S. HRG. 118–227

INVISIBLE WOUNDS OF WAR: IMPROVING MENTAL HEALTH AND SUICIDE PREVENTION MEASURES FOR OUR NATION'S VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

SEPTEMBER 20, 2023

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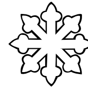

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INVISIBLE WOUNDS OF WAR: IMPROVING MENTAL HEALTH AND SUICIDE PREVENTION MEASURES FOR OUR NATION'S VETERANS

WEDNESDAY, SEPTEMBER 20, 2023

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

The Committee met, pursuant to notice, at 3:41 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Brown, Blumenthal, Hirono, Sinema, Hassan, King, Moran, Boozman, Cassidy, Tillis, Sullivan, and Blackburn.

OPENING STATEMENT OF CHAIRMAN JON TESTER

Chairman TESTER. We call this hearing to order.

September is Suicide Prevention Month. While we are all focusing on this topic today, it must be at the forefront of everything of what we do every day. Mental health is one of the biggest issues facing our country. It is certainly a big issue in my home State of Montana. It is certainly a big issue for our veterans.

That is why it is critically important VA does absolutely everything possible to connect more veterans with the mental health care and the suicide prevention that they need, regardless of where they live.

The latest data shows that 2020 had the lowest number of veteran suicides since 2006. That trend needs to continue. The data shows that more than 60 percent of the veterans who died by suicide in 2020 had no recent engagement with the Veterans Health Administration. That means the VA must work harder to get our veterans into the system.

In recent years, Congress has advanced critical legislation. I was proud to champion many of them, including the John Scott Hannon Veterans Mental Health Care Bill, Veterans Health Healthcare Improvement Act that I did with Senator Moran, and the STRONG Veterans Act of 2022.

These laws have helped the VA's mental health workforce and programs, including through alternative and local treatment options, but the fact is we have much more to do. That is why I recently introduced the Not Just a Number Act to require the Department to provide a more fully picture of the factors contributing to veterans suicide.

By making the Community Care for Veterans Act, would also strengthen veterans' access to life-saving residential treatment programs for mental health and substance abuse disorder.

Congress continues to do its part by giving VA the proper funding for mental health, and suicide prevention programs, and ensuring it has the tools to meet the veterans' needs. And while the VA has made progress, we still have work to do. The VA has been too slow in implementing the Hannon Act Telehealth Grants that would improve rural veterans' access to mental health care by increasing the number of locations that can provide VA Telehealth Services.

That is a particular concern of mine, given Montana has one of the highest rates of suicide in the Nation. A nearly 5-year implementation timeline is far too long. And I will expect an update on that initiative today.

I am also looking for an update on the Veterans Crisis Line. The STRONG Act included my reach for the Veterans Act to improve the Veterans Crisis Line oversight.

Last week, a new IG Report was released, raising more concerns about the Veterans Crisis Line. The Veterans Crisis Line is a life-saving resource for veterans, and it must be a top-performing entity within the VA. But as made clear by recent IG reports, it simply is not. I expect an update from the VA on how it is implementing the provisions from the STRONG Act, and how it is executing the IG's latest recommendations.

Finally, I was recently informed of the death, by suicide, of a longtime VA employee in Montana. That employee, like so many at the VA, was a veteran. VA employees deal with stressful topics and events each and every day, and they face a lot of the same challenges as the veterans they serve.

As the Department continues to improve its Mental Health Service for our veterans, I call on you to redouble efforts to care for its workforce across the enterprise. A workforce that feels understood and supported will be far better positioned to accomplish the mission of delivering vets the care and the benefits they have earned.

Senator Moran is not quite here yet, so we will start with the first panel. And then I will yield to him when he gets here for his statement, if he so chooses to make it.

The first panel is: I would like to welcome VA's lead witness, Dr. Matthew Miller, the Executive Director of the Suicide Prevention at the Veterans Health Administration. He is accompanied by Susan Black, a Suicide Prevention Officer at the Outreach, Transition, and Economic Development Service of the Veterans Benefits Administration.

So we will start with you, Dr. Miller. You may proceed. You have got 5 minutes. Know that your entire written statement will be a part of the record.

PANEL I

STATEMENT OF MATTHEW MILLER

Dr. MILLER. Thank you, sir.

Good afternoon, Chairman Tester, Ranking Member Moran, and distinguished Members of the Committee. Thank you for the opportunity to discuss the Department's efforts to implement legislation related to veterans' mental health care, and suicide prevention.

I want to thank this Committee for its support and continued collaboration on reducing veteran suicide. This critical relationship is reflected in the resources that the Congress has repeatedly secured for VA.

