembers identified by DOD will then be provided to the VA which also require a separate IRB. The VA will conduct their own data analysis on the former servicemembers who were enrolled into the VA, and provide us with de-identified aggregate data. While this is taking place, we will be submitting a second phase of the IRB to the DOD to provide extensive service history of confirmed former servicemembers to the University of Alabama. Without the VA, DOD and coroner/medical examiners and states sharing data, and the University of Alabama analyzing the information in its entirety, the trends would be unable to be shared directly to the communities. As results/trends are identified they are immediately presented to the community for which the data was obtained.

• Phase 2: We will be collecting all non-natural deaths prospectively until 2021 to continue confirmation of veteran status. From 2019 forward, we are conducting interviews with loved ones who have lost a veteran to suicide or self-harm within a two to six month time period of their death. This qualitative data is being obtained through the Sociocultural Death Investigation tool (a semi-structured interview instrument developed by America's Warrior Partnership and University of Alabama that examines community factors related to suicide or self-harm for veterans). That information will be obtained and shared with the community as trends become apparent.

Throughout this study, each community has a multidisciplinary team made up of community stakeholders who champion the study and drive the prevention strategies within the communities as the data identifies trends.

Question 1b. Additionally, how quickly will the communities be able to adjust once taking this new data into consideration?

Response: Communities are reliant on aggregate data in order to provide prevention services. Communities are unaware of the uniqueness of their former servicemembers who have taken their lives compared to other communities. Therefore, once they are made aware of their population, they will have the information to immediately target the specific needs of their former servicemembers in their community.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO COL. MIGUEL D. HOWE

Question 1. In your testimony you mention that any community grant program should adopt the Supportive Services for Veteran Families (SSVF) Model. Can you elaborate why you believe this is the best model?

Response: Mental health conditions, substance abuse, and access to lethal means are the most critical factors that contribute to veteran suicide. Although evidence-based treatments exist for mental health conditions and substance abuse, barriers to seeking and accessing high-quality care include: stigma about seeking help; difficulty navigating a confusing landscape; and limited capacity of effective care. Connection to comprehensive services and solutions at the community level is paramount. The full complement of risk factors in the military and veteran populations for suicide mirror the social determinants of health and successful transitions for veterans from military service to civilian life. An integrated community level approach that addresses all of these variables inclusive of not only quality health care for mental health and substance abuse, but also comprehensive resources and services for benefits, housing, transportation, emergency financial assistance, education, employment, and social connections, will better reduce risk for suicide.

The PREVENTS Executive Order contains important elements to prioritize research, coordinate and align effort across the Federal Government, and to develop proposals to offer grants to state and local governments to support community level efforts toward a comprehensive approach to prevent veteran suicide.

In my June 19, 2019 testimony to the Senate Veteran Affairs Committee Hearing, Harnessing the Power of Community: Leveraging Veteran Networks to Tackle Suicide I delineated five recommendations to maximize those elements of the PREVENTS EO:

- Establish an overarching vision for veteran health and wellbeing;
- Reduce barriers and increase access to effective mental health and substance abuse care;
- Improve connections to care through peer networks;
- Foster meaningful community coordination and partnerships;
- Improve access to, and delivery of, high-quality mental health care for veterans.

As part of my fourth recommendation, Foster Meaningful Community Coordination and Partnerships, I wrote:

> "In order to maximize current grant funding in support of veteran services, Congress should consider repurposing Supportive Services for Veteran Families (SSVF) that focus primarily on ending homelessness and consolidate the program with new community based grants to more broadly support the full continuum of economic and health and human services needs in community based networks that support My-VA communities."

The SSVF model has proven to be an effective public policy program that affords important lessons learned for an integrated community-based approach for suicide prevention in the veteran population. The SSVF has proven to be a successful and relatively cost-effective model for reducing veteran Homelessness. The underlying risk factors for Homelessness and Suicide are parallel and overlapping, and the supportive services to ameliorate those factors are similar. SSVF services benefit veterans at elevated risk for Suicide as well as Homelessness.

I do not know if the SSVF Model is the best model (as you attribute to me in your question), but as delineated in this response to your question, the SSVF model does provide important lessons learned, and existing capacity that can serve as a start point for any new community based grant program for suicide prevention. There are important differences between the driving mandate for Homelessness ("Housing First") and for Suicide Prevention ("Mental Health and Substance Abuse Services, and Reducing Access to Lethal Means"), but the underlying risk factors for Homelessness and Suicide are parallel and overlapping. The individualized veteran approach to wrap around services ameliorate risk factors for both Homelessness and Suicide.

I advocate for you to both consider the SSVF model, and to consider integrating funding of the SSVF model into any new community grant-based programs and public-private partnerships for ending veteran suicide. Integrating any new community-based grant programs for Suicide Prevention, with the SSVF program could result in service delivery efficiencies, improved outcomes for more veterans, and cost savings to the government. It would also provide authorization to Federal agencies to work with community-based connectors to, and providers of, services creating efficiencies for all parties that results in veteran access to the full complement of services across all sectors.

Established in FY 2012, the Department of Veterans Affairs Supportive Services for Veteran Families (SSVF) is a short-term case management program that targets homeless veterans and those at imminent risk of losing their housing. The program awards grants to private Non-Profit Organizations and Community Cooperatives that provide a range of supportive services to eligible very low-income families. These services are individualized to meet each veteran's need and include: health care, daily living services, personal financial planning, transportation, fiduciary and payee services, legal, child care, housing counseling, and can also pay rent to third party entities for short periods of time.

SSVF operates on a housing first model. As such, the VA executes SSVF in partnership with the Department of Housing and Urban Development's Veteran Affairs Supportive Housing (HUD-VASH) program. A veteran does not have to receive a HUD-VASH voucher to take part in SSVF, however, in 2017 29% of all permanent housing placements through SSVF were conducted in conjunction with HUD-VASH vouchers.

Housing is not contingent on compliance with support services. The veteran agrees to lease agreements and then is provided support services in direct support of the lease. While the veteran is able to utilize all programs under SSVF, there is particular emphasis placed on services related to the specific situation currently faced by the veteran. The average length of participation in SSVF has been 116 days. The typical veteran successfully assisted through SSVF rapid rehousing spent 125 days enrolled in SSVF, with half of their program time spent working with SSVF to find and secure permanent housing, and the other half of their program

time spent receiving case management, rental assistance, and other tenancy supports from SSVF while stabilizing in permanent housing.

In FY 2017, SSVF served over 299,176 veterans and family members with over 80% (238,197) successfully transitioned to permanent housing following the program, and only 3% returning to unsheltered locations (with the status of 7% unknown). The remaining 10% either transitioned to shelters, temporary housing, or moved in with family. Those that remained in the program longer than 90 days have had a significantly higher chance of remaining in the housing than those who leave the program sooner.

Since 2012 over 464K veterans have been served through SSVF grants at an average cost of $3539. Over the same period of time 55,000 of those veterans have been leverage HUD-VASH grants at an average cost of $6818 per veteran served. Overall, the SSVF has been viewed as highly effective in getting veterans into permanent housing, reducing the number of homeless veterans by 49% from 2010–2018.

Important elements of SSVF success include: a Housing first approach; Federal partnership with HUD; and public-private partnerships that result in connection to the full continuum of supportive services at the community level beyond the capacity of Federal agencies. Those services address the underlying risk factors that resulted in Homelessness. These are the aspects of SSVF which could be leveraged in a community base public-private partnership model to address suicide.

Just as the SSVF/HUD-VASH program makes housing first the key pillar in eliminating homelessness, a community-based program should make mental health care and substance abuse for veterans in acute crisis, or at elevated risk, the key pillar of suicide prevention services. While the VA does not deliver actual housing services (relying on HUD and community based private sector partners) the VA does deliver health care services for Mental Health and Substance Abuse. Not only is the VHA the largest integrated health care system in the United States, its mental health and substance abuse programs for veterans are best in class. As such Congress should consider how to integrate VHA services as a foundational element of any new suicide prevention programs.

Congress should also integrate new VA grant programs with Health and Human Services (HHS) as a critical partnership and key component of any VA community-based veteran suicide prevention program. Just as HUD provides grants and expertise to SSVF programming, HHS can provide expertise and existing grant programs for mental health services. Whether under SAMHSA, the CDC or HRSA (Health Research Services Administration), HHS has a number of grant programs which foster connection and access to mental health and substance abuse services for veterans. The VA could provide not only VHA health care services, SSVF lessons learned, and staff and oversight to a partnered program, while the HHS could provide infrastructure and expertise in community level grant making for mental health and substance abuse services.

In addition to existing SSVF grant partners, community based collaboratives such as those piloted by America's Warrior Partnership, Combined Arms, the IVMF's America Serves, San Diego 211 and the National Veterans Initiative are promising practices for how to better connect our veterans and their families to the full continuum of health and social services at the community level (to include VHA). They also follow a similar approach to the SSVF model, and reduce risk factors for not only Homelessness, but Unemployment, Suicide, and set the conditions for a successful transition from military service to civilian life for veterans. An integrated approach—Federal-State-Local, and public-private—that connects veterans to the full suite of health, human and social services, will not only reduce risk for suicide, but set the conditions for veterans to thrive.

A P P E N D I X

PREPARED STATEMENT OF JENNIFER SATTERLY, CO-FOUNDER, ALL SECURE FOUNDATION

TO THE MEMBERS OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS: All Secure Foundation was founded more than three years ago to help combat warriors and their families heal from the invisible wounds of war, Post-Traumatic Stress. Our very first speaking engagement was a Congressional Briefing held by NAMI on veteran mental health issues in November 2017, and while we would have preferred to get our start at a VFW hall or a high school, my husband, Command Sgt. Major (retired) Tom Satterly and I jumped at the opportunity to share our story in hopes to create awareness of the issues millions of American servicemen and women and their family face.

We were told by many, including a former House of Representative elected official that our presence and statement wouldn't make a difference; that we would be met with a hand shake and a photo op, and that we would be forgotten as soon as the room cleared of staffers headed to the next briefing. We had to try though, we had to make our voices heard, and maybe, just maybe, the stories we shared that afternoon would reach the heart of someone who not only could stand up and say no more but someone who actually WOULD stand up and say no more. Not our warriors. Not our spouses and caregivers. Not our children.

We walked, more like ran, the halls of the Capital buildings and sat one on one with several Members of the Senate, Congress, and House of Representatives. My husband who was a Delta Force CSM for over 20 years shared his story about nearly becoming a veteran suicide himself just 4 years prior. As he choked back his tears telling his story of yet another divorce, a son he barely knew, chronic pain from multiple explosions and surgeries which lead him to a place he never thought he would be, sitting in a parking garage, gun in hand trying to decide if today was the day to pull the trigger. As Tom and I became emotional, Senator Patty Murray reached across the table to put her hand on mine, looked me in the eyes and said, "tell me your story, tell me about the spouses."

It was the first time that day, and the only time that day, that someone at the Capital asked us about those who also serve this great Nation, those who have sacrificed a stable home life, those who watch their children painfully leave another house and have to adapt to a new town and school yet again, those who go to bed with a prayer that the love of their life will make it back to the base that night safely in a very unsafe place thousands of miles away, those who wait patiently for the day they will be together again only to discover that when they are, the person they married is now a stranger who's wounds may not be visible, but are no less painful, deep, and in need of treatment.

You might be thinking, "What does a spouses' story have to do with combating veteran suicide?" My answer is . . . everything.

I have spent the last 7 years working alongside and with Special Operation Soldiers, Sailors, Airmen, and Marines. I have talked to hundreds of the toughest, most elite, intelligent, and highly trained warriors that our country dispatches around the world to do it's bidding. I have heard combat stories that would keep any listener awake at night with images so disturbing that you wonder just how a person ever comes home ok after that experience, not to mention dozens of those experiences. I have heard stories of unbearable loss, of heartbreak and of guilt for making it out when their brother or sister did not. I have heard more stories than I can count that are just like Tom's, a well-trained and elite soldier who everyone thought was ok sitting alone with a loaded gun in their hand trying to decide if today is the day to leave the debilitating emotional and physical pain behind. I am most often a stranger to these men and women, a voice on the phone who cares, who listens, who lets them know that the heartache and pain they feel and try to bury is the very

thing that makes them human not weak, and after what they saw and did, that they have the fight of their lives ahead of them at home to rebuild what war took away from them. That the trauma has shaped them into a new person and that person has value in this world not in spite of it but because of it. That they matter. That they are seen and heard. That they don't need to fill the empty void and pain with toxic and addictive quick fixes in the vast darkness that they occupy day and night. That they are not evil, bad, or monsters that they sometimes feel they are, but instead heroes our Nation called to fight evil, to remove the bad, and battle the monsters that our politicians have labeled as such.

Very few, if any, share the stories they share with me with their spouses. They tell me over and over again, "I don't want to bring the war home. I can't tell them what I saw and what I did. They've already been through so much." The protection they feel for their spouse is also a cover; a cover for the fear that they will be judged or no longer loved for who they were and what they had to be overseas. Vulnerability is a path toward healing yet they are conditioned and trained to keep quiet and that vulnerability is a weakness. Yet there is no healing without it. Distance and isolation in the relationship is created, just another symptom of PTS. The spouse gets tired of asking "what's wrong?" with no response and the warrior doesn't know how to share the unthinkable. The war torn home is not reserved alone for countries thousands of miles away, the war torn home is an American home and to heal the veteran you have to heal the whole family unit. Hurt people, hurt people. If you don't heal everyone involved, the hurt persists, the cycle cannot be broken, and the pain becomes generational. When a veteran takes his or her life the impact is greater than they can imagine. And that pain is passed on.

Let's talk about what no one wants to talk about, the anger, the physical and emotional abuse, the neglect, the pain, the addiction, the reckless behavior, the anxiety, the perfection-driven aggression, the paranoid behavior that keeps everyone in the house on eggshells. This is the face of Post-Traumatic Stress. These are suicide triggers. The feeling of no longer being who they were and not being able to control or understand what is going on in their mind or with their bodies. No one has explained the biology of PTS, that it is a normal and natural response to a traumatic event, so they feel it's something they should be able to control verses a biological response that is beyond their control and in need of treatment just like any other wound. In the veteran family, no one speaks up, no one asks for help, no one knows where to turn.

Veterans are not just killing themselves because of what they saw and did and lost overseas it is also what they saw and did and lost at home. The shame of another divorce. The pain and heartbreak of a child who doesn't really know who they are, or worse, is afraid of them. The drinking and abuse of pills to dull the senses and memories. The feeling of uselessness, hopelessness, chronic physical pain, and the loss of a tribe that you once would have given your life for. The military's cultural stigma that asking for help is a sign of weakness. The toxic belief that they should "just get over it" now that they're home or the ringing in their ears they've heard from the ignorant masses of "they knew what they were getting into when they signed up to serve." The insecurity of starting a new career over in their 30's or 40's. Not fitting in civilian life, a stranger in a strange land.

It is the spouse, the caregiver, that is most often their advocate, sometimes their only advocate for healing. When a veteran is in crisis, they are not thinking clearly and a spouse or caregiver often is the only one to get them the help they need. That is if they know where to turn for help.

In a recent study by the VA, 80% of veterans would like more family involvement in their care. 80%. We are asking our veterans to take healing upon themselves alone, but that is not what they are asking for. They want their families help. They need their families help. If you want to tackle veteran suicide you must include the family in the treatment of PTS.

There are days that Tom doesn't want to get out of bed. There are days when he wants to bury the pain with one drink too many. There are days he is in so much physical pain that he can barely walk and doing the smallest task causes excruciating pain. There are days when he is so angry that his friends won't see their children graduate or walk down the aisle because their number was up that he takes it out on me, the person who will still be there when the anger settles. There are sleepless nights and long tired days. There is depression.

Then there are my days as a spouse. Days I force him to get out of bed. Days that I take him on a trip for a hike verses a trip to the bar. Days and nights researching alternative treatment options because no one has told or helped us battle PTS. The weeks and months of driving him daily to Transcranial Magnetic Stimulation treatments, physical therapy, and Cognitive Behavioral therapy sessions. I searched and applied for a scholarship for him to learn Transcendental Meditation.

I became certified as a health coach just to gain the knowledge and to understand the way food, vitamins and minerals can heal his body and mind. I worked with doctors to get him off medications that were making him worse, not better. I make sure to be aware of loud noises and clutter in the home because I know those are triggers. I make him sit at a restaurant with his back to the door and tell him to relax because I'm keeping an eye out. I cry with him on anniversaries of friends he's lost in combat. I hold his hand as he answers yet another call that one of his friends he served with died from a rare cancer, or had a stroke at 45 years old, or has taken their life. No one tells you being a military or veteran spouse means you need to be a healer, a doctor, a therapist, a researcher, and a teacher but that's what's required. If you have an invested spouse in healing measures, you will most likely have an invested veteran. Spouses and caregivers need the tools to help their loved ones heal, to help identify signs of severe distress, and what to do in a crisis situation. We are left out here on the battlefield alone, no weapons, no armor, no training to fight this unseen enemy. We suffer from Secondary PTS. We are tired, frustrated, angry, confused, and heartbroken too.

When a warrior gets help and the spouse does not, there is a greater chance for substance abuse relapse, there is a greater chance for divorce, there is more turmoil in the home in front of the children, and there is a greater chance for suicide. This is something we have heard and experienced with those we work with over and over and over again. The story is so similar we can play it back before it's even been said.

Why do so many veteran's commit suicide? The reasons are as many and as varied as there are people. This is not a one size fits all problem or a one size fits all solution.

How can we reduce veteran suicide? The answers are also as many and varied as there are people. This is not the government, the VA, the military, or any organizations' task alone. This is an epidemic the country must address together and we need all hands on deck. No one answer alone is right or wrong. Not all treatments work for all veterans. It takes years to address and heal from PTS. There is no magic pill or cure. This is the long game and why it is critical for the veteran to have support at home.

Let me ask you then, what area of helping and healing can you tackle today? Not just the Senate Committee, but you personally. Who will you call? What program will get the attention it deserves? How can you create policy or help to push one through that's been sitting on someone's desk for far too long? How can your voice and vote help the millions of American veteran families suffering at home who don't know who to turn to or how to get the help they so desperately need and deserve?

There are many places to start, like encouraging and funding the exploration and research of alternative methods of healing Post-Traumatic Stress, implement a training program for VA doctors and staff on alternative modalities of healing, or create a bill to allow our veterans to get coverage for those treatments and allow families suffering from secondary PTS to also partake and heal through alternative methods of healing. We have to dispel the myth that raising your hand for help while serving in an active duty role will mean a loss of security clearance or your job, you can set policy to help protect those that do reach out. The DOD needs additional funds to train military leaders, doctors, therapist, and social workers on how to get help for the war fighters and their families post-deployments. We have heard far too many times that there was no help while in service, there was no one to turn to after, and that no one really cares about them anyway. Will you show our heroes you care? That as a country, we all care and their lives mean something.

Last, I ask for a minute of silence, not only to honor the thousands of veteran lives lost to suicide but to the more than 22 veteran lives that will be lost today at their own hands. America has failed them. We all have failed them. And after a moment of silence for our fallen veterans, I ask you to be anything but silent and leave no man, woman or child behind.

Thank you.

ARIZONA DEPARTMENT OF VETERANS' SERVICES,
Phoenix, AZ, June 19, 2019.

Hon. JOHNNY ISAKSON,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE: My name is Wanda A. Wright, Director of the Arizona Department of Veterans' Services (ADVS), member of the National Association of State Directors of Veterans Affairs (NASDVA) and the VA Advisory Committee on Women Veterans. I am honored to present my state's efforts to reduce suicide in the veteran community.

NATIONAL LANDSCAPE OF VETERAN SUICIDE

According to the Department of Veterans Affairs, we lose 20 veterans to suicide on average each day. While veterans make up just 8.5 percent of the total U.S. population, they account for 18 percent of total deaths from suicide nationally. Despite significant efforts and financial investment in programs and initiatives, the rate of suicide among veterans has been steadily increasing and is 32 percent higher than it was in 2001. Additionally, we know that completed suicides are only the tip of the iceberg of a larger ongoing mental health crisis and that many more veterans are struggling with suicidal ideations and attempts.

According to the CDC Preventing Suicide Technical Package, for every 1 completed suicide, an estimated 227 people have experienced serious thoughts of suicide. Applying these same estimates to the 6,079 known veteran suicides recorded by the Department of Veterans Affairs in 2016, this translates into over 1.3 million veterans who had thoughts of suicide in that year alone. Additionally, we can estimate that over 164,000 veterans attempted suicide and over 54,000 veterans were treated in hospital emergency rooms for self-harm injuries. While there are a confluence of complex factors contributing to this tragic loss of life, it is clear that immediate and collective action is necessary. In order to truly honor the service and sacrifice of our veterans, we must identify, innovate and support initiatives that help those that served and their families in not only navigating, but also thriving, in civilian life.

VETERAN SUICIDE IN ARIZONA

In Arizona and the west, we are witnessing some of the highest veteran suicide rates in the country. A 2017 survey of Arizona servicemembers, veterans and their families revealed that half of all respondents know of a servicemember or veteran who has died by suicide and 41 percent reported experiencing thoughts of suicide themselves. Approximately one-third of Arizona veterans have had traumatic experiences that put them at risk for elevated chronic physical and mental health conditions. One in three respondents reported a current mental health condition related to depression, anxiety or Post Traumatic Stress Syndrome and another third know a servicemember or veteran with unmet mental health needs. 43 percent of our servicemembers and veterans report having sustained physical injuries or issues as a result of their military service. Additionally, 1 in 10 Arizona veterans use and/or abuse substances to cope with trauma, depression and anxiety. When considering the role of location, veterans in our rural communities appear to carry a heavier burden than their urban counterparts regarding this issue with 20 percent higher risk of suicide compared to urban-dwelling veterans and less access to services that address their social determinants of health.

CRISIS INTERVENTION VS. UPSTREAM SUICIDE PREVENTION

Historically, suicide prevention has been primarily focused on crisis intervention. Though this is a critical and necessary service in the spectrum of suicide prevention tactics, it represents only a narrow window of opportunity for intervention. While we continue to advocate for the expansion of the existing national, state and local crisis intervention infrastructure, particularly in rural areas with limited access, we also believe that it is time to take a different approach to suicide through upstream prevention. Upstream suicide prevention creates a wider window of opportunity to reach individuals and ideally provides support before an individual reaches the point of a mental health crisis. However, it is critical that we work towards added coordination and state-level infrastructure to connect existing resources in urban and rural areas as well as continue to educate the community on their role.

THE COLLECTIVE IMPACT

Arizona is responding to this crisis through a collaborative statewide suicide prevention initiative led by ADVS and Arizona Coalition for Military Families (ACMF), a nationally-recognized public/private partnership that focuses on building Arizona's capacity to care for, serve, and support servicemembers, veterans, their families, and communities. Through the use of a collective impact model, we have successfully engaged and convened key stakeholders across Arizona to lead a coordinated and targeted effort to reduce suicide among the military and veteran community. Collective impact is a model defined by Stanford University that brings together people, organizations and systems in a structured way to achieve social change. There are five key elements: 1) common agenda, 2) shared measurement, 3) mutually reinforcing activities, 4) continuous communication, and 5) strong backbone team. It's important to note that with a collective impact model, many different efforts can be aligned to work toward a common goal.

Arizona's collective impact initiative around suicide prevention is built upon a highly effective program implemented at the height of the post-9/11 deployments. In partnership with the Adjutant General and numerous state partners, ACMF led the development of a program specifically for the Arizona National Guard called "Be Resilient" which focused on reducing stigma, shifting military culture regarding suicide and mental health through training, and increasing access to care. Be Resilient included 24/7 support by phone and training for all Arizona National Guard members on resiliency, suicide prevention, and recognizing stress levels. Using this approach, Be Resilient successfully reduced suicide rates from their highest-ever level in 2010 to zero suicides during the 3 years the program was in operation.

BE CONNECTED ARIZONA

In 2015, the Clay Hunt Suicide Prevention for American Veterans Act was signed into law and through the support and leadership of the late Senator John McCain, Arizona was selected as a pilot site to test new methods of preventing veteran suicide through VA/community partnership. Based on the successful program model of Be Resilient, ADVS and ACMF launched a statewide suicide prevention initiative for all servicemembers, veterans, and their families called Be Connected in 2017. The Be Connected program includes a 24/7 support line, online and in-person resource navigation, and training on military culture and resources for everyone in the community. The Be Connected program is unique in its approach of reducing veteran suicide by formally recognizing and building support services to address the complex web of social, emotional, economic and systemic factors that contribute to mental health crises experienced by our veterans and their families, with a focus on upstream prevention before crises develop. By leveraging all the existing resources of national, state, and community-based agencies serving veterans, Be Connected provides a statewide point of coordination for any servicemember, veteran, family member, or helper to turn to for help and support.

ROLE OF THE VA IN COMMUNITY SUICIDE PREVENTION

We know that as many as 70 percent of veterans who have died by suicide were not actively seeking care from the VA at the time of their death. This illustrates the importance of crafting solutions that think outside of the health care system and use every possible community resource to connect with our veterans and get them the support they need. We also feel it is important to get our veterans engaged with the VA for assistance, care and support if they aren't connected already. We know that veterans are less likely to die by suicide if they are supported by their health care system. Be Connected drives traffic back to the VA to give the veteran an opportunity to seek care with providers who understand the complex issues that can surround a veteran's health. The more veterans we can get enrolled in the VA, the better their health outcomes will be overall. Be Connected acts as a care coordination model to connect veterans to health-related services provided by the VA as well as the many social services offered in the community. The goal of this model is to provide the right resource at the right time to the right individual. No matter the need, if a veteran requests support from Be Connected, they should know that we will do everything in our power to get them the help they need.

KEVIN'S STORY

To demonstrate the power of Be Connected, let me share with you the story of Kevin. Kevin is a disabled Air Force veteran who called the Be Connected support line because he was struggling financially and in fear of losing his home. During

his first couple of phone calls, Kevin reported that he would likely commit suicide if he lost his home and the belongings inside. The Be Connected support line responder contacted several organizations in Kevin's community that were able to provide him with legal assistance, donations, and volunteers to help him make necessary home repairs. Kevin is now financially stable and able to live in his own home. He told the responder that he is very grateful for Be Connected and that thanks to these efforts, he now has hope again. Kevin's story is one of thousands whose lives have been changed for the better by Be Connected.

EXPANSION OF BE CONNECTED ARIZONA

In the past 2 years of operation, Be Connected has fielded over 10,000 support line calls, provided resource navigation to over 8,000 individuals, and provided training to thousands of community members. The majority of those requesting assistance from Be Connected are not explicitly seeking mental health services. Analysis of support line data shows that 44 percent of calls were related to housing, employment, or financial concerns, while only 6 percent of calls were specifically requesting mental health services. In addition to expanding access to mental health care and crisis services, we urge this Committee to also consider the importance of addressing the "upstream" factors of suicide. This upstream approach not only recognizes the importance of access to health care services, but also the daily impact of a myriad of other social determinants outside of the clinical walls. Restricting our interventions to health care specific issues presents missed opportunities to address these upstream factors. As such, it is imperative that we tackle this devastating issue collaboratively and purposefully as an entire community to ensure that we are properly meeting our duty to those that met theirs.

NEXT STEPS

We are encouraged by Congress's interest in this issue and the White House's action through the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide, also known as PREVENTS. We ask that Congress continues to build on this roadmap and explore legislation that supports and expands the capacity of Be Connected and other developing initiatives across the country through three main recommendations: 1) capacity building on the state level to ensure states and communities are coordinated 2) funding for backbone teams in states, such as the Arizona Coalition for Military Families 3) support for initiatives using the upstream suicide prevention model, such as Be Connected.

This is in contrast to an approach that is purely service delivery oriented with no focus on organizing and connecting efforts. In order to create an effective national strategy to preventing veteran suicide, we need to embrace a national collective impact initiative that engages, equips and connects states and communities. Those states and communities will then be able to engage, equip and connect serve members, veterans and family members through an upstream suicide prevention model with a collective impact approach. Every state and community does not have to have the exact same program, however every state and community needs to be working toward a common goal with common standards.

Sincerely,

COL. WANDA A. WRIGHT, USAF (RET.),
Director,
Arizona Department of Veterans' Services.

PREPARED STATEMENT OF KEN FALKE, CHAIRMAN, BOULDER CREST RETREAT FOUNDATION & EOD WARRIOR FOUNDATION

Our nation has been at war for nearly 18 years—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 resources being poured into solving this problem across the public and private sector.

As a 21-year Navy combat veteran, and the Chairman of the EOD Warrior Foundation and Boulder Crest, which includes two privately-funded wellness centers—Boulder Crest Retreat Virginia and Boulder Crest Retreat Arizona—and the Boulder Crest Institute for Posttraumatic Growth, that serve combat veterans and family members struggling with suicidal thoughts and other mental health challenges, we have gained a unique perspective not only on the question of why suicides continue to happen, but how we can prevent them.

THE CAUSES OF SUICIDE

At its core, suicide is the result of hopelessness and loneliness. Suicide stems from a belief that tomorrow will always be the same or worse than yesterday, and that there is no path to a life that is worth living and that nobody really 'knows me or gets me'. Why is it that far too many veterans find themselves on the precipice of suicide? What contributes to their struggle?

We would be reticent to declare that we have all the answers. If there is one thing I can conclude after 21 years in the Navy and now 15 years of working closely with veterans and attending far too many funerals for my brothers and sisters who died by their own hand, it is that there is no such thing as a suicide expert. The data do tell us that depression—not PTSD—is correlated with suicide. Depression is perhaps best defined in the words of the psychologist, Rollo May, who said: "Depression is the inability to construct a future."

This focus on depression is consistent with the VA's research indicating that depression—not PTSD—is the biggest challenge affecting veterans, particularly during and after their transition.

Since opening Boulder Crest Retreat Virginia in September 2013, and Boulder Crest Retreat Arizona in November 2017, we have hosted more than 4,000 combat veterans and family members, and run more than 120 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 veteran suicides, and more significantly, enable veterans to create lives worth living—the true opposite of suicide.

As we reflect on all that they have shared, we see six major causes of struggle for veterans that put them at risk of suicide:

1. VA's Myopic Focus on PTSD

The idea that depression—not PTSD—is the biggest challenge for veterans might come as a surprise to many. That—in fact—is a key element of the challenge. As George Bonano and Meaghan Mobbs noted in a 2018 *Clinical Psychology Review* article, "Even more problematic, despite the looming uncertainty of future treatment needs, currently available interventions for returning veterans have focused narrowly on extreme psychopathology, and typically only on Posttraumatic Stress Disorder (PTSD)."

The assumption that when veterans struggle it must be PTSD-related contributes to applying the wrong treatment to the wrong person, and can, in fact, make veterans worse. The evidence-based treatments for PTSD are not the same treatments one would assign for depression; this is particularly true for Prolonged Exposure. This helps explain why many veterans will never seek treatment and often dropout prior to its conclusion—and struggle mightily as a result.

2. Transition Issues

A second and related issue to the first is the difficulty that many veterans have transitioning. Bonano and Mobbs explain:

> One of the primary reasons for past failures in veteran treatments, arguably is that the dominant focus on PTSD has obfuscated other, often highly pressing transition issues. Research has documented, for example, that many returning veterans may struggle regardless of whether they have PTSD or not. Recent population survey studies have suggested that 44% to 72% of Veterans experience high levels of stress during the transition to civilian life, including difficulties securing employment, interpersonal difficulties during employment, conflicted relations with family, friends, and broader interpersonal relations, difficulties adapting to the schedule of civilian life, and legal difficulties (Morin, 2011). Struggle with the transition is reported at higher, more difficult levels for post-9/11 veterans than those who served in any other previous conflict (i.e., Vietnam, Korea, World War II) or in the periods in between (Pew Research Center, 2011). Crucially, transition stress has been found to predict both treatment seeking and the later development of mental and physical health problems, including suicidal ideation (Interian, Kline, Janal, Glynn, & Losonczy, 2014; Kline et al., 2010). What is more, the majority of first suicide attempts by veterans typically occur after military separation (Villatte et al., 2015).

As evidenced by much lower (albeit growing quickly) suicide rates of active duty servicemembers, much about military service is fulfilling and rewarding. In fact,

military service provides servicemembers with many of the factors that contribute to strong mental health—identity, purpose, meaning, connection, growth, and service. Imagine for a moment a Marine—he joins at 18, and in a short period of time is transformed from an ordinary civilian into a proud Marine. For perhaps the first time in his life, he knows who he is (a Marine), why he exists (to locate, close with, and destroy the enemy), and who his tribe his (his fellow Marines).

That Marine goes on to serve for four years or forty years with honor and distinction, and then gets out. He is thrust from a world of certainty, community, purpose, and meaning into the rather cold and uncaring civilian-dominated world. He begins to struggle as he navigates a deep, profound, and existential journey into who he is now, why he exists (or if he still should), and where he belongs. He has a job but hates it. The struggle starts to get the best of him—he begins to distance himself from his loved ones and friends, and starts self-medicating with alcohol. After an alcohol-related incident, he is persuaded to go see someone. After mentioning that he deployed to Iraq and Afghanistan, the therapist immediately circles in on PTSD as the cause of his issues. He is diagnosed and medicated and turns to disability payments for sustenance; and is now destined to live out the rest of his life as a diminished version of his once powerful and remarkable self. What was a temporary issue of adjustment has now become a permanent diagnosis. At some point, he might decide that this life—just barely getting by, surviving each day feeling numb, broken, and useless—isn't worth living.

This story is not merely an anecdote. It is the story of far too many veterans who struggle with how to transition effectively.

3. A Society Filled with Disconnection and Struggle

A third reason why veterans struggle is encapsulated in the remarkable work of Sebastian Junger. In his book *Tribe*, and in his other writings and TED Talk, Junger speaks about his belief that much of the struggle that veterans experience has far more to do with what they are coming home to rather than what they are coming home from. His belief is supported by the devastating statistics related to civilian mental health—from suicides (in 2017, there were 129 suicides per day, and a stunning 1.4 million suicide attempts—3,836 per day) to opioid, drug, and alcohol overdoses.

When they leave the military, veterans depart a world filled with identity, purpose, meaning, connection, growth, and service and enter one filled with despair, struggle, and disconnection. This despair proves to be contagious—as misery loves company—and combined with transition challenges, overwhelms veterans. The result is self-medication and far too frequently, suicide.

4. Military Training

A number of researchers have studied the symptoms of PTSD and explored the connection between PTSD symptoms and the training servicemembers receive to thrive in combat. One researcher, Dr. Charles Hoge, a retired U.S. Army Colonel and one of the world's most published authors on PTSD, identified the clear connection between military training and veterans struggle, depicted in the table below.

Military Training	Symptoms of Struggle
Sharply Tuned Threat Perception, Rapid Reflexes	Hyperalert, Hypervigilant
Intense Mission Preparation, Rigorous Training, After-Action Reviews (AARs)	Reliving Events, Guilt, Second Guessing
Attention to Details, Minimize Mistakes	Intolerance of Mistakes
Adrenaline/Intensity to Accomplish the Mission	Anger/Rage
Emotional Control in Combat	Detached, Numb
Unit Cohesion, Unit is Family	Social Withdrawal

On the left column of this chart are six key elements of military training that allow servicemembers to thrive in combat. On the right side are the symptoms of PTSD. We take ordinary civilians and train them so they can function effectively in combat—the list of items in the left column. On this path to gain courage and strength, we call them Warriors. As they return home from utilizing, refining, and integrating that skill set and attempt to apply it at home, we call them broken. This is the ultimate Catch–22.

What is clear is that there is nothing wrong with many of our servicemembers and veterans—they are merely a function of their training and experiences. They are struggling because of what happened—not what's wrong. This understanding—which is a foundational element of our Warrior PATHH program at Boulder Crest, the subject of more discussion below—liberates combat veterans to realize that they are far from broken or damaged; they simply need additional training to learn how to apply their unique set of skills, strengths, and abilities at home. This training is particularly important as it relates to one of life's most important skills—the ability to self-regulate. We do know that in the absence of the capacity to self-regulate, most humans will self-medicate. This self-medication often creates a vicious and downward spiral that ends in self-destruction or suicide.

5. An Accumulation of Trauma

As Bonano and Mobbs noted above, the struggle of veterans is viewed nearly exclusively through the prism of PTSD. Some devastating event from the battlefield is claimed to be the cause of all that ails the combat veteran, and with the right treatment and medication, all will be well. Unfortunately this view of life is simply not supported by data.

A great deal of research conducted in recent years explores the childhoods of members of the all-volunteer force, working to understand the range of reasons why people join. These reasons include a yearning for discipline, community, challenge, purpose, and service. It is also clear that a key reason that many join is to escape a dangerous or abusive situation. Members of today's military have experienced more childhood trauma than members of the general public—by a factor of at least two, and possibly more.

As the American Psychological Association notes, "High rates of suicide among military servicemembers and veterans may be related to traumatic experiences they had before enlisting, making them more vulnerable to suicidal behavior when coping with combat and multiple deployments . . ."

The growing science related to childhood trauma—known as Adverse Childhood Experiences (ACEs)—speaks to how such trauma affects core belief systems as well as an individual's capacity to deal with future trauma. By attributing combat veterans struggle solely to what happened on battlefield, we fail to recognize that what they struggle with is an accumulation of traumatic experiences—not a single event.

6. Failure of Treatment

The final factor I want to discuss as it relates to why veterans are at risk for suicide relates to our Nation's approach to mental health. In short, our mental health system—and approach—simply is not working—for depression, PTSD, and suicide.

This is not my opinion, 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."