In 2020, 44,298 adult Americans died by suicide, of those, 6,146 were veterans. These numbers are more than statistics; they reflect veterans' lives prematurely ended, which continue to be grieved by family members, loved ones, and the Nation.

Suicide is a complex problem with multifaceted and interweaving contributing factors. Suicide is not just a mental health issue, with no single cause; there is no single solution to suicide for veterans. Yet, one veteran suicide is one too many. VA cannot do this work alone. In order to address individual, relational, community, and societal risks, and protective factors, VA is collaborating with other Federal agencies, public and private partnerships, government at local, State, and national levels, veterans service organizations, and local communities.

Together, we are implementing a full-public-health approach as outlined in the White House Strategy, and VA's 10-year National Strategy for Preventing Veteran Suicide.

These guiding documents are operationalized through VA Suicide Prevention 2.0 Initiative, Suicide Prevention NOW, and emerging innovations combined with research and program evaluation.

Further implementation of new laws, including the STRONG Act, Hannon Act, COMPACT Act, and the National Suicide Hotline Designation Act, are all critical part of these efforts, as mentioned by you, sir, at the outset.

For example, Hannon Act Section 201 established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, allowing the VA to provide grants to expand Suicide Prevention Services to veterans and their families, to reduce the risk of suicide.

In September 2022, VA awarded $52.5 million to 80 community-based organizations across 43 States, DC, and American Samoa. A second round of grant awards was announced today, ensuring reach to veterans across the Nation, not just those engaged in VA care or benefits.

Additionally, the STRONG Act contains more than two dozen sections that further support veterans' mental health care and suicide prevention, including further strengthening of the Veterans Crisis Line.

In July of 2022, the Veterans Crisis Line rolled out 988–PRESS–1. VCL prepared for the implementation of 988–PRESS–1, by hiring over 900 individuals, responders, to address increased demand, and to increase quality assurance, and program evaluation efforts.

Since that launch, VCL has fielded over one million calls, texts, and chat messages.

On that note, and before I close, I want to acknowledge the recent OIG Report of a veteran's death by suicide following and in the context of a contact with the Veterans Crisis Line.

We, I, as a veteran, grieve the loss of this veteran. From the painful lenses of retrospective review we wish we could have done some things differently. It is our earnest desire and pledge to apply the wisdom gained through this review to strengthen processes as we continue to serve veterans who are at the center of all we do, even at this very minute as we answer calls.

Mr. Chairman, this concludes my remarks. My colleague, Dr. Black, and I are prepared to address any questions that you may have.

[The prepared statement of Dr. Miller appears on page 45 of the Appendix.]

Chairman TESTER. Dr. Miller, thank you for your testimony, and thank you for being here.

I will yield my time to the wily young veteran, former Chairman of this Committee, Senator Murray.

SENATOR PATTY MURRAY

Senator MURRAY. Thank you very much, Mr. Chairman.

Let me just, first of all, thank you both for being here. But the fact that nearly a third of women veterans experience sexual assault or harassment while serving our country in uniform is really staggering. And unsurprisingly, we know that military sexual trauma is a significant cause of mental health issues for these women.

In fact, women who are survivors of military sexual trauma are nine times more likely to develop PTSD than other women veterans. There was a 2018 VHA directive that requires all VA facilities to have a designated coordinator to help veteran survivors of military sexual trauma access mental health care and other resources.

But in my home State of Washington, the Puget Sound VA, which treats, by the way, more than 65,000 veterans, doesn't, does not have a full-time person in this position, which seems notable for a facility of that size, and a position that is so important.

So Dr. Miller, I want to ask you, what steps is VA doing and taking to make sure that all VA facilities, including Puget Sound VA, have enough resources to assist and reach out to survivors of military sexual trauma?

Dr. MILLER. Thank you for the question, Senator. I agree with you 100 percent, as does the VA and Suicide Prevention, that addressing military sexual trauma is critically important and a key component of suicide prevention. Exactly what you have said, there is increased risk with regard to suicide in this area.

We, at the national level, have a policy in place, requirements at the local level regarding the very points of contact that you mentioned. We receive regular reports on a quarterly basis regarding staffing, and then we work with local facilities through the VISN with regard to gaps or according——

Senator MURRAY. So is my VA facility going to get a coordinator or not?

Dr. MILLER. Your VA facility should be receiving a message stating, "Tell us what the plan is to fulfill this FTE 1.0."

Senator MURRAY. When will that occur?

Dr. MILLER. I don't know the exact timing of that vis-à-vis the current date. I would imagine by the end of the quarter. or the start of the quarter, but I would be happy to check on this and then send this——

Senator MURRAY. If you can get back to me and tell me specifically when that is going to happen, I would appreciate it.

Dr. MILLER. Yes, ma'am.