The reliance on evidence-based treatments, noted in the JAMA Psychiatry quote above, has proven to have serious limitations. Jonathan Shedler, Ph.D., noted in a 2015 article entitled "Where is the Evidence for 'Evidence-Based' Therapy?," "Research shows that "evidence-based" therapies are weak treatments. Their benefits are trivial. Most patients do not get well. Even the trivial benefits do not last." Shedler continues:

> "In the typical randomised controlled trial for 'evidence-based' therapies, about two-third of the patients get excluded from the studies a priori (Westen et al, 2004). That is, they have the diagnosis and seek treatment, but because of the study's inclusion and exclusion criteria, they are excluded from participation. Typically, the patients that get excluded are those who meet DSM criteria for more than one diagnosis, or have some form of personality pathology, or are considered unstable in some way, or who may be suicidal. In other words, the two-thirds that get excluded are the patients we treat in real-world practice. So two-thirds of the patients who seek treatment get excluded before the trial begins. Of the one-third that do get included, about half show improvement. So we are now down to about 16 percent of the patients who initially sought treatment. If we consider the percentage of patients who actually get well, we are down to about 11% of those patients who originally sought treatment. If we consider

the percentage that get well and stay well, we are down to roughly 5 percent."

The concerns expressed by many of the best and brightest in the field are proven out in the statistics. The veteran suicide rate has barely budged from 20 a day for several years. More concerningly, of those 20 suicides a day, only six are in active VA care. This unwillingness to seek care keeps at least 50 percent of veterans who might benefit from mental health from ever going to see someone. Of those who do access mental health, between 40–80 percent will dropout prior to the conclusion of the treatment, often due to a lack of provider-patient connection, or a sense that treatment is making them feel worse. As noted above, the near-exclusive focus on PTSD (rather than transition struggles) may contribute to this fact. Only 40 percent of those who complete treatment will experience any benefit, which is often fleeting, as Shedler noted above.

Notably, in June 2018, in response to a CDC report indicating that suicides across the United States had increased 33 percent since 1999, Dr. Thomas Insel—the former director of the National Institute for Mental Health—asked, "Are we somehow causing increased morbidity and mortality with our interventions?"

When we have asked combat veterans who have attended programs at Boulder Crest Retreat Arizona or Virginia why they didn't benefit from traditional treatments, they shared the following reasons:

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 unable to connect with their providers (often civilians who lack a strong understanding of the military culture and 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 with 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.

In sum, of the 900,000 post-9/11 combat veterans who are struggling with mental health related challenges, only 3 percent will find meaningful and sustained help from the current mainstream approaches. We can and must do better.

WHAT CAN WE DO?

I have shared six of the reasons why the veterans suicide epidemic is continuing to go from bad to worse. The critical question that the Committee is asking—as are many who are gravely concerned about the state of veteran's well-being—is what do we do about it?

This question is what I have worked to answer since starting the EOD Warrior Foundation in 2004, opening Boulder Crest Retreat Virginia in September 2013, Boulder Crest Retreat Arizona in November 2017, and the Boulder Crest Institute for Posttraumatic Growth in September 2018. Our mission is to ensure we provide combat veterans with what they require to live great lives—filled with passion, purpose, growth, connection, and service. This is truly the opposite of suicide.

In May 2014, after nine months of operating Boulder Crest Retreat Virginia, I began a journey to understand what actually worked when it came to mental health, PTSD, and suicide. I traveled around the country and met with leading psychiatrists, psychologists, social workers, life coaches, and trauma experts. Time and time again, when I asked them, "What works to allow people to live great lives in the aftermath of trauma?"—I was told, "Nothing."

In principle this is true because it is not what our mental health system—broadly speaking—is focused on accomplishing. The mental health system is nearly exclusively focused on one thing when it comes to its clients and patients—managing and mitigating the symptoms associated with times of struggle; often through a combination of medication and talk therapy.

The first glimmer of hope I encountered on my journey would be found at the University of North Carolina, Charlotte, in the person of Dr. Richard Tedeschi. Dr. Tedeschi, along with his colleague, Dr. Lawrence Calhoun, coined the term Posttraumatic Growth (PTG) in 1995 to describe the ways in which people reported growth in areas of their life in the aftermath of traumatic events and experiences.

I asked Dr. Tedeschi if he was interested in partnering with us to develop a training-based program for combat veterans that would, for the first-time ever, be designed to cultivate and facilitate Posttraumatic Growth in those who were struggling. Dr. Tedeschi agreed, and since 2014, we have been hard at work on the development and delivery of Warrior PATHH.

A NEW, INNOVATIVE, AND EFFECTIVE APPROACH TO PTSD AND SUICIDE

Warrior PATHH is an 18-month program that begins with a 7-day intensive and immersive residential initiation for combat veterans who struggle with a range of challenges—from depression to PTSD, transition issues to suicide. The 7-day initiation is supported by Boulder Crest's custom-built *myPATHH* technology platform, which connects and supports students through the remaining 77 weeks—providing ongoing training, connection, and accountability.

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 self-regulate thoughts and emotions; creating an environment of trust and safety to facilitate disclosure of past challenges from childhood and military service, which is supported by a delivery team composed of combat veterans; 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.

The 18-month study, led by Dr. Tedeschi and Dr. Bret Moore, was completed in January 2019, focused on exploring the impact of Warrior PATHH in three key areas: Symptom Reduction, Quality of Life improvement, and Posttraumatic Growth experienced. With responses at the pre, post, 1, 3, 6, 12, and 18-month marks and the use of 24 well-respected and bespoke measurement tools, this effort represents one of the most robust evaluations of a mental health effort ever initiated. The evaluation effort included 8 Warrior PATHH Programs (49 students) and a response rate of 95 percent. Key highlights include:

Symptom Reduction:

- 54% sustained reduction in PTSD symptoms
- 52% sustained reduction in depression symptoms
- 41% sustained reduction in anxiety symptoms
- 39% sustained reduction in Insomnia
- 44% sustained reduction in drug use

??? 24% sustained improvement in positive emotions experienced; and 25% sustained reduction in negative emotions experienced

Quality of Life Improvement:

- 14% sustained improvement in Couples Satisfaction
- 33% sustained reduction in stress reactivity
- 11% sustained improvement in physical activity
- 26% sustained improvement in nutrition
- 12% sustained improvement in financial wellness

Posttraumatic Growth:

- 56% sustained improvement in Personal Growth (PTG)
- 78% growth in Spiritual-Existential Change
- 69% growth in Deeper Relationships
- 58% growth in New Possibilities
- 36% growth in Personal Strength
- 26% growth in Appreciation for Life
- 32% sustained improvement in ability to change perspective/psychological flexibility
- 23% sustained improvement in capacity to integrate problematic life experiences.

- 22% sustained improvement in self-compassion
- 40% sustained increase in reading
- 9% sustained decrease in disruption to core beliefs

In short, we have a program that achieved the vision that we set forth—to ensure combat veterans could be as productive at home as they were on the battlefield, and live great lives—filled with passion, purpose, growth, connection, and service—at home. In response to this unparalleled success, we are now working with partners so that Warrior PATHH can be scaled to ten locations across the country.

WHY WARRIOR PATHH WORKS

Warrior PATHH is modeled on military-style training. It is intensive, immersive, and 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 who leverage the inherent understanding, trust, and connection that is implicit within the brotherhood and sisterhood.

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.

Ultimately, Warrior PATHH works because it acknowledges the wise words of Dr. Vikram Patel, a pioneering psychiatrist who has developed incredibly effective, peer-based programs across the developing world: "Mental health is too important to be left to mental health professionals alone."

MEASURING IMPACT

As a retired bomb disposal specialist, I come from a world with the unofficial motto: Initial Success or Total Failure. Bomb techs simply cannot make mistakes; if we do, and are lucky enough to survive, we certainly don't make them again. Throughout my journey—15 years of supporting combat veterans and the establishment of two non-profits—I have grown immensely frustrated by the willingness of advocates and so-called experts to insist that we continue to do the same thing over and over again when it simply does not work. Albert Einstein called this "insanity."

The current mental health community approach is not working. The data are beyond clear about that. As we explore new and innovative approaches, however, we must move beyond anecdote. The story of the horse or the dog that saved a veteran's life simply is not good enough. We need concrete and conclusive evidence of what does work so we can scale it to meet the massive need that exists.

We believe our comprehensive program evaluation represents an important first-step in that direction for several major reasons.

First, we must get beyond exploring just symptom reduction. Veterans who struggle are not simply looking for the absence of particular symptoms—they are seeking the existence of positive elements in their life; things like growth, joy, love, connection, passion, meaningful work, and the ability to be of service again. The evaluation methodology we utilize explores outcomes in three ways: symptom reduction, quality of life improvement, and Posttraumatic Growth/cognitive flexibility experienced. This explicit focus on improvements in a veteran's quality of life speaks to the way in which any kind of intervention is meaningfully impacting their day to day life. The focus on growth is critical; as humans, we yearn for two things: to be able to grow and to feel like we are making a contribution to the world.

Second, we must measure the impact of what we are doing, with a focus on each individual veteran. One of the most stunning parts of the independent evaluation conducted as a result of the Clay Hunt Act was the lack of VA data and tracking related to the well-being of individual veterans. If we aren't asking them how or if treatment is working, how can we possibly adapt or alter it?

Third, we must listen to the voices of those who struggle. In my testimony, I have sought to share the first-hand views of the thousands of veterans who we have hosted over the past six years. Our belief in listening—versus acting as an expert who sits on the sidelines—is how Posttraumatic Growth came into existence (with

bereaved parents) and the source of Dr. Vikram Patel's innovations in the developing world.

Importantly, we must be willing to listen to veterans so we can understand why they do not seek treatment; why they dropout early; why they fail to benefit from traditional approaches; and what they are seeking in terms of support, guidance, and training.

We must not hide behind evidence-based treatments to proclaim that any patient who doesn't experience meaningful progress must be "treatment-resistant." Veterans surely deserve better than a label that evokes hopelessness and despair.

Fourth and finally, we must explore how veterans respond to interventions over the long-term. Our evaluation was an 18-month exploration across seven different collection points with a 95 percent response rate. We understand the trajectory of a Warrior PATHH graduate and how their life ebbs and flows over time, and what additional support, guidance, and training they may require.

I believe deeply in the power of research and the importance of data. Throughout my Navy career, my business, and nonprofit life, I have used such information to guide me in the pursuit of effective solutions and strategies. Research and data only work, however, if they are collected with an open mind and a focus on solving a problem, not propping up institutional interests or protecting the way things are done.

We must stop doing the same thing over and over again and expecting a different result. Far too many veterans have paid the ultimate price as a result, and the impact on their families, friends, and communities is incalculable.

CONCLUSION

Rather than focusing on suicide prevention and more of the same in terms of mental health services, we should focus to ensure 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 good friend and USMC General officer, their time in the service cannot be the greatest accomplishment of their lives. Doing so requires an integrated and collaborative approach, and we look forward to being a part of the solution and any questions that arise from this written testimony.

Finally, I have personally hosted the last three Secretary's of the VA at Boulder Crest Retreat, Bob McDonald, Dr. David Shulkin, and most recently, Robert Wilkie. All three Secretaries have sat at a table in our kitchen and within minutes of their arrival to our Virginia Retreat said "this is exactly what post-9/11 veterans want." Let's make this happen together!

PREPARED STATEMENT OF KRISTINA KAUFMANN, CODE OF SUPPORT FOUNDATION

THE PROBLEM

Despite a massive effort and billions of dollars spent by the government, and tens of thousands nonprofit organizations dedicated to supporting the military/veteran community over the past 18 years of war, the needle hasn't moved for Servicemember and Veteran suicide. Americans who have served in our Armed Services are twice as likely to die by suicide than their civilian counterparts.

And, while it's not talked about openly (or tracked) military/veteran spouses and children are taking their own lives as well. As an Army wife, and the CEO of Code of Support Foundation (COSF), I myself have personally known five wives and caregivers who have died by suicide. COSF has also covered the funeral cost for a 13-year-old boy—whose father, a veteran died by suicide after losing his battle with PTS. Four years later, his son Alex—wearing his Dad's dog tags—took his own life as well (see attached Huffington Post article "Collateral Damage"). The one thing we do know for certain about suicide—is that its ripple effects and impact on family and community, are wide spread and devastating.

So, with all this effort, why aren't we seeing better outcomes?

Simply put—Servicemembers, Veterans and their Caregivers/Family Members (SMVCF) are adrift in a sea of resources available to serve them. This fragmentation of effort, and lack of coordination exists within government agencies (i.e. VA, DOD and HHS), it's happening between these agencies, between government agencies and community-based organizations, and between nonprofits themselves.

Forty plus years ago, when our Vietnam Veterans returned home, they had next to no services to address their needs. This generation of Post-9/11 veterans has so

many, it's almost impossible to navigate. Either way, the end state is the same—too many SMVCF are not getting the support they need to stabilize and thrive.

We know that our approach to preventing suicide must be a holistic one. The number of veterans receiving mental health care from the VA had steadily risen, yet the number of veterans dying by suicide has remained essentially the same. This is in no way to suggest that there are enough mental health resources available to meet the needs of our military/veteran community (or for civilians for that matter). Additional investments must be made to increase capacity—especially within the community.

A whole health approach to suicide prevention includes providing services to address not just physical, mental health and substance abuse issues, but family unrest, access to benefits, transportation, employment services, legal problems, financial instability, housing insecurity and social disconnection.

As such, COSF strongly supports the funding of local coordination hubs as proposed the draft legislation (Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019) co-sponsored by Senators Moran and Tester. But local coordination hubs won't be enough. Building and maintaining high functioning local hubs require 1) a sustainable funding stream 2) a "backbone" organization responsible for delivering case coordination 3) a local culture willing to work together and 4) technology platform(s) to facilitate the coordination. Obtaining and sustaining all four of these capabilities in every city, or every state for that matter, is a bridge to far.

Providing the necessary coordination of services for SMVCF across the country requires a national strategy, and integration of effort between public and private sector organizations that does not currently exist.

HOW DO WE FIX IT?

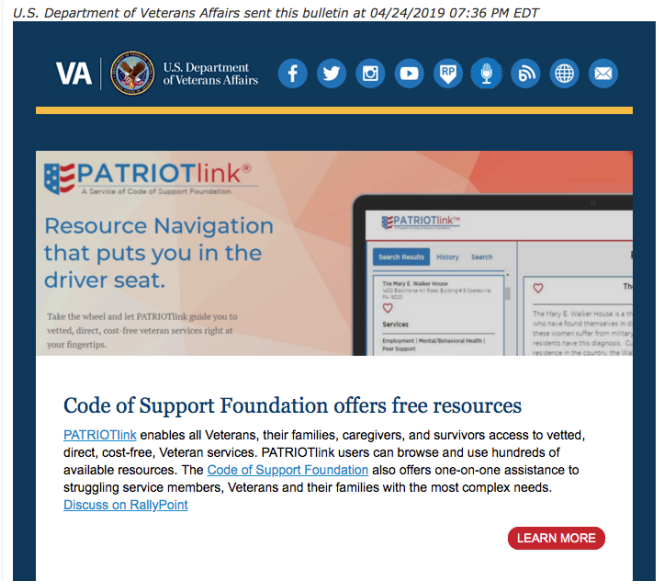
National Case Coordination Center and a Centralized Veteran Resource Navigation Platform Integrated into Transition Assistance Program

"Collaboration" and "Collective Impact" have become buzzwords in the veteran support sector over the past several years. And, there are some encouraging trends. The VA's Office of Veterans Experience has executed Memorandums of Understanding and is working closely with a number of nonprofit organizations (including COSF, AWP and America Serves/IVMF).

In the nonprofit sector, there are some fantastic local coordination models and initiatives happening across the country (detailed below). However, our concern is that these few local coordination hubs, are not networked amongst themselves (i.e. existing in the same stove-pipes they were meant to breakdown). The fact is, most SMVCF don't know about these local hubs, and/or aren't fortunate enough to live near one. They need a national organization to turn to, one number to call. A non-governmental organization that knows where all the local coordination hubs operate, and can perform warm handoffs when appropriate, or provide one-on-one case coordination services to them directly.

Code of Support Foundation is the only national organization providing in-depth case coordination to troops, veterans and family members regardless of service era, discharge status or geographic location. As such, 65% of our clients are referred to us from partner organizations and agencies (including 20% from the VA), who are unable to serve the totality of their needs.

The need for a National Coordination Center was made even more clear on April 24th of this year, when the VA sent out a newsletter highlighting COSF's Case Coordination Program and our PATRIOTlink® resource navigation platform. Within 48 hours, 250 veterans and caregivers applied for our case coordination services, and over 7,500 signed up for PATRIOTlink.



As per our SOPs, our Veteran and Caregiver Peer Navigators (Case Coordinators) performed warm handoffs to local coordination hubs for the 80 veterans fortunate enough to live in their geographic coverage area. The rest of the cases, we took on ourselves. As we said in our report back to the VA, if the level of need for case coordination from one email isn't an indication of how badly SMVCF need help navigating the morass of resources out there, we don't know what does. We serve as the hub to the many spokes of local collaboratives and the thousands of points of service delivery across the country.

In addition, the transitioning servicemember and veteran support sector desperately needs one portal by which SMVCF can get connected to resources and opportunities (including local coordination hubs), regardless of their geographic location. Code of Support Foundation, with $2 million dollars of seed funding from Bristol Myers Squibb Foundation, has developed this portal—PATRIOTlink®. Currently over 8,000 SMVCF and providers are using PATRIOTlink, quickly and easily identifying the help they need, while searching from over 12,000 (a number increasing every day) pre-vetted and verified services (additional information attached and demo's available upon request).

COSF is already working with the VA to deploy PATRIOTlink with Suicide Prevention Coordinators (SPCs), the Veterans Crisis Line (VCL), VA social workers and Vet Centers. We also have an MOU with the Army Reserve and are working with the National Guard to deploy the platform to the over 400 Family Assistance Centers across the country. Marine for Life and Soldier for Life are also actively using the platform. In addition, over 100 nonprofit organizations are using the PATRIOTlink—so we're off to a good start. PATRIOTlink compliments and enhances current coordination efforts and CRMs (i.e. case management/share technologies). A landscape analysis of coordination efforts and technologies is included below.

But it's integrating PATRIOTlink into the Transition Assistance Program (TAP), that will transform access to support for the 200,000 transitioning servicemembers that leave the military every year. Servicemembers will be able to identify and leverage resources—both public and private—where they are relocating (as most active duty members don't stay where they ETS). In addition to ensuring resource is getting to need, the aggregated search data PATRIOTlink captures will allow COSF and the VA to perform real time trend identification (hot spots of need around the Nation) and gap analysis (local resource deserts). Currently, the needs assessments (which are often a year old by the time they're released) and VSO membership surveys (which can be skewed based on an organizations membership demographics), are what we have to inform program, policy and funding decisions. Real time data to inform real time decisions is what we need.

While we are talking to the VA about getting PATRIOTlink upstream in TAP, it's going to be difficult to do without legislation (to include appropriated funding) from Congress. PATRIOTlink is the one-stop-shop portal we've all been talking about for years, and once widely deployed and adopted, it will be a game changer in our collective efforts to drastically minimize negative outcomes for SMVCF—including suicide.