VA Response: Per VHA Directive 1115 Military Sexual Trauma (MST) Program, each facility must have a designated MST Coordinator who is typically given at least 0.2 FTE of time specifically dedicated to the administrative responsibilities of the role. VA Puget Sound Health Care System has 2 MST Coordinators labor mapped 0.3 and 0.2 FTE; the current MST Coordinators' start dates were March 20, 2020 and July 19, 2021.

Senator MURRAY. Thank you. Let me ask about homelessness. There are 33,000 veterans experiencing homelessness in the U.S., 1,500 of them in my State, veterans who have experienced homelessness are four times more likely than other veterans to attempt suicide. And I know the VA has made progress in reducing the number of veterans who lack housing, but we also need to make sure that we are utilizing our knowledge of risk factors and engaging with these veterans to help prevent them from experiencing homelessness in the first place.

So Dr. Miller, what is the VA doing right now to reach out to veterans who are experiencing homelessness, and provide them with the mental health services that they need?

Dr. MILLER. I think that the answer to that question, ma'am, starts with identifying where are veterans at the highest risk for suicide within that particular situation. And what we have learned is that veterans are at the highest risk for suicide 30 to 60 days prior to homelessness status or losing their home. So a big part of the issue for us is identifying veterans who are at high risk.

Senator MURRAY. How do you do that?

Dr. MILLER. I think that it is an issue of measuring and monitoring through the Homeless Program Office at the local level, up to the national level.

Senator MURRAY. Is that happening?

Dr. MILLER. It is happening. I don't think that it is perfect, because it is very difficult to identify, 100 percent, who is at risk within 30 to 60 days. We had a situation that we faced this week where I assisted, along with some other colleagues, a veteran and his spouse who found out within 5 days that they were losing their home. We put them in direct contact with resources and assistance, but the timing can be very short. There are areas for improvement there, and we are committed to working on them.

Senator MURRAY. Okay. Well, Congress and the VA have been putting a lot of effort into reaching out to veterans with the message that it is okay for them to ask for help.

Dr. MILLER. Mm-hmm.

Senator MURRAY. That when they are feeling alone, when they are feeling depressed, there is people and resources available for them. So it is really concerning to see on the VA's website that the wait time for a mental health appointment at the Puget Sound VA Medical Center is over a month long. I have personally had vet-

erans tell me that they have had to wait as long as 3 months just to get an appointment.

I know it is challenging. I know it is complicated. But what is the VA doing to make sure that veterans who are experiencing a mental health crisis access the care they need when they need it?

Dr. MILLER. Same-day access is the first step that should be in place at every local facility regarding this, following same-day access, attending to staffing, and ensuring that staff can accommodate the demand.

Senator MURRAY. Okay, but it is not happening. So what do we do?

Dr. MILLER. Then we, from a national level, we consult, we offer consultation to the local level regarding where they are seeing barriers, where they are seeing impediments to access, and assisting them with constructing a plan, an action plan for following through and making improvements.

Senator MURRAY. Okay, can I get you to get in touch with the Puget Sound VA Medical Center and find out why these wait times are so long, and follow up on what we are going to do to fix it?

Dr. MILLER. Absolutely.

Senator MURRAY. Thank you.

VA Response:

Current Average Wait Times for a New Mental Health Individual Appointment

- Includes appointments scheduled in advance over the past 30 days, including telephone appointments; however, does not include appointments made the same day
  - Seattle VA Medical Center–37 days
  - American Lake campus–11 days
- Includes all scheduled appointments, including those scheduled the same day, over the past 6 months; however, does not include telephone appointments
  - Seattle VA Medical Center–20.2 days
  - American Lake campus–22.5 days

Note: All eligible Veterans have same-day mental-health access at the American Lake and Seattle clinics with no pre-scheduled appointment necessary.

Chairman TESTER. Senator Moran.

SENATOR JERRY MORAN

Senator MORAN. Chairman, thank you. I will forego my opening statement and maybe make a few comments at the end. But let me ask questions of Dr. Miller.

Dr. Miller, the Office Inspector General published a report last Thursday, September 14th, detailing deficiencies at the Veterans Crisis Line and how the Crisis Line staff failed to take appropriate action with the veteran who died by suicide that same night, the night that he contacted the crisis line. The report also details significant issues with the Veteran Crisis Line leadership and some staff. What are you doing, personally, to make certain that the deficiencies detailed in the Inspector General's Report are fixed quickly?

Dr. MILLER. Thank you for the question, Senator. We are better than what was depicted in that report. And we have to do better than what was depicted in that report. Personally, since you asked

for that particular perspective, when I was first presented with the situation, with a call from OIG, directly, telling me about their concerns, I enacted pulling the responder from responder duties and initiating a full review of the work.