ADDITIONAL INFORMATION

Hasn't a National Veteran Resource Navigation Platform Been Attempted Before?

Yes. The National Resource Directory (NRD), currently managed by the Office of Warrior Care Policy in the Office of the Secretary of Defense, has been in existence for ten years. Frankly, if NRD had worked, COSF wouldn't have had to develop PATRIOTlink. NRD has underperformed and been underutilized for several reasons.

The first, and most important of which, is that the government is not well-positioned to vet and verify non-governmental organizations, as they cannot be perceived as favoring on over another. Each resource in PATRIOTlink has undergone 90 minutes of vetting. NRD has limited capacity to keep data clean or to market the platform to SMVCF and community-based organizations, even though the majority of veterans and essentially all their family members are getting care and support outside of the VA. It doesn't allow for targeted searches based on eligibility criteria and does not have the ability to capture user behavior in the back end or integrate with other technology platforms, unlike PATRIOTlink, which has these capabilities.

Coordination Models and Technology in the Veteran Support Sector: A Landscape Analysis

There is a fair amount of confusion about who is doing what to help troops, veterans and their family members navigate, identify and leverage the services, support and benefits they need, and how these organizations differ from each other.

COSF recognizes that we are not the only organization working to provide and facilitate service coordination—although we are the only one providing case coordination to SMVF in crisis, regardless of when they served, discharge status or where they live. America Serves (14 sites/9 states), AWP (5 sites with 2 under development/5 states) and Mission United (22 sites/11 states), are all community integration initiatives providing valuable service coordination in local communities. These three nationally driven, locally implemented collaboratives are functioning in a total of 16 states combined, whereas COSF serves SMVF in every state.

National Veterans Intermediary (NVI), works primarily with the Community Veteran Engagement Boards (CVEBS) across the country (currently over 70 communities/32 states) to identify best practices and provide small grants to nonprofit organizations to facilitate collective effort, but they do not provide service coordination themselves. We are working with NVI to ensure CVEB member organizations have access to PATRIOTlink.

There are also a number of "homegrown" collaboratives (i.e. Houston Combined Arms; San Diego 211, BeConnected Arizona, Illinois Joining Forces, TexVet, etc.) actively providing coordination of services in their states and local communities. COSF is the national backstop for SMVF who aren't fortunate enough to have access to case coordination in their geographic location (which is the majority of SMVF).

All collective effort requires technology platforms to facilitate resource coordination and navigation between service entities. Organizations providing services to this community are all using some type of CRM (customer relationship management) platform. Many organizations are moving to Salesforce as their CRM, as it is highly customizable, and PATRIOTlink will have the capability of integrating with Salesforce by the end of 2019. That way, providers using the CRM can import search results from PATRIOTlink into their own case management systems. However, a CRM in and of itself does not address the challenge of ensuring troops, veterans and their families are connected to resources, benefits and opportunities.

There are four nationally deployed technology platforms in the veteran support space facilitating coordination of resources via several functionalities (PATRIOTlink, UniteUs, Warrior Serves, 211). Of the four, PATRIOTlink is the only pre-populated and centrally managed resource navigation platform. It complements the other three CRM platforms—all of which have some level of case share/coordination capabilities—but contain primarily local resources. PATRIOTlink is populated with local, regional and national resources, which opens the aperture of services for those communities. And of course, the majority of organizations across the country do not belong to a collaborative, so PATRIOTlink provides access to resources those organizations might not otherwise have known existed.

ATTACHMENT 1

COLLATERAL DAMAGE

Kristina Kaufmann, Code of Support Foundation

Huffington Post, December 2, 2015.

Four years ago, combat veteran James Christian Paquette lost his battle with Post Traumatic Stress and shot himself in the head. This summer, his son Alex, wearing dog tags with his dad's picture, followed in his father's footsteps. His mother found a note in his room that read in part, "I'm going to see dad in heaven."

Alex was 13 years old.

The American public hears stories about the devastating impact that mental wounds of war can have on a combat veteran, and how far too often, the Department of Veterans Affairs is failing them.

But there's an untold story behind these tragic deaths that no one is talking about, an invisible population of veterans' children whose entire lives have been shaped by a war that has come home. An estimated 22 veterans die by suicide every day in this country, leaving shattered families behind—collateral damage from wars that have all but left the headlines.

We now have an entire generation of military families who know nothing but war. An estimated 30–35% of the 2.7 million troops who have deployed since 9/11 are struggling with Post Traumatic Stress (PTS), Traumatic Brain Injury (TBI) and/or substance abuse. These are conditions known to affect entire families, and can derail the mental health and development of the over two million children who have had a parent deployed over the past 14 years.

A growing body of evidence indicates that some children of military families—especially those living in PTS/TBI households—have been negatively affected by their parent's deployments. Research conducted by the University of Southern California found that military connected adolescents have a higher rate of suicidal thoughts than their civilian counterparts, and other studies indicate that military spouses —particularly those serving as caregivers to support their wounded veterans—are more at risk to suffer mental health problems.

To make matters worse, in most cases spouses and children of the over 60% of post-9/11 troops who have left active duty, are not eligible for healthcare from the Department of Veterans Affairs. No one Federal agency is held accountable, and there is no coordinated system to respond to the needs of these families. In fact, for the most part they are invisible to the systems that could be providing them services. While the Department of Defense has been directed by Congress to start tracking suicides among active duty family members, the VA has no such mandate to track family members once they leave active duty.

We, as a Nation, are failing these families, many of whom feel abandoned by the country their loved ones fought to protect. Helping these families isn't just a moral imperative, it's a public health concern. RAND estimates that the lost productivity among post-9/11 caregivers (mostly young wives) will confer a societal cost of almost 6 billion dollars. And the National Center for Child Traumatic Stress reports that poverty, addiction and mental illness are just some of the conditions that have their roots in untreated childhood traumatic stress.

What can be done?

Children and Family Futures, a California based advocacy organization, recommends the Departments of Defense, Veterans Affairs and Health and Human Services expand their research program to better assess the behavioral health needs of veteran children. Currently, the bulk of research focuses on active duty families, who have far better access to care. In addition, mental health conditions related to wartime service sometimes take years to manifest, which means hundreds of thousands of veteran family members are at risk of falling through the cracks.

Second, an estimated 350,000 veteran families lack health insurance. This requires a targeted outreach campaign—at both the Federal and local levels—to educate and enroll these families in health coverage under the Affordable Care Act.

Third, the VA must do more to identify and help these families. Currently, there are no screening or assessment protocols used to determine the service needs of veteran caregivers or children. The VA is struggling to keep up with the growing demand in mental health services for veterans, and does not have the capacity (or congressional authority) to provide behavioral health support for family members. But, they can certainly do a far better job of ensuring warm hand-offs to community based mental health agencies.

The fact is, the majority of veteran families in need of behavioral health care will be seen by community based organizations. These agencies will require the funding, cultural competency and education in evidence based practices to expand their ca-

pacity and effectively serve veteran families in crisis. The VA's Supportive Services for Veteran Families (SSVF) program, which grants $300 million dollars a year to community based organizations, has been widely credited for helping to drastically reduce veteran homelessness. This same model can be used to support community based behavioral health care for veterans and their families.

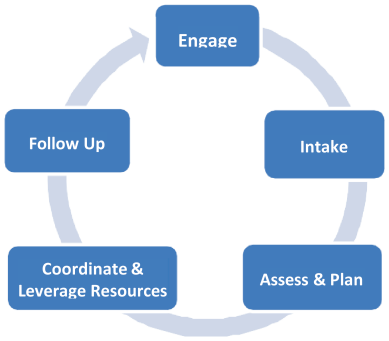
The yellow ribbons have faded and the welcome home parades are a distant memory. But there's a price to pay for outsourcing our national defense to less than one percent of the population over 14 years of war. This isn't a military problem. It belongs to all of us.

Alex's mom, Jami, and her remaining son are now getting the counseling they need through a local Vet Center. As painful as it is for her to speak openly about her tragic losses, she is committed to raising awareness. It's too late for Alex, but we can still save hundreds of thousands of families damaged by war, and give them a chance to become whole again.

CASE COORDINATION PROGRAM

Launched in 2013, Code of Support Foundation's (COSF) **Case Coordination program provides customized and holistic one-on-one support to service members, veterans, caregivers and their families** (SMVCF). COSF serves all eras, regardless of discharge status or geographic location. Of the 22 million veterans in our nation, an estimated **30% are struggling or are in crisis** and many, including family members, do not qualify for the Department of Veterans Affairs (VA) programs. While there are more than 40,000 nonprofits and government programs committed to helping this nation's heroes, their varying scope and eligibility requirements means that no one agency or nonprofit, has the capacity to fulfill their multiple and complex needs.

Identifying Needs and Leveraging Resources. COSF's Case Coordination program takes a holistic approach when working with military and veteran families. Its team of trained Veteran and Caregiver Peer Navigators work with these families to identify and prioritize their most pressing needs, and help them build a customized service plan that leads to self- sufficiency. Through leveraged collaboration with organizations and agencies across the country, COSF's Peer Navigators are able to help these families overcome life's challenges and significantly improve their quality of life. Just as importantly, the Peer Navigators stay with these families until their needs are met, and follow up at regular intervals to ensure their continued well-being.

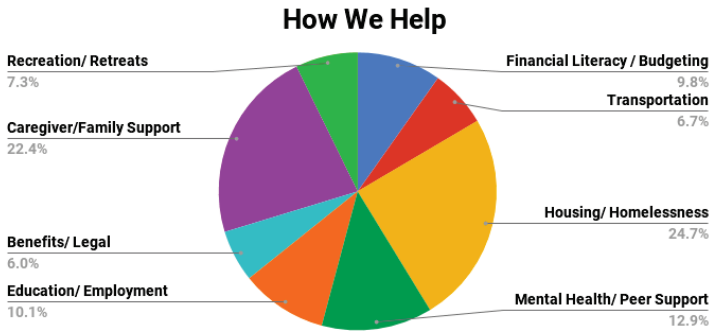


"Brendon and I cannot thank Code of Support enough for all of the help offered to us. It means a lot to us to know that there are people who truly care for our veterans and are there in a time of need. Thank you again for all the time you invested to help us find the help we needed."- Janette Cameron

Measuring Results. Case Coordination outcome measures aren't simply based on the number of families assisted, or the monetary value of the services leveraged on the client's behalf. Peer Navigators communicate directly to determine a client's wellbeing (emotional and physical health, social, and financial) throughout the process: during intake, before a case is closed and in follow up communications. COSF also works with its partner Ernst & Young (EY) to continue to refine performance measures and analytics.

Best Practices. Because of the program's integrated comprehensive approach, COSF receives 50% of its client referrals by partner organizations including some of the largest veteran organizations and agencies in the country, including the **Departments of Defense, Veterans Affairs** and most recently **The Elizabeth Dole Foundation**. In addition to the client referrals, COSF's Case Coordination process is recognized as a best practice for assisting service members, veterans, caregivers and their families. It has been briefed at the **Red Cross Learning Summit**, **Fisher House Managers Conference**, and the **Bristol-Myers Squibb Foundation Summit.**

Innovation. It was through COSF's case coordination experiences that lead to the creation of **PATRIOTlink®**, a cloud-based resource navigation platform designed by service providers for service providers. The strategically populated provider assistance tool empowers veteran service providers to easily navigate and find resources for the service members, veterans, and families they are assisting. It facilitates COSF's more comprehensive approach to veteran transition and wellbeing, and has the potential to significantly improve collaboration between veteran support organizations. PATRIOTlink® allows increased efficiency and efficacy of COSF's own Case Coordination program, which in turn allows its Peer Navigators to help more



service members, veterans, caregivers, and families.

Special Thanks to our Fellowship Sponsors:

ATTACHMENT 3: PATRIOTLINK NEWSLETTER

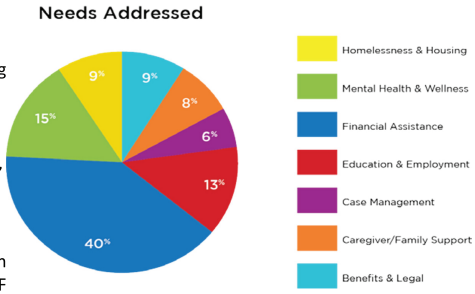
PATRIOTlink®

A Service of Code of Support Foundation

*"**PATRIOTlink®** is a daily benefit for my work at the American Red Cross Military and Veteran Caregiver Network. One of the biggest calls to action I have as a peer supporter is to find and recommend resources for specific needs… being a national organization it can be hard to know what community level resources are available to veterans, families and their caregivers, with **PATRIOTlink** I have a vetted and monitored resource referral system that I never hesitate to use. Peer referral is powerful and I pride myself on only sharing resources I know the caregivers can access and qualify for. **PATRIOTlink** is the tool I choose to find quality, dependable resources for our military and veteran caregivers of all eras." -**Melissa Comeau, American Red Cross Military and Veteran Caregiver Network***

Empowering the Veteran and Caregiver Population Across the Nation. Out of the 22 million veterans in the U.S., an estimated 30% of veteran families are in crisis and require critical assistance from one or more service providers to ensure they have wrap-around support for their needs. Currently, there are tens of thousands of nonprofits and thousands of local and federal government resources in the veteran support space with varying scope and eligibility requirements. Code of Support Foundation (COSF) recognizes that no one agency, government or nonprofit has the capacity to fulfill veteran families' entire complex and often multiple needs, especially for those in crisis. That is why COSF developed **PATRIOTlink®**, a national cloud-based resource solution designed for service members, veterans, caregivers, and their families as well as social service agencies and organizations who support veterans and the caregiver population.

The Need. In 2014 COSF began an in-depth environmental scan of service organizations across the nation. COSF determined that existing resource databases were difficult to navigate and often ineffective in identifying and leveraging the multiple resources required to serve a client's needs. The end result being that, across the nation, veterans in crisis were falling through the cracks.



The Solution. Based on COSF's own research and case coordination experience the COSF team developed PATRIOTlink®, a cloud-based resource solution that facilitates integrated efforts among support organizations and enables users to efficiently identify and effectively leverage all resources available. Since 2016, Code of Support Foundation has piloted PATRIOTlink in over 50 organizations across the country including, Catholic Charities, National Guard, The American Red Cross National Military and Caregiver Network, Psych Armor, Elizabeth Dole Foundation, Volunteers of America, USO, Service Women Action Network, Homes For Our Troops, and Project Sanctuary. These pilot users have provided valuable feedback which has helped guide the development efforts.

Code of Support Foundation is a national 501(c)(3) nonprofit organization that provides essential and critical one-on-one assistance to struggling military service members, veterans and their families who have the most complex needs. COSF's integrated programs include personalized, holistic long-term case coordination services that serve all service eras across the nation.

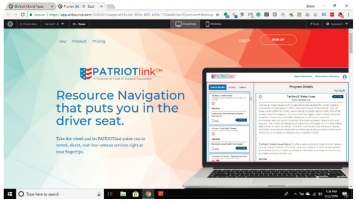
The Process. The PATRIOTlink® program team ensures that each organization's profile represents program capacity, services provided, and resources tagged based on eligibility criteria such as service era, disability rating, discharge status, deployment history, and geographic coverage. This allows a user to perform searches that result in resources their client qualifies for, significantly reducing the amount of time it takes to find the specific assistance their need.

CRITERIA. In order for any organization to be qualified for PATRIOTlink®, they must meet these essential requirements:

- Provide a direct and a cost-free service (i.e. legal, mental health)
- Be fiscally responsible and financially transparent (i.e. 990)
- Ensure capacity to serve additional troops, veterans and their families
- Be responsive when contacted by phone and/or email

Quality over Quantity. The PATRIOTlink® platform is different than other resource directories or search engines because of COSF's continued dedication to ensuring that the data remains accurate.

This highly involved process uses human resources to keep the data clean so that users can quickly locate essential and valid resources to accurately fulfill the multiple needs of veteran families' looking for assistance.



Impact Data & Trends. Just as importantly, PATRIOTlink® has the potential to also provide COSF with local impact data. The data collected (without disclosing client confidentiality) through the platform could allow COSF to identify issue trends and "hot spots" in real time. COSF'S ability to provide this real time data to local organizations and communities, could lead to possible advocacy for policy changes and/or funding. The value of this real-time data collection cannot be overstated in providing greater assistance to veterans in our communities.

COSF's corporate funders, **Bristol-Myers Squibb Foundation** and **Noblis, Inc.**, have been generous supporters in the launch and pilot phase of PATRIOTlink®.

Bristol-Myers Squibb noblis

To sign up for a free account for to: www.patriotlink.org

Why Is PATRIOTlink different?

- Every organization must provide a direct and cost-free service.
- Each resource undergoes a thorough and standardized vetting process, which requires telephonic verification.
- Continuous resource updates by COSF program specialists ensures data integrity.
- Each organization is tagged not just by the service(s) provided, but also by eligibility criteria - allowing for a more targeted and efficient search.
- Unique features to locate and save resources.
- The ability for service providers to recommend new organizations and resources to COSF for vetting and potential inclusion in PATRIOTlink™.
- A gap analysis and feedback feature fed by user experience to inform the continuing population and design of PATRIOTlink™.

Code of Support Foundation is a national 501(c)(3) nonprofit organization that provides essential and critical one-on-one assistance to struggling military service members, veterans and their families who have the most complex needs. COSF's integrated programs include personalized, holistic long-term case coordination services that serve all service eras across the nation.

PREPARED STATEMENT OF JOHN BOERSTLER, CEO, COMBINED ARMS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, DISTINGUISHED MEMBERS OF THE COMMITTEE: Thank you for this opportunity to discuss the important topic on how communities leverage networks and systems to actively prevent veteran suicide.

After serving in the government and veteran nonprofit space for over 19 years, and now as the CEO of Combined Arms, I am excited to report that in Houston, community collaboration with the VA has never been stronger. It's stronger because of the work of our local VHA and VBA leadership to understand the value that our 56 member agencies composed of other government agencies and nonprofit organizations can serve as agile and effective force multipliers for VA programming and customer service.

THE COMBINED ARMS MODEL

Combined Arms is a dynamic, ever-evolving collaborative impact organization that is using an innovative approach of technology and service delivery to disrupt the veteran transition landscape. By providing a holistic online assessment that efficiently connects veterans to member organizations, Combined Arms is accelerating veteran transition in order to deliver maximum impact in Houston. Combined Arms operates its collaborative system through four major pillars:

1. Combined Arms runs a co-working space for 56 government and nonprofit agencies that is centrally-located and creates intentional collaborative collisions for those professionals that serve military veteran families. The Combined Arms Center is also a single point of entry from transitioning servicemembers, veterans, and their families.
2. Combined Arms created an integrated technology platform that ensures thousands of military veteran families have access to 399 customized resources provided by our 56 vetted member organizations. Combined Arms has flipped the accountability from the veteran to the service organizations through their unique data driven methodology.
3. Combined Arms has developed an innovative marketing campaign that reaches further upstream to attract more military veteran families still on active duty or looking for their next opportunity. Combined Arms is serving the community by attracting more military talent to Houston as a means of economic development for our region.
4. Combined Arms is recruiting, training, and deploying community leaders who have successfully made the difficult transition from military to civilian life to engage those veteran families still making the transition at the neighborhood level to ensure we are all #unitedaftertheuniform. This model not only positively activates successful veterans to volunteer and make a social impact on our community but also ensures more veterans in transition have direct access to the resources provided by our member organizations.