That became what you see with Responder 2 and 3 in the review and the report. From that time, we have been working very aggressively to make changes. Such that, to the point right now, there is 11 recommendations specific to the Veterans Crisis Line in this report. We have made significant progress on eight of the eleven. There are two that involve close collaboration with the Office of Information and Technology. There is one that involves new information from a personnel perspective that we are pursuing.

Senator MORAN. Dr. Miller, what would be your—why does it take an Inspector General Report for this to be addressed? What is not taking place at the VA to get this solved before this particular veteran committed suicide?

Dr. MILLER. There are aspects of this situation that involve standards and expectations that are new to the field of crisis call; for example, text retention. Text retention is not a standard for the National Suicide Prevention Lifeline, nor is it known how many even in the Lifeline engage in text retention. It also has significant challenges, from an OIT perspective, balancing privacy, security with retention.

We have been engaging for the last 2 years, even prior, to this particular situation, in what we would need to do to change our text platform to allow us retention. This report is not the first time we have thought about this and tried to move to this. The issue is finding a platform that OIT approves of that does not jeopardize veteran safety.

Senator MORAN. As you might expect, I think my staff and I will have additional questions, perhaps in writing, and maybe in a conversation.

Dr. Miller, let me follow on a different topic, within the John Hannon Act, there is the Staff Sergeant Fox program, it seems to be overly administratively burdensome and has significant, what I would call, excessive restrictions on the use of funding. Do you disagree with those broad conclusions? And what changes would you expect to alleviate—make to alleviate the concerns that I am raising, or the concerns that have been raised to me?

Dr. MILLER. Yes. Thank you, Senator. I appreciate that. We, as you are, are proud of the Fox Grant Program. I do not disagree, however, with your statement. I think that this is a developmental process. This is the first time that we have engaged in grants, and we are learning to walk that fine line between too much and too little, in terms of requirements and measurements.

I think that there is at least three things that I would be happy to talk with you at greater depth, that we are learning along the way about walking that proverbial fine line. But we are committed to learning, growing, adapting as we move forward.

Senator MORAN. There is a lot of things that are really pleasing to me in this legislation, and this grant program is one of them that I think gives an opportunity for community and personal engagement in veterans' lives.

Dr. MILLER. Yes.

Senator MORAN. That I think is really, really important, and I want to see it succeed. And if there is something, I would like to have the conversation, but also if there is something that is missing legislatively, congressionally, please make sure that I know that.

Dr. MILLER. I appreciate that. We will do so, sir.

Senator MORAN. Thank you.

Chairman TESTER. Senator Hassan.

SENATOR MARGARET WOOD HASSAN

Senator HASSAN. Thank you, Mr. Chair, and Ranking Member Moran for the hearing. And Dr. Miller and Ms. Black, thank you as well for being here.

I was really glad to see that the VA has chosen a week next month, October 16th to 20th, to designate as the first official Buddy Check Week in which veterans conduct peer-to-peer wellness checks. As you know, Senator Ernst and I introduced and passed into law the bill to make this happen, our bipartisan legislation required the VA to build on what the American Legion had already started with the Buddy Check Week, by making it a nationwide VA initiative.

Can you talk about how the VA plans on conducting outreach to maximize the impact of the first nationwide VA Buddy Check Week?

Dr. MILLER. Yes, thank you for the question. We are really looking forward to the first Buddy Check Week; that is scheduled for October 16th to initiate. We are also hoping to, and targeting, pairing the release of our annual report with the initiation of Buddy Check Week as a call to action. We are currently engaged in the process of talking with our close partners, the VSOs, regarding Buddy Check Week and implementation.

One of the biggest concerns that we have with implementation is, making sure veterans feel equipped to engage in it constructively and helpfully. We have completed training, therefore, for Buddy Check Week, and we will be rolling that out within the next week.

Senator HASSAN. Great, thank you for that. I wanted to follow on Senator Murray's lead to talk a little bit about women veterans right now. Women veterans face unique hurdles to accessing VA health care and benefits, even though more than 30 percent of new VA health care users are women, and there have been—there has been a threefold increase in the number of women veterans accessing VA mental health services since 2005.

So I want to help raise awareness among women veterans about the Women Veterans Network, or WoVeN Program, which aims to develop peer support networks that are specific to the unique needs of this growing population of women veterans. What steps has the VA taken to address the unique mental health challenges that women veterans face? And how has the WoVeN Program been developed to help improve outcomes for the women who participate in it?

Dr. MILLER. Yes. Thanks for that question. And thanks for highlighting this as an example of an important program for women veterans. I agree with you. It absolutely is. What we are doing at

the outset, in terms of broad messaging, is talking about the point that you made: that women veterans have unique risk factors, they have unique protective factors, and we need to be able to address those in a tailored way.

In terms of WoVeN—pardon me—in terms of WoVeN, we have made some significant, I think, program evaluation observations and adjustments after the initial implementation. I think two examples serve as important to know for that. Number one, we have developed a Train the Trainer Program. Number two, we have learned that we can go from a co-lead paradigm to a single individual leading. These two lessons learned and the implementation plan will, exponentially, increase in the next year our ability to implement more of these groups and opportunities.

Senator HASSAN. Okay. That would be really excellent. One of the things I continue to hear, especially in rural areas in New Hampshire, from women veterans, is how hard it is for them to know where the other women veterans are and to provide the kind of peer-to-peer support that is so important. So I would look forward to continuing to work with you on that.

A last question is about something I worked with Senator Cramer on: The bipartisan and bicameral push to enact the Solid Start Program. That directs the VA, as you know, to contact every veteran at least three times by phone in the first year after they leave active duty service, to check in and help connect them to the VA programs and benefits that they have earned and deserve. Last month alone, the VA contacted 23,479 veterans through the Solid Start Program. How does the VA tailor outreach through the Solid Start Program to veterans with mental health care concerns, and what have you done to ensure that those mental health concerns are being addressed as quickly and effectively as possible?

Dr. MILLER. Great question, not to be punny, but VBA is taking the lead on doing solid work in this. I defer to Dr. Black.

Dr. BLACK. Yes. And thank you for that question. So when you look at the Solid Start Program, that is one of the primary focuses, is ensuring that when we are making those contact with the veteran, that we are asking those questions. So all of our Solid Start representatives, they are trained in suicide prevention awareness; so when they are on those calls that is one of the topics that is discussed, that is a topic that is discussed.

And not only that, our Solid Start makes a priority for any veteran who was seen in mental health the year prior to separating from the service. We make that a priority, and we engage those individuals as far as suicide prevention and mental health topics. About 80 percent of those priority veterans, we have made those successful connections with, so that is definitely a priority.

Senator HASSAN. Okay, that is really, really helpful because obviously if they had had a mental health consult or issue during service, the confusion or unease during transition, which is just, from what veterans tell me, it can be a pretty confusing time, makes them even that much more vulnerable, right?

Dr. BLACK. Yes, and ensuring that we have—make that warm handoff from care to care is vital.

Senator HASSAN. Excellent. Well, thank you, Dr. Black and Dr. Miller.

Chairman TESTER. Dr. Cassidy.

SENATOR BILL CASSIDY

Senator CASSIDY. Hello. This is an incredibly damning OIG Report, incredibly damning. And I am struck that the executive director, who apparently interfered with the OIG Report, was not fired. She is reassigned, I presume still getting a paycheck; I assume she is still building a pension, having demonstrated her lack of truthfulness in conversation with the OIG.

I am told that the Director of Quality and Training, or Training and Quality, is in the same position as this person was before. Now, we have passed accountability measures for people who don't do their job, and it sounds like interfering with an investigation of a suicide, which may have been inappropriately handled on a Veterans Crisis Line, is incompetence.

So it may be a decision above your pay grade, but can you tell us why the only accountability that has been had so far is that somebody moved over to the Secretary's Office?

Dr. MILLER. Dr. Cassidy, we agree 100 percent with the necessity of accountability and holding our staff and team members to the highest level of standards when it comes to serving our veterans. The Executive Director that you mentioned is not named in "interference", to use the term that you used; the individual who was listed as Director of Quality is discussed in that, the information that we had to that effect is new from the OIG evaluation in their review. It is not uncommon to receive new information——

Senator CASSIDY. Well, then maybe, "The Executive Director," I am quoting, "Reported that after completion of a quality assurance review, it was decided there is," quote, "Insufficient information for us to really move forward on a root cause analysis; however, leaders initiated the root cause analysis after the OIG notification of the inspection, although the text conversation had not been obtained."

Now, it sounds like somebody is asleep at the wheel, and the question is, was it just incompetence, or was it just a cover up? So is anything being done about it? What is this person earning? Are they earning less than they were before?

Dr. MILLER. No, sir. What you are referring to is an RCA in the context of reviewing the text exchange; this gets to the text retention issue.

Senator CASSIDY. Stop. I am not asking text retention. I am asking, were the people responsible for the failure of this system, and who did not initiate the appropriate follow-up, and/or apparently tampered with people, responder number one, have said things which may have influenced the way they responded to the OIG; how are they being held accountable?

Dr. MILLER. They are under review using an appropriate personnel, guidance policy, and subject matter experts.

Senator CASSIDY. And the person who was transferred, did they get a cut in pay? Are they making the same money; or are they making more?

Dr. MILLER. I am not aware of a person transferred, sir.