These four pillars have effectively connected over 5,000 unique veteran clients to the 399 resources provided by the 56 member organizations since 2016. It is self-driven by the veteran and custom-fit for their needs based on how they answer the assessment. Little effort is required on behalf of clients who may be in crisis mode, unable to access other services, or unaware of services that exist. If a client reports a score less than 13 from the World Health Organization wellbeing index or "WHO 5" on the profile, then an alert is sent to the intake team for additional follow up on mental health. Every time a client returns to our system 30 days apart, the system automatically asks for an update on the WHO 5 and tracks the data so we can see trends of their responses. Similarly, if clients report being homeless or living in a shelter, then an alert is sent to the Intake Team for additional follow up and assessment to ensure the client is properly referred to vetted housing programs. The Intake Team provides ongoing follow up with veterans reporting they are homeless until permanent housing has been confirmed. The Combined Arms Intake Team is trained on STRONG STAR's Crisis Response Plan (https://www.strongstartraining.org/what-we-do) if they engage with clients demonstrating suicidal ideation.

The Combined Arms system actively prevents client retraumatization, as pertinent information can be shared between the Combined Arms system and the member organization delivering services. Clients are not asked the same questions multiple times, thus reducing frustration and increasing speed and efficiency of service delivery. The standard procedure is that Combined Arms member organizations follow up with the referred client within 4 days per the contract agreed upon. All of the aforementioned components act as "prevention nudges"—minor yet impactful structural supports that keep clients engaged in care and community which are both preventative measures and facilitators of veteran health. Case progression is monitored by Combined Arms regularly to ensure that no clients are slipping through the cracks. Because of this experience, we firmly believe that suicide prevention lies in the ability to provide direct access to social services to the veteran as far upstream in their transition process as possible. If we can prevent unemployment and underemployment, substance abuse, family challenges, homelessness, and criminal behavior by accelerating veteran access to critically needed resources in a faster, more efficient way then we will prevent veteran suicides.

VA COLLABORATION

15 different VA programs and clinics at the Michael E. DeBakey VA Medical Center (MEDVAMC) have been assigned to work within the Combined Arms system ranging from the Post Deployment Clinic to Womens Clinic to the Mental Health

and TBI and Benefits programs and other peer support or outreach programs. The objective is for the VA to utilize the Combined Arms system to refer veteran patients to vetted government and nonprofit agencies delivering social services not provided by MEDVAMC. Similarly, other agencies can refer veteran clients into the VBA and VHA programs. Additionally, on a monthly basis, Combined Arms, MEDVAMC, and Houston Regional Office (VBA) join forces on "Vet Connect Days" to make VBA and VHA programs and care more accessible to veteran clients seeking services through the Combined Arms system. These events increase client enrollment into VA programs. Finally, through the work of the Mayor's Challenge, the Combined Arms Transition Center is a distribution site for gun locks from the VA.

MEDVAMC is also one of few VA hospitals in the Nation that work with local organizations like Combined Arms and county Medical Examiner to track, analyze, and report veteran suicides in the region served. Based on the data available to these partners, the Combined Arms team and VA partners discovered that approximately 65 veterans died by suicide in Harris County—the fourth largest veteran population in the United States—last year. Their average age is 53 with the most vulnerable populations being the youngest and oldest generation of veterans, aged 25–33 and 65+ years. This data is important for Combined Arms partners to better understand what programs and services can be deployed to actively prevent future veteran suicides and ensure that the number of deaths by suicide each year continues to decline.

CONCLUSION

Combined Arms remains in constant communication with our member organizations and the community and are provided ongoing reports of incidents of veterans in crisis in need of outreach including via social media, suicides, and attempted suicides. The Intake Team will follow up, assess needs, and connect to appropriate partners including the VA who are notified in advance of the system referral regarding the severity of the situation to ensure immediate follow up by our partners. This innovative model can better prevent suicide if our member organizations are given the opportunity to provide direct access to social services to veterans as far upstream in their transition process as possible. If we can prevent unemployment and underemployment, substance abuse, family challenges, homelessness, and criminal behavior by accelerating veteran access to critically needed resources in a faster, more efficient way then we will prevent more veteran suicides in the communities veterans return to.

Thank you again for your consideration of this written testimony and for your continued service to our military veteran community.

PREPARED STATEMENT FROM ROBIN KELLEHER, PRESIDENT/CEO, HOPE FOR THE WARRIORS

HARNESSING THE POWER OF COMMUNITY: LEVERAGING NETWORKS TO TACKLE SUICIDE

Veteran suicide is a tragic reality and has become an oft-cited data point; the reality is that clearly defined predictors are difficult to catalogue as part of a logical equation where the sum of all factors leads to another self-inflicted veteran death. HOPE appreciates the Committee recognizing the power of community to enhance veteran wellness. Our experience supporting post-9/11 servicemembers, veterans and military families for the last 13 years provides a window into the myriad issues that veterans and their families deal with, and oftentimes struggle with.

Hope For The Warriors (HOPE) knows that the opportunity to instill resilience starts at a young age at home, but can be impacted by an individual's engagement with society, military service, and community. Therefore, we all—the VA, the Department of Defense, community organizations, and care providers—have an obligation to ensure military family wellness is a priority at every level—individual, community, state, and national—through continuous collaborative communication with each other.

ABOUT HOPE FOR THE WARRIORS

The mission of Hope For The Warriors is to restore self, family and hope to the warrior communities we serve—servicemembers, veterans, military families, caregivers and families of the fallen. It's more than a mission, however; it's who we are. HOPE was founded by military families aboard Marine Corps Base Camp Lejeune, North Carolina, in 2006, as we felt the effects of war on our friends, colleagues, families and ourselves. What began as post-combat bedside care and support has

evolved to a national organization that has adapted to ongoing changes within the military community. We stayed the course with our country's post-9/11 veteran population as physical wounds healed, but emotional wounds still needed care. We recognize that there are many factors aside from combat that can contribute to mental health, including trauma from life events not directly associated with service. We've opened our arms to those who seek hope.

Our work today is still just as individualized and community-based as it was in HOPE's earliest years. We provide more than 12,000 services to over 4,200 military families in all 50 states annually. We believe warriors can thrive with access to integrated services focused on their individual and collective well-being. We recognize every servicemember and military family has their own goals and needs, and ideal resources do not always exist in their communities. We will restore SELF, FAMILY and HOPE through our national services, virtual capabilities and partners in mission.

LEAD FACTORS TO VETERAN CRISIS AND RISK FOR SUICIDE

Isolation and a feeling of detachment are two of the primary causal factors in a person's ultimate decision to choose suicide. Military servicemembers are, by definition, trained to succeed in the unrelenting environment that is combat. Very often, disconnecting from one's own emotions is critical in order to execute the physical and mental requirements of combat operations. "Compartmentalization" is a by-product of the DOD's training skillset but the consequences of the last 18 years of continuous global combat operations has resulted in the current crisis of psychological health issues. Isolation is further compounded by an increasing disconnectedness from foundational belief systems, family, faith, and identity, all leading to a feeling of hopelessness.

HOW COMMUNITIES PROVIDE SUICIDE PREVENTION RESOURCES TO VETERANS

The military unit is a servicemember's first "community organization," therefore the important aspects of community that the VA, veteran organizations and this Committee recognize as a critical power to harness must begin at the start of military service, and continue in a collaborative ecosystem of supporting organizations.

Military service is connected to a belief system. We shouldn't ignore faith, patriotism, moral obligation and legacy of service as important conduits to the feeling of a greater purpose. In a society where there are groups actively attacking spirituality, the National Anthem and our country's flag, it's easy to see how a veteran who answered a greater calling can feel isolated. Community combats isolation, and our job is to reconnect veterans to supportive communities. We must view communities in a broader scope to maintain the necessary constant connection. It's not just what is found in one's neighborhood; it's tapping in to virtual resources, social media, veteran-based programming and promoting military cultural awareness in existing community resources, like houses of faith and special interest groups. HOPE activates each of these communities to carry out integrated case management.

HOW THE VA CAN LEVERAGE COMMUNITY RESOURCES

Sustainable care for the veteran population doesn't reside in one place, rather it exists in a network of support that surrounds an individual. The VA must function within a comprehensive system of strategic relationships with the Department of Defense, veteran and military service organizations and other community groups, to ensure ongoing, sustainable, individualized care for the veteran population. The first step in building emotional/psychological fitness MUST become part of the DOD/military training programs. Building resiliency . . . and the methods and modalities to ensure it's sustained and maintained . . . needs to begin while a servicemember is still in uniform. There should be a clear handoff from DOD to VA and veteran community organizations to ensure continuity of care. Organizations like Hope For The Warriors that emphasize a veteran's holistic well-being, and includes his or her family in the healing journey, open access to the communities he or she needs for lifelong support and resiliency.

HOPE FOR THE WARRIORS' EFFORTS TO REDUCE SUICIDE IN THE VETERAN COMMUNITY

Hope For The Warriors has built programs that address the known risk factors associated with military suicide, specifically disconnection and isolation. Our programs are designed to restore connection to self, family and most importantly, Hope. Our programs build emotional strength, resiliency, purpose and sustainable coping

skills that are all necessary to combat isolation and detachment, thereby keeping the thought of suicide from becoming the act.

Our greatest tool is community connection, through virtual workshops, meaningful events, military family-based programming and a strong referral system to like partners in mission. Collaboration is necessary to create an environment where everywhere a veteran looks, he or she sees Hope.

Additionally, Hope utilizes innovative techniques to identify wellness risk factors, propensity for risk behaviors, etc. Artificial Intelligence is actively used across businesses to increase performance and "drill down" into human factors of their customers—veteran support networks must be just as innovative.

Our dedication to mental health services includes the entire military family. We thrive on connecting veterans and families to communities of support in order to bridge the gap of understanding between military and civilians. Our constant is a message of Hope.

HOW COMMUNITY ORGANIZATIONS COLLECT/USE DATA FOR COMMUNITY-BASED VETERAN SUICIDE PREVENTION

Suicide provides definitive data, only captured after it's too late, so we must work together in tracking trends among an ever-changing veteran population. Basic demographic information, health trends and regional data from the VA will help nonprofits better understand the veteran community's needs. Identifying and sharing the VA's service gaps can lend to a team approach to fill every gap and meet every need by outsourcing services. It is critical that we leverage innovative technology to support predictive analysis allowing for intervention and ultimately eliminating veteran suicide crisis.

Understanding that sustainable care and successful suicide prevention is individualized, there is no single program that works for everyone, we must do more than share data; we must collaborate to create a national community of support and tackle suicide one person at a time.

PREPARED STATEMENT OF KIM PARROTT, SISTER OF CDR JOHN SCOTT HANNON, DECEASED

My brother, John Scott Hannon, joined the military at 18 and retired 23 years later as a Navy SEAL Commander. In the course of his career he was awarded 10 service medals, including two bronze stars. He was also awarded over 100% disability for PTSD, Traumatic Brain Injury, chronic pain, depression and bi-polar disorder. His re-entry into civilian life was anything but smooth. It ended with him taking his life on February 25, 2018.

As our family sought out effective treatments over the course of a decade, we discovered an extraordinary multitude of resources available to veterans through the government, non-profit and for-profit sectors. Upon closer inspection, however, the majority of these programs stand alone as isolated initiatives, with no connection to what happened before or after in the veteran's life. This pattern is echoed in the anecdotal evidence we've heard from other injured vets—that their post-military treatment has been disjointed at best.

This led us to ask: What if a larger template was created to integrate multiple treatment modalities? For example a customized pathway for vets and their families that addresses physical, emotional and spiritual healing as well as financial and vocational skills?

I met with providers at a VA Hospital and a Vet Center. They agreed.

Currently the demobilization process consists of several days chock full of lectures and thick binders on transitioning back into civilian life. The information is good but it's overwhelming and mostly landing on the deaf ears of soldiers fixated on getting home as soon as humanly possible.

If mobilization takes weeks, months and even years in the case of Special Operations Forces, how could effective demobilization occur in a week? Put another way, if a deep-sea diver doesn't decompress from a dive properly and surfaces too quickly, they are at risk of getting very sick or even dying.

Soldiers emerging from the pressures of combat are no less at risk.

Being able to provide veterans a continuum of support once they are back in their own communities could make a world of difference. Working proactively with soldiers before leaving the military would make an even bigger difference. Imagine transitioning into civilian with a life vision, career path and coherent treatment plan for visible and invisible wounds? I was told this kind of shift in resource allocation would require an Act of Congress.

The Veterans Mental Health Care Improvement Act named after my brother is a huge step in the right direction. Treatment was too fragmented and too late to save my brother's life, but his experience enabled him to become an articulate champion for what could help other veterans facing similar mental health challenges in the future.

This bill is in complete alignment with John Scott's beliefs and efforts. It embraces a broader range of treatment and therapy options. It supports research to identify what really works. It promotes more practitioners trained in mental health care. It advocates for collaboration between the VA and DOD. In short, this act will move us away from a reactive and piecemeal approach toward a proactive and evidence-based continuum of support. Isn't this what we owe the men and women who have served our country with their minds, bodies and souls?

Thank you.

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

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 "Harnessing the Power of Community: Leveraging Veteran Networks to Tackle 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 lifecycle, 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.

I am the Director of the Center for Mental Health Research and Recovery (CMHRR) at Montana State University. While the CMHRR does have statewide suicide prevention research, none of that research funding presents a conflict with this testimony. I have also been appointed to the Creating Options for Veterans' Expedited Recovery (COVER) Commission. This testimony does not reflect the views of Montana State University, the Montana University System, or the COVER Commission.

II. RECOMMENDATIONS

A. The Veterans Administration should develop a telehealth resource to deliver Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) to emergency rooms throughout the country.

In 2008, the Blue Ribbon Panel on Veteran Suicide recommended the development and implementation of an Emergency Department (ED)-based intervention for suicidal Veterans who are discharged from the ED VA leadership responded to this recommendation and developed a clinical demonstration project: Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) project.[1] This program was specifically designed to address the issue of the "dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care."[2]

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[1] Knox, K., L., Stanley, B., Currier, G., Brenner, L., Holloway, M., & Brown, G.K. (2012). An emergency department based brief intervention for Veterans at risk for suicide (SAFE VET). *American Journal of Public Health*. 102 suppl(1): S33–7, 2012

[2] Stanley, Barbara, et al. "Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department." *JAMA psychiatry* 75.9 (2018): 894–900.

In September 2018, *JAMA Psychiatry* published the results of a large-scale cohort comparison study to determine whether the SAFE VET intervention was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.[3] The study found that SAFE VET was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behavior over 6 months (odds ratio, 0.56; 95% CI, 0.33–0.95, P = .03). Additionally, veterans that received the SAFE VET intervention had more than double the odds of attending at least 1 outpatient mental health visit (odds ratio, 2.06; 95% CI, 1.57–2.71; P < .001).

A study published in the Archives of Suicide Research analyzed medical staff perceptions of the SAFE VET intervention.[4] Almost all staff perceived that SAFE VET was helpful in connecting veterans' follow-up services. A slight majority of staff believed SAFE VET increased the safety of participating veterans. The study found that medical staff members also benefited from the implementation of SAFE VET, because their comfort discharging Veterans at some suicide risk increased.[5]

The SAFE VET program is ready for a broader scale intervention. The logistics of providing the intervention in person to veterans in emergency rooms across the country are likely infeasible. However, the Suicide Safety Plan portion of SAFE VET could be delivered via telehealth networks to participating emergency rooms, with the follow-up conversations being administered telephonically.[6]

The VA has a strong expertise in delivering telehealth care. The agency is in an excellent position to be able to deliver this critical intervention across the country.

B. The Veterans Administration and the National Institute of Mental Health need more funding to develop research-proven suicide prevention initiatives.

In June 2017, Psychiatric Services published "Suicide Risk Assessment and Prevention: A Systematic Review Focusing on Veterans."[7] This research was funded by the Quality Enhancement Research Initiative, Office of Research and Development, Veterans Health Administration (VHA), U.S. Department of Veterans Affairs.

The systematic review's authors sought to update evidence of the accuracy of methods to identify individuals at increased risk of suicide and the effectiveness and adverse effects of health care interventions relevant to U.S. veteran and military populations in reducing suicide and suicide attempts.[8] While the study did have some exclusions such as interventions involving medication, it can be seen as a broad view of the current state of the science for this critical issue.

The conclusions of the systematic review were bleak:

> Risk assessment methods have been shown to be sensitive predictors of subsequent suicide and suicide attempts, but the frequency of false positives limits their clinical utility. Future research should continue to refine these methods and examine clinical applications. Studies of suicide prevention interventions provide inconclusive evidence to support their use, and additional RCTs of promising individual therapies and site-randomized population-level interventions are needed.[9]

The author's statement that further research is needed is mirrored by 2014 article in Psychiatry, "Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors."[10] That research behind that article was funded by Department of the Army, the U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health (NIH/NIMH). That article's authors concluded that, "Moving forward, the prevention of suicide requires additional research aimed at: (a) better describing when, where, and among whom suicidal behavior occurs, (b) using exploratory studies to discover new risk and protective factors, (c) developing new methods of predicting suicidal behavior that synthesize information about modifiable risk and protective factors from multiple domains, and

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[3] *Id.*

[4] Chesin, Megan S., et al. "Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans." *Archives of suicide research* 21.1 (2017): 127–137.

[5] *Id.*

[6] In person discussion between Matt Kuntz of NAMI Montana and Dr. Barbara Stanley Ph.D., one of the SAFE VET program developers. Columbia University. April 18, 2019.

[7] Nelson, Heidi D., et al. "Suicide risk assessment and prevention: a systematic review focusing on veterans." *Psychiatric services* 68.10 (2017): 1003–1015.

[8] *Id.*

[9] Nelson, Heidi D., et al. "Suicide risk assessment and prevention: a systematic review focusing on veterans." *Psychiatric services* 68.10 (2017): 1003–1015.

[10] Nock, Matthew K., et al. "Suicide among soldiers: a review of psychosocial risk and protective factors." *Psychiatry: Interpersonal & Biological Processes* 76.2 (2013): 97–125.

(d) understanding the mechanisms and pathways through which suicidal behavior develops." [11]

C. Expand the VA's existing Precision Mental Health program as described in the bipartisan Commander John Scott Hannon Veterans Mental Health Care Improvement Act.

According to the authors of "Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors," "The fact that the vast majority of suicides occur among people with a current mental disorder makes this risk factor a prime target for screening and prevention efforts." [12]

However, the state of the science in the screening, diagnosis and treatment of mental health conditions is in flux. A strong analysis of this issue is given by Dr. Thomas Insel MD, et al. in the paper introducing the National Institute of Mental Health's Research Domain Criteria effort. At the time of this article was published, Dr. Insel was the Director of the National Institute of Mental Health.

> Current versions of the DSM and ICD have facilitated reliable clinical diagnosis and research. However, problems have increasingly been documented over the past several years, both in clinical and research arenas. Diagnostic categories based on clinical consensus fail to align with findings emerging from clinical neuroscience and genetics. The boundaries of these categories have not been predictive of treatment response. And, perhaps most important, these categories, based upon presenting signs and symptoms, may not capture fundamental underlying mechanisms of dysfunction. One consequence has been to slow the development of new treatments targeted to underlying pathophysiological mechanisms.
>
> History shows that predictable problems arise with early, descriptive diagnostic systems designed without an accurate understanding of pathophysiology. Throughout medicine, disorders once considered unitary based on clinical presentation have been shown to be heterogeneous by laboratory tests—e.g., destruction of islet cells versus insulin resistance in distinct forms of diabetes mellitus. From infectious diseases to subtypes of cancer, we routinely use biomarkers to direct distinct treatments. Conversely, history also shows that syndromes appearing clinically distinct may result from the same etiology, as in the diverse clinical presentations following syphilis or a range of streptococcus-related disorders.[13]

The critical nature of this issue to the VA's services is one of both issue severity (veteran suicide) and scope. According to the VA's Office of Research and Development, "More than 1.8 million Veterans received specialized mental health care from VA in fiscal year 2015." [14]

Therefore, the VA serves almost 2 million veterans a year in a treatment system based upon mental health diagnosis categorization that the former Director of the National Institute of Mental Health has deemed not to be *"predictive of treatment response."* [15] (emphasis added)

The VA's Precision Mental Health Program led by Amit Etkin, M.D., Ph.D. of the Palo Alto VA is tackling some of the most critical questions about how to improve the diagnosis and treatment of psychiatric conditions. The program recently published the results of its groundbreaking study, "Using FMRI Connectivity to Define a Treatment-Resistant Form of Post-Traumatic Stress Disorder." [16] That research "We found that a subgroup of patients with PTSD from two independent cohorts displayed both aberrant functional connectivity within the ventral attention network (VAN) as revealed by functional magnetic resonance imaging (fMRI) neuroimaging and impaired verbal memory on a word list learning task. This combined phenotype was not associated with differences in symptoms or comorbidities, but nonetheless could be used to predict a poor response to psychotherapy, the best-validated treatment for PTSD." [17]

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[11] *Id.*
[12] *Id.*
[13] Insel, Thomas, et al. "Research domain criteria (RDoC): toward a new classification framework for research on mental disorders." (2010): 748–751.
[14] Office of Research & Development website. Department of Veterans Affairs. Accessed on June 19, 2019. https://www.research.va.gov/topics/mental_health.cfm
[15] Insel, Thomas, et al. "Research domain criteria (RDoC): toward a new classification framework for research on mental disorders." (2010): 748–751.
[16] Etkin, Amit, et al. "Using fMRI connectivity to define a treatment-resistant form of Post Traumatic Stress Disorder." *Science translational medicine* 11.486 (2019): eaal3236.
[17] *Id.*

The VA's Precision Mental Health program is making real headway in identifying the scientific tools to improve care for veterans' brain health treatment. There is also room to add additional partners for the program. For example, the "Establishing Moderators and Biosignatures of Antidepressant Response for Clinical Care for Depression (EMBARC)" has made significant strides in their analysis of depression.[18] That effort and related efforts by Dr. Madhukar Trivedi's team at the University of Texas Southwestern have identified potential biosignatures involving inflammation,[19] blood,[20] [21] and advanced imaging.[22]

D. The VA needs to continue to work on its suicide prevention messaging to ensure that it carries the overall point that suicide is not a rational brain response to adverse experiences

1. There is significant danger of having suicide prevention models be lost in the weeds of this complex and evolving science.

The circularities and similarities between mental illness symptoms and suicide risk factors make it incredibly difficult to determine after a suicide if someone would actually have the right number and type of symptoms that they would have been diagnosed with a mental illness. This makes it difficult to determine how to interpret unresolved question that arises from the statistic that "50% of veterans who completed suicide had received a mental health diagnosis before their death."[23]

What about other 50%? How many of them would have had the right symptom cluster to have been diagnosed with a mental illness? Would the numbers agree with what used to be a general acknowledgment that "over 90% of those who committed suicide had a psychiatric diagnosis at the time of death?"[24] Is it lower? Is it potentially even much lower? Is it possible to even come close to the right number and how relevant is the symptom cluster possible mental illness diagnoses question anyway.

Dr. Jerry Reed Ph.D. of the Suicide Prevention Resource Center spoke to the issue. "We certainly need to learn more about the relationship between mental illness and suicidal behaviors. I welcome any research and dialog that will help clarify this association. But from a prevention standpoint, we should not let the "90 percent" figure limit our pursuit of solutions or prevention opportunities."[25]

NAMI Montana fully agrees with Dr. Reed and we believe that the VA and other partners are following his advice of not letting this debate limit the "pursuit of solutions or prevention opportunities." However, there is a need for an overall model to communicate to veterans, family members, and others how to prevent suicide and why certain strategies work.

In NAMI Montana's opinion, any effective suicide prevention model must be based on the irrationality of suicide while incorporating both susceptibility for suicidality and the impact of stressful situations.

2. NAMI Montana recommends using that the VA use the Stress-Diathesis Model as a foundation in its suicide prevention messaging.

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 ground our message in the Stress Diathesis Model. As described in an article in Lancet Psychiatry, "The stress-diathesis model posits that suicide is the result of an interaction between state-dependent (environmental) stressors and a trait-like diathesis or susceptibility to suicidal behavior, independent of psychiatric disorders."[26]

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[18] National Institute of Health, National Library of Medicine, ClinicalTrials.gov website. Accessed on June 19, 2018. https://clinicaltrials.gov/ct2/5show/NCT01407094

[19] Jha, Manish, and Madhukar Trivedi. "Personalized antidepressant selection and pathway to novel treatments: clinical utility of targeting inflammation." *International journal of molecular sciences* 19.1 (2018): 233.

[20] Czysz, Andrew H., et al. "Can targeted metabolomics predict depression recovery? Results from the CO-MED trial." *Translational psychiatry* 9.1 (2019): 11.

[21] Furman, Jennifer L., et al. "Adiponectin moderates antidepressant treatment outcome in the combining medications to enhance depression outcomes randomized clinical trial." *Personalized medicine in psychiatry* 9 (2018): 1–7.

[22] Cooper, Crystal M., et al. "Cerebral blood perfusion predicts response to sertraline versus placebo for major depressive disorder in the EMBARC trial." *EClinicalMedicine* (2019).

[23] Dr. Keita Franklin Ph.D. presentation to COVER Committee on January 30, 2019.

[24] Bertolote, José Manoel, and Alexandra Fleischmann. "Suicide and psychiatric diagnosis: a worldwide perspective." World Psychiatry 1.3 (2002): 181.

[25] http://www.sprc.org/news/90-percent

[26] Van Heeringen, Kees, and J. John Mann. "The neurobiology of suicide." *The Lancet Psychiatry* 1.1 (2014): 63–72.

The article "Suicide as a Public Health Burden" goes into more depth:

> In this model, diathesis describes the development of risk, defined by conditions that create an enduring vulnerability to be suicidal. Stress refers to triggering environmental (and contextual) factors that promote acute risk and the breakdown of protective factors among those already vulnerable. The development of suicidal behavior is the result of an interaction between stressors and a susceptibility to suicidal behavior (diathesis). A typical stressor includes the acute worsening of a psychiatric condition, but often an acute psychosocial crisis seems to be the most proximate stressor or "the straw that broke the camel's back" leading to suicidal behavior. Pessimism and aggression/impulsivity are components of the diathesis for suicidal behavior. Sex, religion, familial/genetic factors, childhood experiences, and various other factors influence the diathesis stress model. The model posits that suicide is the result of an interaction between state-dependent (environmental) stressors a trait-like diathesis or susceptibility to suicide behavior, independent of psychiatric disorder. Stressors, such as life events and psychiatric disorders, are important risk factors for suicide, but the diathesis concept explains why only a few of these individuals exposed to these stressors will take their own life. Early-life adversity and epigenetic mechanisms seem to be related to causal mechanism for diathesis.[27]

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. Other suicide factors can be added to the diathesis or stress categories. The model also has a strong basis in neurobiology which renders it less susceptible to changes in the process of diagnosis and treatment of psychiatric conditions.[28]

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 conditions 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.

E. Ensure that all veterans who in the VHA system have access to effective care for treatment-resistant depression.

The VA/DOD Major Depressive Disorder (MDD) Clinical Practice Guidelines (VA/DOD Guidelines) state that, "Military personnel are prone to depression, at least partially as a result of exposure to traumatic experiences, including witnessing combat and separation from family during deployment or military trainings."[29] [30] The VA/DOD guidelines highlighted data from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) as an example.

Army STARRS described the 30-day prevalence of MDD as 4.8% compared to less than 1%—five times higher—among a civilian comparison group.[31] In fiscal year 2015, among Veterans served by the Veterans Health Administration (VHA), the documented prevalence of any depression (including depression not otherwise specified) was 19.8% while the documented prevalence of MDD only was 6.5%.[32]

The VA's ability to effectively serve veterans with depression is hampered by the current state of the science to diagnose and treat depression. As described by the Depression Task Force, "An estimated 50% of depressed patients are inadequately

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[27] Wilcox, Holly C., et al. "Suicide as a Public Health Burden." *Public Mental Health* (2019): 207.

[28] Van Heeringen, Kees, and J. John Mann. "The neurobiology of suicide." *The Lancet Psychiatry* 1.1 (2014): 63–72.

[29] VA/DOD Major Depressive Disorder Clinical Practice Guidelines, Version 3.0–2016. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/VADODMDDCPGFINAL82916.pdf. Citing Depression and the military. March 29, 2012; http://www.healthline.com/health/depression/military-service#1.

[30] *Id. Citing* Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. Mar 1 2006;295(9):1023–1032.

[31] *Id. Citing* Kessler RC, Heeringa SG, Stein MB, et al. Thirty-day prevalence of DSM-IV mental disorders among nondeployed soldiers in the US Army: Results from the Army study to assess risk and resilience in servicemembers (Army STARRS). JAMA Psychiatry. 2014;71(5):504–513.

[32] *Id. Citing* Veterans Health Administration Mental Health Services. Preliminary findings regarding prevalence and incidence of major depressive Disorder (MDD), non-MDD depression diagnoses, and any depression diagnosis in FY 2015 among Veterans. Veterans Health Administration Mental Health Services; 2015

treated by available interventions. Even with an eventual recovery, many patients require a trial and error approach, as there are no reliable guidelines to match patients to optimal treatments and many patients develop treatment resistance over time. This situation derives from the heterogeneity of depression and the lack of biomarkers for stratification by distinct depression subtypes."[33] Other estimates of the prevalence of treatment-resistant depression range from 30%[34] to 50%[35]. A recent study in the United Kingdom found treatment-resistant depression rates of 55%.[36]

The Depression Task Force saw hope in the future, "Recent advances in methodologies to study genetic and epigenetic mechanisms, as well as the functioning of precise brain microcircuits, prompt new optimism for our ability to parse the broad, heterogeneous syndrome of human depression into biologically-defined subtypes and to generate more effective and rapidly-acting treatments based on a knowledge of disease etiology and pathophysiology and circuit dynamics."[37]

However, the possibility of future scientific advancements does not relieve the current burden that the VA bears to provide adequate care options for veterans with treatment-resistant depression. The VA/DOD Major Depressive Disorder (MDD) Clinical Practice Guidelines have the following recommendations for veterans with treatment resistant depression.[38]

- "For patients with treatment resistant MDD who had at least two adequate pharmacotherapy trials, we recommend offering monoamine oxidase inhibitors (MAOIs) or tricyclic antidepressants (TCAs) along with patient education about safety and side effect profiles of these medications."[39]
- "We recommend offering electroconvulsive therapy (ECT) with or without psychotherapy in patients with severe MDD and any of the following conditions:"[40]
  - Catatonia
  - Psychotic depression
  - Severe suicidality
  - A history of a good response to ECT
  - Need for rapid, definitive treatment response on either medical or psychiatric grounds
  - Risks of other treatments outweigh the risks of ECT (i.e., co-occurring medical conditions make ECT the safest treatment alternative)
  - A history of a poor response to multiple antidepressants
  - Intolerable side effects to all classes of antidepressant medications (e.g., seizures, hyponatremia, severe anxiety)
  - Patient preference
  - Pregnancy
- "We suggest offering treatment with repetitive transcranial magnetic stimulation (rTMS) for treatment during a major depressive episode in patients with treatment-resistant MDD."[41]

NAMI Montana believes that the VA must make all of these treatment modalities available to veterans that need them. Treatment-resistant depression is such a major component of the veterans' patient population that there is no excuse for not making the service available either within the VA or through contracts with outside treatment providers. While the VA does appear to be offering these services as some

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[33] Akil, Huda, et al. "Treatment resistant depression: a multi-scale, systems biology approach." *Neuroscience & Biobehavioral Reviews* 84 (2018): 272–288.

[34] Rush AJ, Trivedi MH, Wisniewski SR, Nierenberg AA, Stewart JW, Warden D, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006;163:1905–17. 10.1176/appi.ajp.163.11.1905.

[35] Souery DA, Oswald P, Massat I, Bailer U, Bollen J, Demyttenaere K, et al. Clinical factors associated with treatment resistance in major depressive disorder: results from a European Multicenter study. J Clin Psychiatry 2007;68:1062–70. 10.4088/JCP.v68n0713.

[36] Wiles N, Thomas L, Abel A, et al. Clinical effectiveness and cost-effectiveness of cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment-resistant depression in primary care: the CoBalT randomised controlled trial. Southampton (UK): NIHR Journals Library; 2014 May. (Health Technology Assessment, No. 18.31.) Chapter 8, The prevalence of treatment-resistant depression in primary care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK261988/

[37] Akil, Huda, et al. "Treatment resistant depression: a multi-scale, systems biology approach." *Neuroscience & Biobehavioral Reviews* 84 (2018): 272–288.

[38] VA/DOD Major Depressive Disorder Clinical Practice Guidelines, Version 3.0–2016. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/VADODMDDCPGFINAL82916.pdf

[39] *Id.* at 19.

[40] *Id.* at 20.

[41] VA/DOD Major Depressive Disorder Clinical Practice Guidelines, Version 3.0–2016. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/VADODMDDCPGFINAL82916.pdf at 20.

of its flagship facilities, our perception is that the VA does not offer them consistently across its facilities—particularly in rural states like Montana.

III. 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.

PREPARED STATEMENT OF TEAM RED, WHITE & BLUE

Military service assimilates individuals into a socially cohesive force to address dangerous and traumatic situations that have no counterpart in civilian life. Upon leaving active duty, many veterans experience a "reverse culture shock" when trying to reintegrate into civilian institutions and cultivate supportive social networks. Poor social reintegration is associated with greater morbidity and premature mortality in part due to the adoption of risky health behaviors, social isolation, and inadequate engagement in health care services. Team Red, White & Blue (Team RWB) was created to help veterans establish health-enriching social connections with communities through the consistent provision of inclusive and locally tailored physical, social, and service activities. We offer programming in over 200 cities, and are committed to tackling these issues through local engagement with veterans and their surrounding community members.

With roughly 18 million veterans living in communities nationwide today, and 250,000 veterans leaving active duty this year to join them, we have a significant opportunity to positively impact their lives. They face isolation, lack of physical fitness, and lack of purpose. Additionally, as highlighted last year by Deputy Assistant Secretary of Defense Smith, the military-civilian divide has never been greater and is a threat to the viability and sustainability of the all-volunteer force.

We know that quality social relationships are a critical protective factor, not only to combat loneliness, but for maintaining overall health, happiness, and an 'enriched' life.[1] [2] Evidence reveals targeted activities that focus on engagement and positive social relationships can improve overall well-being and reduce depression symptoms. To that end, we've worked with veteran thought leaders and academic partners to develop a theory-based framework for veteran health—the Enrichment Equation, with three core constructs: health, people, and purpose.

There is no silver bullet to ending suicide in veterans, and while much research has been done on this topic, there still do not exist widely agreed upon and validated factors which could be used for intervention.

There are, however, predictive factors which may be important targets for future suicide prevention efforts in veterans such as: suicidal intent, attempt history, suicide ideation, PTSD symptoms, alcohol use disorder (AUD) symptoms, and depression,[3] and much promise exists in facilitating a healthy reintegration process for veterans such that these predictive factors can be avoided or treated pre-crisis.

We believe the health-enriching social connections we provide with our programs help to achieve Team RWB's long-term goal of preventing future health problems among at-risk veterans by "funneling" or linking veterans to other people and resources before the onset of serious health problems emerge.

TEAM RWB'S EFFORTS TO REDUCE SUICIDE IN THE VETERAN COMMUNITY

It should be noted that Team RWB's mission and programs are not designed specifically to reduce veteran suicide. Rather, they are focused on prevention by enriching veterans' lives through increasing health, people and purpose as detailed above and thus facilitating effective reintegration. Nor does the organization track individual member referrals of members to suicide intervention and/or mental health treatment.

However, given the academic work referenced above to develop our "Enrichment Equation" and our history of community-based operations, we believe Team RWB is able to contribute in a meaningful manner on this topic.

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[1] Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. Plos Med. 2010;7(7):e1000316.

[2] Uchino BN. Social support and health: a review of physiological processes potentially underlying links to disease outcomes. J Behav Med. 2006;29(4):377–387.

[3] A longitudinal study of risk factors for suicide attempts among Operation Enduring Freedom and Operation Iraqi Freedom veterans

Through its programs, Team RWB provides regular community engagement combined with inclusive membership participation to help create an environment for health-promoting social networks developed through peer-to-peer veteran engagement and broad civilian support.

These social networks begin supporting health using physical activity as a low cost, low barrier mechanism to maintain these networks. In addition to its use in maintaining social networks, regular physical activity is an evidence-based behavior that positively affects subjective and psychological well-being, including management of depressive and anxiety symptoms and recovery from alcohol and substance use disorders.[4 5 6 7 8]

However, it is not just the positive effects on health supported by physical activity that is achieved through the use of these social networks. Through Team RWB's networks, veterans become more willing to self-identify and address reintegration challenges and/or physical or mental health issues.

These networks help to achieve Team RWB's long-term goal of preventing future health problems among at-risk veterans by "funneling" or linking veterans to other people and resources before the onset of serious health problems emerge.

While not explicitly designed to reduce veteran suicide, we believe that the prevention of future health problems for veterans through the adoption of physical activity and strong social connections at the local level is vital. We acknowledge the difficulty in measuring effectiveness in long term "non-events" in veterans health, but believe that a long term, prevention-based approach is a critical component to the challenge of veteran suicide.