Senator CASSIDY. I thought somebody was transferred to the Secretary's Office out of the position they had. Am I right on that? That is correct. I am told that is correct.

Dr. MILLER. There is an individual who took a different job; there was not an individual that was transferred.

Senator CASSIDY. Okay, took a different job. Just voluntarily took it and everybody said, incredibly well qualified, and no stains upon the record?

Dr. MILLER. I can't speak to the hiring process that was engaged, sir.

Senator CASSIDY. And when did the process of review begin for each of these two individuals?

Dr. MILLER. The process of review began for the first situation with responder one, that is mentioned in the report, immediately. The process of review——

Senator CASSIDY. I am sorry. What is the date on that?

Dr. MILLER. The date would be November——

Senator CASSIDY. And I am sorry. And I don't mean of the root cause analysis.

Dr. MILLER. Oh.

Senator CASSIDY. I mean of the apparent attempt to influence how the OIG was spoken with.

Dr. MILLER. Right. We did not—we did not become aware of that till OIG gave us feedback to that effect, which was about a year after the answer——

Senator CASSIDY. And how long ago was that?

Dr. MILLER. That would have been in the spring of 2021—I am sorry, '22.

Senator CASSIDY. And so the spring of 2021, and so a person has been—'22, has been under review since then; has anything resulted from that review?

Dr. MILLER. That is different, sir. You are talking about the review with regard to responder one.

Senator CASSIDY. Mr. Miller, I feel like you know what I am asking, but you are deliberately dodging the question. I want to know when did the review begin, of the two people whom this report alleges interfered with the investigation and/or told folks how to respond differently than what apparently was the truth?

Dr. MILLER. The answers to your question, sir, require technical responses——

Senator CASSIDY. Okay. But tell me what day—what month did those investigations, of those two people began, by the VA?

Dr. MILLER. The investigation with responder one initiated——

Senator CASSIDY. And again, I am not speaking of the fact that the veteran died. I am speaking of the fact that the supervisor, apparently, shall we say, misbehaved. When did the supervisor's misbehavior begin to be investigated?

Dr. MILLER. That began when we learned of——

Senator CASSIDY. And what was the date of that?

Dr. MILLER. The draft report was received by the OIG, I want to say, maybe two, three months ago; that is when we first came to the information of the——

Senator CASSIDY. And so how long will this investigation take to still hold them accountable, if indeed, the OIG is correct, that their actions were as you described?

Dr. MILLER. I can't answer that question for you.

Senator CASSIDY. That veteran was ill-served, and there—as best as I can tell, an attempt not to hold people accountable. And my, gosh, that is a pattern. Thank you.

Chairman TESTER. Thank you, Senator. There is no doubt your line of questioning is appropriate. And your disgust with the situation is entirely appropriate. I think that we demand excellence from the people in the VA, and people need to be held accountable, and we are going to ensure that—I am going to be following up with the IG on this issue tomorrow, and I will download with you from his perspective.

With that, Senator Hirono.

SENATOR MAZIE K. HIRONO

Senator HIRONO. Thank you, Mr. Chairman.

I noted that Senator Murray, my colleague, mentioned the high incidence of military sexual trauma experienced particularly by women. Dr. Miller, would you consider that a factor? Experiencing sexual trauma in the military a factor in suicide?

Dr. MILLER. Absolutely, it is a risk factor, yes.

Senator HIRONO. So I would say that, as I read your testimony, and you know these various risk factors, I would suggest to you that you include sexual military trauma in this list that you have. I think that is really important to call it out because of the high incidents of women who experience MST. So in noting the number of—by the way, would you start doing that as you prepare testimony for these kinds of hearings?

Dr. MILLER. Are you are referring to the written testimony——

Senator HIRONO. Well, that you should put in that military sexual trauma is a factor in suicide.

Dr. MILLER. Yes.

Senator HIRONO. So when we look at the numbers that you noted in 2020, that seems to be the most recent numbers we have. I hope those numbers are relatively accurate and not vastly undercounted. But 6,146 were veterans who committed suicide. Do you know how many of this number were women?

Dr. MILLER. Yes, that is available within our report.

Senator HIRONO. What is it?

Dr. MILLER. Off the top of my head; I am sorry, I don't know. It is by count much lower than men. It is by rate, rising, and higher.

Senator HIRONO. I think that is what should concern us because as more and more women enter the service, their suicide numbers, sadly, are going up. And do you know how many of these suicides had—was associated with opioids?

Dr. MILLER. In terms of opioid overdose or prescribing——

Senator HIRONO. Yes. I would start that, opioid overdoses?

Dr. MILLER. Yes. We do have a report that is available for opioid deaths, overdose that is separate from suicide reporting.