DETAIL FACTORS TEAM RWB HAS IDENTIFIED THAT PUT A VETERAN AT RISK FOR SUICIDAL IDEATION

Following on from the above section, Team RWB does not engage in academic efforts to specifically identify predictive factors for risk of veteran suicide. However, starting in 2014, a Team RWB-led research team worked to develop the Enriched Life Scale (ELS)—a 40-item scale to assess enrichment on the key domains of health, relationships, and purpose.[9] The ELS does not screen for predictive factors of veteran suicide, but it can be used to measure physical health, mental health, supportive relationships, sense of purpose, and engaged citizenship in veteran and civilian samples for research or clinical purposes. This is important to the factors detailed below.

It is known that physical, mental, and emotional health issues are often comorbid and diminish the quality of life in veterans.[10 11]

One key factor that applies in this instance relates specifically to the reintegration and/or transition process and the behavior of veterans as they navigate this transition.

In the years immediately following military discharge, veterans experience significant decreases in meeting recommended physical activity levels,[12] increased nicotine

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[4] Whitworth JW, Ciccolo JT. Exercise and Post Traumatic Stress Disorder in military veterans: a systematic review. Mil Med. 2016;181(9):953–960.

[5] Conn VS. Depressive symptom outcomes of physical activity interventions: meta-analysis findings. Ann Behav Med. 2010;39(2):128–138.

[6] Edwards MK, Loprinzi PD. The association between sedentary behavior and cognitive function among older adults may be attenuated with adequate physical activity. J Phys Act Health. 2017;14(1):52–58.

[7] Vallance JK, Eurich DT, Lavallee CM, Johnson ST. Physical activity and health-related quality of life among older men: an examination of current physical activity recommendations. Prev Med. 2012;54(3–4):234–236.

[8] Linke SE, Ussher M. Exercise-based treatments for substance use disorders: evidence, theory, and practicality. Am J Drug Alcohol Abuse. 2015;41(1):7–15.

[9] Caroline M Angel, Mahlet A Woldetsadik, Nicholas J Armstrong, Brandon B Young, Rachel K Linsner, Rosalinda V Maury, John M Pinter. The Enriched Life Scale (ELS): Development, exploratory factor analysis, and preliminary construct validity for U.S. military veteran and civilian samples. Translational Behavioral Medicine, iby109, https://doi.org/10.1093/tbm/iby109

[10] Spelman JF, Hunt SC, Seal KH, Burgo-Black AL. Post deployment care for returning combat veterans. J Gen Intern Med. 2012;27(9):1200–1209.

[11] Taylor BC, Hagel EM, Carlson KF, et al. Prevalence and costs of co-occurring Traumatic Brain Injury with and without psychiatric disturbance and pain among Afghanistan and Iraq War Veteran V.A. users. Med Care. 2012;50(4):342–346.

[12] Littman AJ, Jacobson IG, Boyko EJ, Smith TC. Changes in meeting physical activity guidelines after discharge from the military. J Phys Act Health. 2015;12(5):666–674.

and alcohol use,[13] and rapid weight gain [14] such that within a couple years following military discharge, 75%–84% of OEF/OIF veterans are considered overweight or obese.[15] [16]

Thus, veterans are significantly affected by obesity and related cardiovascular conditions [17] [18] that are derived from the adoption of unhealthy lifestyle habits as they navigate the reintegration process.

However, they are also affected by other conditions that are related to their military service such as musculoskeletal injury with chronic pain,[19] [20] sleep disturbance,[21] and Traumatic Brain Injury.[22]

As these issues are often comorbid, however, they do not just affect the physical health of veterans—they are often related to mental health conditions such as depression, post-traumatic stress, and alcohol misuse, which, as referenced above, are conditions that show promise as strong predictive factors for suicidality.

The challenge of coping with comorbid mental and physical health symptoms can also be an impediment to physical activity among veterans,[23] [24] which can further perpetuate the aforementioned health problems and create a vicious cycle.

Physical activity and strong social connection in veterans are two important protective factors contributing to overall well-being, and may be important in veterans avoiding the conditions listed above, or for seeking treatment for those conditions, some of which have been identified as predictive factors for veteran suicide.

TEAM RWB'S IDEAS ON HOW COMMUNITIES CAN COLLECT STANDARDIZED DATA ON BEST PRACTICES FOR COMMUNITY BASED SUICIDE PREVENTION EFFORTS

The collection of standardized data on community based suicide prevention efforts is inherently difficult, for several reasons listed below and others beyond this list:

- The widely varied nature of the organizations taking part in these efforts, from small non-profits to large health care systems.
- Referrals that routinely happen between organizations, thus creating data in multiple locations.
- The privacy requirements that exist, to include the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The inherent difficulty is measuring suicide prevention.

That being said, we do believe there are some important steps that can be taken at the community level that will improve overall data collection efforts and standardization.

An important step is for organizations to utilize valid and reliable instruments for data collection, especially as it relates to wellbeing. Though well intentioned, there

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[13] Widome R, Laska MN, Gulden A, Fu SS, Lust K. Health risk behaviors of Afghanistan and Iraq war veterans attending college. Am J Health Promot. 2011;26(2):101–108.

[14] Littman AJ, Jacobson IG, Boyko EJ, Powell TM, Smith TC; Millennium Cohort Study Team. Weight change following US military service. Int J Obes (Lond). 2013;37(2):244–253.

[15] Maguen S, Madden E, Cohen B, et al. The relationship between body mass index and mental health among Iraq and Afghanistan veterans. J Gen Intern Med. 2013;28(suppl 2):S563–S570.

[16] Rosenberger PH, Ning Y, Brandt C, Allore H, Haskell S. BMI trajectory groups in veterans of the Iraq and Afghanistan wars. Prev Med. 2011;53(3):149–154.

[17] Fryar CD, Herrick K, Afful J, Ogden CL. Cardiovascular disease risk factors among male veterans, U.S., 2009–2012. Am J Prev Med. 2016;50(1):101–105.

[18] Nelson KM. The burden of obesity among a national probability sample of veterans. J Gen Intern Med. 2006;21(9):915–919.

[19] Spelman JF, Hunt SC, Seal KH, Burgo-Black AL. Post deployment care for returning combat veterans. J Gen Intern Med. 2012;27(9):1200–1209.

[20] Helmer DA, Chandler HK, Quigley KS, Blatt M, Teichman R, Lange G. Chronic widespread pain, mental health, and physical role function in OEF/OIF veterans. Pain Med. 2009;10(7):1174–1182.

[21] Seelig AD, Jacobson IG, Smith B, et al.; Millennium Cohort Study Team. Sleep patterns before, during, and after deployment to Iraq and Afghanistan. Sleep. 2010;33(12):1615–1622.

[22] Taylor BC, Hagel EM, Carlson KF, et al. Prevalence and costs of co-occurring Traumatic Brain Injury with and without psychiatric disturbance and pain among Afghanistan and Iraq War Veteran V.A. users. Med Care. 2012;50(4):342–346.

[23] Hall KS, Hoerster KD, Yancy WS Jr. Post-traumatic stress disorder, physical activity, and eating behaviors. Epidemiol Rev. 2015;37:103–115.

[24] Hoerster KD, Jakupcak M, McFall M, Unützer J, Nelson KM. Mental health and somatic symptom severity are associated with reduced physical activity among US Iraq and Afghanistan veterans. Prev Med. 2012;55(5):450–452.

[1] Being part of and engaging in a greater community improves motivation, health and happiness (Hall, 2014)

[2] When individuals feel connected to others, they are less isolated and as a result may come to the realization that they are not alone in their suffering or that others may have experienced similar challenges (Hall, 2014).

are still many organizations that utilize self-created surveys and measures to attempt to understand the wellbeing of their members. Though the intent is laudable, it creates a concluded and potentially inaccurate system of data across the nation.

Another critical step is for organizations to put steps in place to ensure a feedback loop exists in their data collection processes. As much as possible, put systems in place to follow-up and verify the accuracy of the data which is collected.

Though not directly related to standardization of data collection efforts across the country, we also believe there are several issues of note that relate to these community based efforts on data collection.

We believe it is important that organizations do not use instruments that will diagnose mental health disorders, if the organization does not have the resources available to provide adequate care or efficiently make referrals. Organizations should measure that which they are designed to affect, and there is an inherent risk for all parties involved to screen for mental health conditions, but not act on the results.

Also, we believe organizations should take great care when collecting data, and avoid using language typically associated with post-traumatic stress or other diagnostic criteria that could potentially evoke stigmatizing feelings or shame and would be counterproductive to assessing wellbeing. If this is done, it's important to make individuals aware of resources that are available to them in case of need.

In closing, we are grateful for the opportunity to provide a written testimony for this hearing. Veteran suicide is an issue of critical importance to our country, and we at Team RWB are glad to be able to provide our perspective on this topic.

[The included report "2017 Enriched Life Scale Manuscript" can be found at: https://academic.oup.com/tbm/article/10/1/278/5257713]

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND DISTINGUISHED MEMBERS OF THE COMMITTEE ON VETERANS' AFFAIRS: Thank you for inviting Wounded Warrior Project (WWP) to submit this statement for the record of today's hearing to explore how community-based support networks can be leveraged to help prevent veteran suicide. We appreciate the Committee's interest in learning more about the work these networks are doing to support veterans and their families, and we are grateful for the opportunity to offer our perspective on how new and existing initiatives and collaborations across the public, private, and non-profit sectors can help our collective effort to improve veteran mental health and wellness.

Wounded Warrior Project's mission is to honor and empower wounded warriors. Through community partnerships and free direct programming, WWP is filling gaps in government services that reflect the risks and sacrifices that our most recent generation of veterans faced while in service. Over the course of our 15-year history, we have grown to become an organization of nearly 700 employees in more than 25 locations around the world, delivering over a dozen direct-service programs to warriors and families in need. Our partnerships with like-minded organizations are augmenting these programs, enhancing our advocacy efforts, and fostering a culture of collaboration to better meet the needs of the wounded, ill, and injured veterans we serve.

MENTAL HEALTH & UNDERSTANDING THE POPULATION WE SERVE

Wounded Warrior Project strives to be as effective and efficient as possible and we recognize that we must be willing to adapt our programs and approaches to meet the evolving needs and unique challenges facing the warriors and caregivers we serve. To learn more about their physical, social, economic, and mental health needs, WWP has conducted the Nation's largest and most comprehensive survey of post-9/11 veterans who have sustained both physical and hidden injuries while serving the Nation. Since its first edition in 2010, this annual survey has helped us identify trends and needs among registered warriors, to compare their outcomes with those of other military and veteran populations, and to measure the impact of continual programmatic engagement—all to determine how we can better serve veterans, servicemembers, and their families.

For the fourth year in a row, WWP's Alumni survey revealed that Post Traumatic Stress Disorder (PTSD) was the most frequently reported health problem from service (78.2%), followed closely by depression (70.3%), anxiety (68.7%), and sleep problems (75.4%), which are often linked to mental health challenges. Completed by over 33,000 warriors in 2018, WWP's Alumni survey contains a significant amount of data to help our organization better serve veterans and others in their support networks. This data guides our analysis of current programming, helps us identify

partners who best complement our mission, and informs our advocacy before Congress. In addition to the points above, several data points can help frame the issue before the Committee today:

- *Self-assessments reflect poor health:* Overall, almost half of warriors report their health as being excellent, very good, or good, but unfortunately, the other half (50.9%) consider their health to be only fair or poor.
- *Poor health affects social activities:* Over 40% reported that their current health impacts normal social activities with their family, friends, and others all of the time or most of the time.
- *Poor health affects employment:* Their decreased health also impacts their employment outlook as warriors cite mental health issues, difficulty being around others, and not being physically capable as the top three barriers to finding employment.
- *Warriors have a good support system as they deal with challenges:* More than 80% of warriors said there are people in their lives that they can depend on to help them when they really need it. These family members and caregivers continue to make major sacrifices while supporting the recovery of their warriors.
- *Desire for social engagement:* Over half of warriors (55.8%) have participated in at least one WWP activity within the past year, with Warrior Engagement Events and Family Inclusive Events having the highest participation rates. These events are extremely important to warriors because they provide an opportunity for warriors to interact with other veterans that share similar experiences and circumstances. Of the many resources and tools provided to warriors with needs, including health care provided by the Department of Veterans Affairs (VA) and prescription medications, interacting and talking with other veterans remains a top three resource for helping them to address their mental health concerns. These interactions, along with the many other benefits provided by the WWP programs and services, are vital to the rehabilitation and recovery of warriors as they seek to improve their current health, employment, and financial status

While no single point of data can capture the needs and appropriate responses for the warriors who look to WWP for support, the figures above begin to tell a narrative that reinforces our organization's belief that suicide prevention must move beyond the healthcare/crisis management model toward an integrated and comprehensive public health approach focused on resilience and prevention. A multi-disciplinary approach to treatment—whether clinical, community-focused, or a combination—is required.

FACTORS THAT LEAD A VETERAN TO CRISIS

Given the prevalence of mental health challenges among the warriors we serve through direct services and partnerships, mental health programs are WWP's largest programmatic investment—in 2018, WWP spent $63.4 million on our mental health programs. Based on our experience as a program provider and a partner to others in the community who are addressing veteran mental health in a variety of ways, WWP can attest to what we know—and what we have learned from others—about the individual, relational, and societal factors that can lead a veteran to crisis.

The Department of Veterans Affairs has identified several risk factors in its *National Strategy for Preventing Veteran Suicide* that should be guideposts for the community. VA appropriately states that a prior suicide attempt, mental health status, availability of lethal means, and stressful life events are characteristics associated with a greater likelihood of suicidal behavior. Stated differently, it is a combination of factors that can lead to a crisis. Pre-existing psychiatric conditions, like depression and/or PTSD, are risk factors, but in addition there may be significant life stressors related to occupational functioning, relationships, the ability to live independently, or chronic medical conditions that a veteran has difficulty managing. Chronic conditions such as pain, sleep difficulties, and/or financial problems can wear down resolve. Sudden psychosocial changes such as a deterioration or dissolution of a relationship, sudden change in family dynamics (i.e., child custody) or job loss may all play a role in psychological crisis—especially when they occur suddenly and exceed the veteran's ability to cope.

Fortunately, our community has a growing understanding of protective factors that can help mitigate stressors. Access to mental health care, positive coping skills, and social connectedness are similarly addressed in VA's *National Strategy for Preventing Veteran Suicide* as being characteristics associated with a lesser likelihood of suicidal behaviors. As WWP has testified previously, mental health treatment works, but every individual has unique needs, and there is no one-size-fits-all solution.

Suicide prevention cannot just be about saving someone's life when they are in crisis; it must be about creating a life worth living. Our end goal is continual engagement until the warrior is far enough in their recovery to "live our logo" (i.e., help carry a fellow warrior). Although WWP has over a dozen free programs and services for veterans, two in particular are addressing risk factors—social isolation and poor physical health—through nontraditional methods that are improving overall health and wellbeing, and helping insulate veterans from reaching a crisis point.

In-Focus: WWP's Alumni Program & Combating Isolation

Whether because of psychological ("invisible wounds") or physical ("visible wounds") trauma or a combination of both, every warrior who registers with WWP is provided with a unique path of individual and collective recovery that he or she can pursue through our direct services and other support networks. While there is no predetermined path for each warrior registering with WWP, a warrior's first engagement with our organization is often through our Alumni Program. While in the military, many servicemembers form bonds with one another that are as strong as family ties. WWP helps re-form those relationships by providing warriors opportunities to connect with one another through community events and veteran support groups housed within this program. WWP also provides easy access to local and national resources through outreach efforts and with the help of partners like The Travis Manion Foundation, The Mission Continues, Team Red White & Blue, Team Rubicon, and over 30 other funded partner organizations. Though most events are warrior-focused, WWP also hosts a variety of family-based activities.

While engagements may range from recreational activities and sporting events to professional development opportunities and community service projects, the Alumni Program was formed with an appreciation for the fact that a desire for post-service camaraderie is what often brings veterans to our organization. In this context, our Alumni Program focuses on engagement and connection and not simply the activity or event itself. We diversify our connection-focused offerings in regions to attract a wide variety of warriors and families, and it is through these events that they develop a relationship with the organization and trust WWP to help resolve more challenging and personal obstacles in their rehabilitation and recovery. Our organization averages more than 11 engagements like this every day.

Everything WWP does, including initial or ongoing participation for warriors in the Alumni Program, is focused on creating a life worth living with a purpose, thereby creating a protective fabric in the battle against veteran suicide. The Alumni Program's value becomes clearer when we conceptualize WWP "membership" and engagement as a possible first step in recovery for those seeking or in need of help. Obstacles to seeking mental health care support may be difficult to overcome, especially when amplified by stigmatizing messages. In many ways, these obstacles can seem monumental to overcome to veterans and serve to further isolate those who may already feel marginalized. A possible first step to overcome those hurdles is engagement with peers.[1] During such peer engagement warriors may be exposed to peer testimonies that can, in turn, serve to break some barriers to seeking mental health care such as stigma. Engagements may also provide a specific strategy and action items that can assist the veteran in feeling empowered as they traverse a system that may feel complicated and foreign. WWP programs provide veterans with a specific path toward care and engagement in order to simplify their navigation in seeking care. Such paths may lead to career fulfillment, financial security, physical wellness, and other protective factors against suicide. Warriors may attend an engagement event to spend time with fellow veterans but may leave with newly acquired psychoeducational information and new friendships that empower them to take an additional step in their recovery.[2]

Alongside the Alumni Program, WWP-sponsored Peer Support Groups are led by, and designed for, warriors who want to empower their counterparts with disclosure of personal challenges and how those challenges were overcome. This can create a new sense of belonging and normalize psychological symptoms and conditions. Peer Support Groups, which can be found in communities across the country, lead to new friendships, provide a renewed sense of community, strengthen bonds through shared experiences, and introduce new solutions to challenges. WWP trains Peer Support Group leaders to facilitate productive discussions and maintain a safe, judgment-free environment for warriors. These groups not only serve as "force mul-

[1] Being part of and engaging in a greater community improves motivation, health and happiness (Hall, 2014)

[2] When individuals feel connected to others, they are less isolated and as a result may come to the realization that they are not alone in their suffering or that others may have experienced similar challenges (Hall, 2014).

tipliers" for our organization but also assist WWP with identifying individuals in crisis.

Meaningful relationships are vital to the success of warriors' transitions back into civilian life, and suicide is best combated through preventive measures such as providing mental health programs, connection opportunities, and pathways to build confidence and a sense of purpose.[3] We must be proactive when engaging warriors and showing them how their lives matter in their homes and communities.[4] Offerings like WWP's Alumni Program and Peer Support Groups provide avenues to recurring engagement and a way to stay connected prior to a crisis.