Senator HIRONO. Oh. Thank you. So what would that number be?

Dr. MILLER. That is a report that is generated by the Substance Use Disorder Program Office within the Office of Mental Health. There is also a publication from 2019 that updates that information, but we can take that back.

[The publication referred to by Dr. Miller appears on page 103 of the Appendix.]

VA Response: VA's most recent reporting regarding Veteran overdose mortality is available in the following publication:

Begley MR, Ravindran C, Peltzman T, Morley SW, Stephens BM, Ashrafioun L, McCarthy JF. 2022. Veteran Drug Overdose Mortality, 2010-2019. Drug and Alcohol Dependence. 233:109296. doi: 10.1016/j.drugalcdep.2022.109296. Epub 2022 Jan 12. https://pubmed.ncbi.nlm.nih.gov/35219064/ PDF also attached.

Per Table 3, in 2019, there were 229 opioid overdose deaths among women Veterans, and there were 3,197 opioid overdose deaths among all Veterans.

Per the Begley et al. paper, attached, which includes the following information:

Table 3

Veteran Drug Overdose Mortality Counts 2010–2019, Overall and by Drug Category

	Overall Drug Overdose		Opioid Overdose		Stimulant Overdose	
	2010 Deaths	2019 Deaths	2010 Deaths	2019 Deaths	2010 Deaths	2019 Deaths
All Veterans	3669	4865	1891	3197	612	2172
Sex						
Female	356	372	172	229	35	102
Male	3313	4493	1719	2968	577	2070

Senator HIRONO. So would you say that that is a significant number of opioid overdoses that involve veterans?

Dr. MILLER. Yes. Yes. That is a significant issue.

Senator HIRONO. So thank you for telling us that opioid overdoses are not counted as suicides, because I think that it would be enlightening. I would have thought that it would be a part of that information.

Dr. MILLER. May I add—may I add one caveat to that?

Senator HIRONO. Yes.

Dr. MILLER. It depends on what the medical examiner puts on the death certificate. If the opioid overdose is viewed as an accident, it is not a suicide.

Senator HIRONO. It is not. I understand. I do have a question about some of the categories or the—some specific populations that have a higher incidence of suicides. And in one of your reports, I noted that the rate of suicides among Asian-American, Native Hawaiian, and Pacific Islander veterans is higher. And as a part of a response to a question that I had asked of Secretary McDonough, he noted that there were demonstration projects related to tailored mental health outreach for specified veteran populations, including AANH veterans and women veterans.

So can you describe what you would consider a tailored outreach for women veterans? And a tailored outreach for AANHPI veterans?

Dr. MILLER. Yes. We have been working on this, and happy to talk about it. We have developed a partnership with the Rocky Mountain MIRECC to study suicide prevention in this particular area, and specifically dedicated upon it. One publication has thus far emerged from that on geospatial considerations and how it impacts our knowledge of this population and in turn our programs. And they are currently in active recruitment for individuals to participate in the next phase of research.

Simultaneously, we spent a couple of weeks this summer traveling to Guam and to the Mariana Islands to talk firsthand with important points of contact there, including Governor's Challenge teams.

Senator HIRONO. You are telling me, then, that you are specifically focusing on certain ideations relating to AANHPI veterans?

Dr. MILLER. Yes.

Senator HIRONO. I would like to find out more about what you are doing, what you are learning, and whether that informs some of the resources that you are providing toward outreach to these populations.

Dr. MILLER. Yes.

Senator HIRONO. And I am particularly interested also in your outreach to women veterans.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Blackburn.

SENATOR MARSHA BLACKBURN

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you for being here. This is an area that we all have concerns about in Tennessee, with our clinics, with our large veteran's population that is there. We do hear a good bit about this. I want to ask you all this: If I were a veteran in crisis and I reached out on the 988 right now and asked to be seen by the VA, how long would my wait be?

Dr. MILLER. So—I want to give you a technical answer, but you don't want a technical answer. The real answer to that is, it depends on the local facility that you would be referred to through the——

Senator BLACKBURN. All right; I pulled some numbers.

Dr. MILLER. Yes.

Senator BLACKBURN. Out of our region 32 of the 33 VAs in our region, the wait time would be longer than a week. And the reason I looked at that is because we looked at the National Library of Medicine Study that goes in and they do the surveys on those that are hospitalized because they attempted suicide. They did not succeed. Forty-eight percent of them said, within 10 minutes, from the time they thought about it to the time they made the attempt, that that was the amount of lapsed time.

Dr. MILLER. Yes.

Senator BLACKBURN. Now, if you want to look at some of these numbers. And this is what startled me, because these are individuals that are in crisis, we, as a Nation, a government, have promised these veterans healthcare. And then if you look at the—one of the clinics in Nashville, it is a seven-day wait; the Alvin C. York

Veterans' Hospital over in Murfreesboro, eight days; sixty-six days at the Cookeville Clinic.