In-Focus: Physical Health and Wellbeing

Consistency with physical activity has proven to have a myriad of benefits to include improved mood, short and long-term memory, mobility, decisionmaking, and self-esteem, while lessening symptoms of anxiety, stress, depression, use of medications, and pain. The impacts are so pronounced and validated that mental health professionals often prescribe daily exercise in conjunction with other treatment modalities. There is no shortage of outdoor experiential activities such as surfing, rock climbing, and mountain biking targeted for veterans afflicted with PTSD. For these reasons, WWP offers its own programs and unites with others, including VA, to provide and promote physical health and wellness opportunities.

- *Adaptive Sports:* WWP will be supporting the VA's Summer Sports Clinic as the primary sponsor in San Diego this September, a weeklong experience offering veterans the opportunity to engage in instruction with cycling, surfing, kayaking, sailing, and adaptive CrossFit. Adaptive sports programming has long been used to reengage a veteran with a sense of community, team, spirited competition, and a sense of pride. WWP's adaptive sports team aims to expose veterans to a variety of sports, while also connecting them to resources in their community to continue regular play. This focus on long-term involvement, support, and accountability is critical as episodic experiences will only provide short term impacts to mental health.
- *Social Community and Confidence:* Soldier Ride is an adaptive cycling program that allows veterans to ride alongside fellow injured servicemembers and reclaim their confidence and mental fortitude in a supportive environment. Cycling offers a low-impact opportunity to reengage with physical activity and experience the improvements in mood created by exercise and a positive social network. Mountain biking and the ride modalities of ski and snowboard are devoted to improving a participant's skill, while enhancing focus, confidence, and self-esteem. The additional value of exposure to nature has shown a strong correlation to mood enhancement. Ride groups develop social networks that provide long-lasting camaraderie, motivation, and a shoulder to lean on when needed.
- *Coaching and Ongoing Support:* WWP's Physical Health and Wellness program engages veterans in a 90-day coaching experience that commences with four days of intensive instruction for fitness, nutrition, mindfulness, and sleep. Through the SMART Goals process, warriors identify their purpose, and why a healthy lifestyle is important to them. Biweekly check ins with their coach ensure adherence to goals, adjustments when necessary, and a mechanism of support that improves accountability. While many seek out this variety of programming for physical outcomes, they are pleasantly surprised at the immediacy of improvement to mental wellbeing. Collaboration with the VA's Whole Health initiative affords veterans additional resources, ongoing support, and a more impactful treatment strategy with their primary care team.

As these programs and engagements illustrate, WWP embraces a holistic approach to overall wellbeing. Even though our mental health services represent our largest programming spend, we continue to build and invest in other programs that complement our mental health offerings and even serves as a bridge to more direct mental health engagements. Warriors most often reach out to WWP for help accessing VA benefits, but once they have registered and become more familiar with our other services, mental health programs emerge as the top internal referral destination. As such, we encourage the Committee to take a wide and comprehensive view of what helps veterans not just survive but thrive in their communities.

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[3] Psychological distress (i.e., depression) has been correlated with stronger negative reactions to social interactions, which may lead to further isolation (e.g., Gotlib, Kash, et al., 2004; Mogg & Bradley, 2005).

[4] Interpersonal interactions can have a strong impact upon one's cognitions, emotions, and behaviors (Baumeister & Leary, 1995).

APPROACHING SUICIDE PREVENTION AS A COMMUNITY

Conceptualizing a community approach to suicide prevention should reflect another key insight from VA's *National Strategy for Preventing Veteran Suicide*—that not all veterans have the same risk for suicide. Prevention strategies are most effective when considered alongside the risk factors they are addressing. VA and the National Academy of Medicine illustrate prevention strategies as falling into three levels (universal, selective, and indicated) that match risk, and community actors can and should follow this model to tailor programs to meet the needs of all veterans, some veterans, or relatively few individual veterans. Similarly, it cannot be overstated that although risk variables can be identified, the depth and breadth of their impact may be individualized to that person.

In this context, WWP can attest that there is a huge collective effort underway to decrease suicide among veterans. VA alone has an organized national strategy comprising primary, secondary, and tertiary prevention approaches, and mandating a trained Suicide Prevention Coordinator at every VA medical center. The Center for Disease Control (CDC) has published comprehensive recommendations aimed at preventing all suicides (not making a particular distinction between veterans and non-veterans), including changes to economic policy, social and educational programs, and mental health services nationwide. Approaches from VA and CDC should soon become more aligned with other Federal agencies following the recent launch of the President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS) task force.

In the private and non-profit sectors, several networks have been developed to meet the mental health needs of veterans in their own communities over the past several years. These networks include WWP's Warrior Care Network, the Cohen Veterans Network, and the Headstrong Project among others. Each of these organizations provide direct clinical care to veterans at various locations around the U.S., and suicide prevention is an implicit aim (although the central mission is more one of overall mental health and well-being). Meanwhile, coalitions like the Bush Institute's Warrior Wellness Alliance are focused on convening organizations with limited individual reach in order to build collective input for wider application, extend impact to a broader population, and optimize the support and services available to veterans and their families.

As an example, WWP is proud to offer programs to more than 130,000 registered veterans and servicemembers; however, this population is just a fragment of post-9/11 warriors who may need help. Since September 11, 2001, more than 2.7 million brave men and women have been deployed to protect our Nation's freedom and according to the National Center for PTSD, more than 500,000 servicemembers have been diagnosed PTSD as a result of traumatic war-time experiences (e.g. combat, motor vehicle accidents, military sexual trauma). For these reasons, WWP joined the Warrior Wellness Alliance in order to amplify the reach of empowerment for post-9/11 warriors. The member organizations that comprise the alliance come together to discuss innovative ways to reach warriors and meet their needs. This passionate group is tasked with not only devising innovative ways to meet current warrior needs, but addressing potential future needs to come as the population continues to age and conditions worsen.

As the greater community becomes more aligned, it currently stands that a component of all suicide prevention strategies is efficient access to effective interventions for the various factors that correlate to increased suicidality of which mental health is one. Mental health access needs to be available through varied settings and providers as people at risk of suicide are unlikely to persist in navigating the complex mental health system. By providing a community of providers through VA, the Department of Defense, and civilian providers, we can establish "no wrong door" for accessing effective interventions.

In-Focus: State, Local, and Social Media Collaboration (Universal Strategy)

Veterans struggling with mental health issues like PTSD, depression, and anxiety may find themselves on a path to self-destructive coping behavior and isolation. These barriers to seeking care are enhanced by stigma that still surrounds mental health treatment. While many in the community are familiar with facts and figures around suicide, the truth is that the actual numbers are illusive at best, given for example premature deaths from high risk-taking behavior, which one could conceptualize as being suicidal in nature.

A critical step is getting organizations across the country to engage and extend a much-needed dialog regarding suicide. For the last three years WWP has coordinated a Facebook Suicide Awareness Live event, during suicide awareness month (September). We have partnered with subject matter experts from the VA, DOD and

Bush Institute. The event encompasses panel discussions describing warning signs, stigma, strategies for discussing suicide prevention as well as veteran experiences. A panel of veterans discuss how their challenges and experiences led to their engagement with programs at WWP, VA and DOD. In 2018, our broadcast reached over 139,000 individuals, and we hope to reach even more in 2019.

As WWP increases its exposure through presentations at various platforms to various audiences (i.e., conferences), we are increasingly viewed as a community resource and are invited to continue our engagement in this much-needed discussion. For instance, WWP has been invited to present multiple times at Governors and Mayors Challenges and the VA/DOD Suicide Awareness Conferences. These presentations have led to additional meetings to at the state level. For instance, WWP is scheduled to meet in Austin with the Texas Governor's challenge team to discuss partnership and collaboration between Texas Governor's Challenge to Prevent Veteran Suicide and WWP.

In-Focus: WWP's Warrior Care Network & Partnering with VA (Selective Strategy)

Within WWP's Continuum of Mental Health Support programming, warriors needing intensive treatment for moderate to severe PTSD can take part in the Warrior Care Network. This innovative program is a partnership between WWP and four national academic medical centers (AMCs): Massachusetts General Hospital, Emory Healthcare, Rush University Medical Center, and UCLA Health. Warrior Care Network delivers specialized clinical services through innovative two- and three-week intensive outpatient programs that integrate evidence-based psychological and pharmacological treatments, rehabilitative medicine, wellness, nutrition, mindfulness training, and family support with the goal of helping warriors survive and thrive.

Through these two- to three-week cohort-style programs, participating warriors receive more than 70 direct clinical treatment hours (e.g. cognitive processing therapy, cognitive behavioral therapy, and prolonged exposure therapy) as well as additional supportive intervention hours (e.g. yoga, equine therapy). This is the equivalent of an entire year's worth of therapy in two to three weeks. Warrior Care Network providers and therapy protocols are having exceptional results resulting in significant reductions in PTSD and depression symptoms that translate into increased function and participation in life. Eighty-three percent of patients arrive with severe to moderate PTSD and leave with symptoms in the minimum range, and the program is seeing similar results with depression. The completion rate for patients is greater than 90 percent—forty points higher than the national average. Through WCN, veterans receive world-class care from their providers while building relationships with each other that offer the potential for long-term peer support. Warriors report greater than 95 percent satisfaction rates—agreeing that they would tell their friends about the experience. This greatly helps in de-stigmatizing the act of seeking mental health care.

Each AMC also has specific programming for caregivers and family members at some point during the intensive outpatient program, including family weekend retreats, psychoeducation, or telehealth communications. For example, UCLA's Operation Mend PTSD track includes three weeks for both veterans and caregivers to go through treatment and psychoeducation sessions. This provides caregivers with clinical outlets, as well as in-depth knowledge of PTSD symptoms, effects, and the recovery process. Family and caregiver support is extremely important to WWP, and our Warrior Care Network includes support for these groups to ensure they are fully informed on their warrior's therapy protocol and are poised to support their warrior's long term mental health care.

Providing warriors with best in class care that combines clinical and complementary treatment is still only part of the Warrior Care Network's holistic approach to care. While AMCs provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, a Memorandum of Agreement (MOA) between WWP and VA has been structured to further expand the continuum of care for the veterans we treat. In February 2016, VA signed this MOA with WWP and the Warrior Care Network to provide collaboration of care between the Warrior Care Network and VA hospitals nationwide. VA provided four part-time employees at each AMC to act as liaisons between each AMC and VA, spending 1.5 days per week at their respective sites to facilitate coordination of care and to meet with patients, families, and care teams. Each VA liaison facilitates national referrals throughout the VA system as indicated for mental health or other needs, but also provides group briefings about VA programs and services, and individual consultations to learn more about each patient's needs. Because of the immense impact recognized by all network partners, in November 2018, that MOA was renewed with a growing commitment from VA—VA created four full-

time billets for liaisons at each AMC to enhance their contribution to the partnership. All told, this first-of-its-kind collaboration with VA is critical for safe patient care and enables successful discharge planning.

As the Committee considers ways to improve accessibility of mental health care and to increase collaboration between VA and community providers, it is important to remember that clinical referrals most often occur between healthcare providers at the individual level. To the extent that external, innovative models of care like the Warrior Care Network and other such organizations may be more beneficial to an individual veteran, education could be provided at the system level and filter down to the clinics and providers from which referrals are most likely to originate. A coordinated information campaign to inform healthcare providers would be helpful in increasing the likelihood of veterans accessing available resources, particularly as VA's new Veterans Community Care Program continues to take shape and build networks of care that are responsive to the medical needs of our Nation's veterans.

CREATING A MODEL FOR COMMUNITY COLLABORATION

There is an old proverb, "If you want to go fast, go alone; but if you want to go far, go together." WWP knows no one organization can fully meet veterans' needs. To this end, we proudly partner with other organizations to help our Nation's wounded warriors. Since 2012, WWP has granted $88 million to 165 other veteran and military service organizations. In FY 2018 alone, we invested nearly $15 million in additional impact through grants to 34 partner organizations in support of our warriors and their families. These efforts reflect the value that comes with working with others to harness subject matter expertise, reach a greater number of injured veterans, and provide a more comprehensive network of support.

As a community of service organizations, we each focus on complementary initiatives across missions (sometimes, generations) and together we are forging partnerships, providing cross-referrals and providing a stronger, expanded network of support. When assessing potential partnerships, WWP evaluates existing and potential partners based on how a program complements WWP by:

- *Filling a gap in WWP direct services* by providing a program or service WWP does not offer;
- *Augmenting WWP direct services* by doubling down on services that are in high demand;
- *Amplifying messaging* around issues affecting post-9/11 wounded/ill/injured veterans, caregivers, and their families;
- *Building relationships and collaboration* with organizations serving veterans and families;
- *Growing small organizations with potential* that can have the ability to scale and offer innovative programming.

Although no WWP partnerships specifically address suicide prevention with indicated strategies, several are addressing risk factors or promoting protective factors. As the Committee considers ways to leverage current community networks, the following illustrative examples may provide helpful inspiration drawn from ways WWP has helped develop networks of its own for the benefit of warriors and those who support them.

- *Tragedy Assistance Program for Survivors (TAPS):* In coordination with WWP's mental health programming team, a new 2019 grant will support two Intensive Clinical Programs conducted in partnership with Home Base at Massachusetts General Hospital for survivors who experienced severe trauma after witnessing their loved one's suicide or experiencing the postmortem discovery of their loved one's body. In order to help inform WWP's suicide prevention programming we will learn what activities and crises lead up to a warrior's suicide.
- *Boulder Crest:* In coordination with WWP's mind team, the grant will support 4 Warrior PATHH (Progressive and Alternative Training for Healing Heroes) Retreats, an 18-month nonclinical program, designed to cultivate and facilitate Posttraumatic Growth amongst those struggling with PTSD and/or combat stress, that begins with a 7-day combat stress recovery retreat for warriors.
- *Combined Arms:* WWP funding supports Community Integration for warriors and their families in Houston, TX. In this veteran-dense area (300,000+ veterans), warriors and families are linked to local and national resources via a connection hub that provides assistance with employment, finances, homelessness, volunteerism, and health & physical activities. The availability of these resources empowers veterans to live fulfilling lives and stay connected in their community. More than 50 organizations and agencies have joined their collaborative.
- *The Mission Continues (TMC):* Funding has supported expansion and development of community Service Platoons across the country and the community service

Fellowship Program, which is now the Service Leadership Corps. TMC has grown to 84 active service platoons with 48 of those platoon leaders being WWP Alumni. TMC now has a total network of 55,009 (31,720 veterans/military members/23,289 non-veterans).

Pursuing partnerships like those listed above has helped WWP form a unique perspective among veteran service organizations. While we continue to make the largest impact on individual lives through our own programs and services, we can help other organizations do the same through grants and partnerships. Like WWP, many are learning more about the military and veteran populations they serve through sharing best practices, cross collaboration, and increased interaction with the community. Various organizations have even channeled that experience into advocacy. As the Committee considers legislation to allow VA to continue along a similar path with more organizations, WWP can confidently attest to the value of taking a community-wide approach to addressing the full spectrum of challenges veterans and their families face.

Last, it is important for the Committee to know that our approach to grants and partnerships has evolved over time and currently reflects WWP's engagement in leading research in the military-veteran community. Together with the Henry Jackson Foundation (HJF), and partners from the public and private sectors, WWP has funded a longitudinal study of transitioning veterans to better understand the components of well-being and the factors necessary for ensuring a healthy military-to-civilian transition. This study—The Veterans Metrics Initiative—follows a cohort of veterans over the first three years of their transition from military to civilian life. Six comprehensive surveys are being administered at six-month intervals (Waves 1–6) over the course of the three-year period. Each survey assessment is recording participant well-being across four domains: health (mental and physical), vocation (education and career), finances, and social relationships. Participants also identify transition assistance programs they used, if any. Following each assessment, the research team is identifying changes in well-being across various demographic groups, analyzing transition assistance programs identified to distill them into their common components, and examining links between common program components used and well-being outcomes. The TVMI study suggests that there are four components of well-being: Social Relationships; Health; Finances; and Vocation. WWP's investments for direct services and programming are considered and categorized on this evidence-based criteria, and we engage WWP's metrics team to measure our collective work and outcomes.

ADDITIONAL RECOMMENDATIONS FOR POLICY CHANGE AND OVERSIGHT

In addition to efforts to facilitate more effective and efficient collaboration between VA and veteran networks, the Committee should consider the following recommendations that have potential to boost new and ongoing efforts on initiatives in the community.

First, the Committee should maintain oversight of VA MISSION Act-authorized permission to use value-based reimbursement models to enhance mental health care quality. Section 101(i) of the VA MISSION Act allows VA to incorporate value-based reimbursement principles to promote the provision of high-quality care, and this permission can and should be used to help encourage innovative models in physical and mental health treatment. While the health care industry has embraced bundled payment approaches to address episodes of care for hip surgery, diabetes, stroke, cancer treatment, and others, VA lags behind. The expanded migration of this practice to mental health would allow VA to be a pioneer in an area where veterans are catastrophically suffering and drive the wider mental health care industry toward better quality and more cost-effective outcomes. Whether care is ultimately provided at VA or with a community-based provider, policies like this can ultimately serve to increase the volume of providers and the quality of care they are providing.

Similarly, Congress should take steps to embrace innovation in care delivery and payments. Section 152 of the MISSION Act authorized—and VA has since established—a Center for Innovation for Care and Payment to develop new, innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of and access to care furnished by VA. As the steward of taxpayer dollars dedicated to the health and well-being of veterans, Congress has a vested interest in tracking the developments of this center and encouraging action and partnership with the private sector on successful, scalable models of both care and payment.

Last, WWP encourages the Committee to dedicate resources for biomarker research. Specifically, WWP recommends that emphasis be placed on biomarkers for PTSD, TBI, anxiety, and depression—challenges that face a significant portion of

warriors who reach out to WWP for help. Private sector initiatives are already underway, including work being performed and funded by Cohen Veteran Bioscience (CVB) to fast-track the development of diagnostic tests and personalized therapeutics for the millions of veterans and civilians who suffer the devastating effects of trauma to the brain. Recent research published in Science Translational Medicine and funded in part by CVB, identifies a PTSD brain imaging biomarker.[5] This biomarker is important because it may help determine which people with PTSD will respond to PTSD first-line treatment of behavioral therapy, and which individuals with PTSD who don't respond to first-line treatment but may respond to other options. This personalized approach will help connect people to the right PTSD treatment sooner. WWP supports continued research and collaboration into biomarkers for mental health and Traumatic Brain Injury treatment. VA would be an integral partner to work already being done in the community.

CONCLUSION

Wounded Warrior Project thanks the Senate Committee on Veterans' Affairs, its distinguished members, and all who have contributed to the policy discussions surrounding today's discussion about veteran suicide and the power of veteran networks to address this challenge. We share a sacred obligation to serve our Nation's veterans, and WWP appreciates the Committee's effort to identify and address the issues that challenge our ability to carry out that obligation as effectively as possible. We are thankful for the invitation to submit this statement for record and stand ready to assist when needed on these issues and any others that may arise.

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[5] Amit Ekin et al. "Using fMRI connectivity to define a treatment-resistant form of Post Traumatic Stress Disorder." *Sci. Transl. Med.* 11, eaal3236 (2019).