Dr. Black, you have been to UT, you know where that clinic is.

And you know the Chattanooga Clinic, seventy-one days; Campbell County Clinic, ninety-six days. So this access issue is one that we have got to solve.

I want to switch topics to an IG report on a patient suicide following mismanagement of the Veterans Crisis Line, and it was on the 14th of September. I found it interesting that the Director of the Veterans Crisis Line did not define the patient's death as a "sentinel event". So what is the VA definition of a "sentinel event"? Because I would think that that mismanagement and that death would be classified as a "sentinel event".

Dr. MILLER. Yes. According to policy, and I feel badly, talking about policy and technical things in the context of a veteran who is—who is not with us and died by suicide. According to policy a "sentinel event" is defined as a death or near death, and can be reasonably associated with, from a causal perspective, to action or non-action on the part of last contact.

Senator BLACKBURN. Okay. But he committed—he took his life within 30 minutes of speaking to somebody on that line.

Dr. MILLER. Mm-hmm.

Senator BLACKBURN. And if someone were to text, how long does it take you to respond? What is the amount of time on the text? That it would take——

Dr. MILLER. Our response if someone text us, is immediate.

Senator BLACKBURN. Immediate?

Dr. MILLER. Yes. Now, the individual that we are texting with, it is not uncommon that their response is not immediate. There could be 15, there could be 20 minutes lag.

Senator BLACKBURN. Do they ever call that number that they are getting the text from, to make that personal contact? Or do they just sit there and text it?

Dr. MILLER. Yes. Our policy is that if the risk assessment indicates, we need to switch them to phone from text, and that was one of our—that was one of the things that we did wrong in this situation.

Senator BLACKBURN. Okay. I do have some additional questions. My time is running out, but I am wanting to look at your staffing levels—I will submit this to each of you for writing—and the way that you are utilizing community care to help ease the burden on that staffing. I also want to know what kind of training you are doing to individuals that are Crisis Line responders; what kind of training they are receiving?

Thank you, Mr. Chairman.

Chairman TESTER. So Senator Blackburn, we will put that into the record, and get a response for those. So thank you.

Senator BLACKBURN. Yes.

Chairman TESTER. Senator Blumenthal.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thanks, Mr. Chairman.

I want to just return to the exchange you had with Senator Hirono on drug overdoses.

Dr. MILLER. Mm-hmm.

Senator BLUMENTHAL. Those are not counted as suicide?

Dr. MILLER. Drug overdoses that the coroner, or the medical examiner determines on the death certificates are accidental, are not the official CDC definition of suicide, so they are not coded as a suicide. Those do not come to us for the suicide report.

Senator BLUMENTHAL. So it depends on the local coroner?

Dr. MILLER. Yes.

Senator BLUMENTHAL. So the definition that you gave me earlier, or you gave to Senator Blackburn, or you gave us earlier, about in effect, the causal link, how does that factor into what you count as a suicide by overdose?

Dr. MILLER. You know, that is getting into a question of—it is more in the areas of the medical examiner or the coroner. Usually, and very generally speaking, there needs to be indication of motive. Motive can be indicated by the means, motive can be indicated by a letter, or artifacts left behind, as two examples.

Senator BLUMENTHAL. I think what you are telling us is that the numbers of suicide may, in fact, be far greater than what you have tabulated, and what you have given to Congress year after year, because this local coroner, I mean, I am a former State official, lots of coroners have different definitions, different way of applying that, what you called a technical definition.

And I am a lawyer and I can't repeat the way you put it, essentially, it is causal connection. And I don't know how a coroner makes that determination, which then determines the VAs reporting to the United States Congress. I think those numbers are probably tremendously incomplete.

Let me ask you a more general question. You know, according to you: Suicide is a complex problem with a multifaceted interweaving of potential contributing factors; that is true. Would you say that we have really made significant progress over the last 10 years?

Dr. MILLER. I think there the two areas that my mind would go to, to answer that question. Two questions really, have we advanced on understanding and treating or improving the "why"? And have we advanced on improving the "how"?

Senator BLUMENTHAL. Well, have we advanced on the numbers?

Dr. MILLER. We have not advanced on the numbers.

Senator BLUMENTHAL. We have not advanced on the numbers, so I don't know how you could tell me we have made progress on this problem. If the same numbers are dying, if the rate of suicide is 1 in 17, 1 in 20, 1 in 21; I don't even know the most current figure, how it depends on the numbers of veterans, not the numbers of suicides, but the numbers of suicides are basically unchanged. How could you tell us that we have made progress?

Dr. MILLER. Because we have seen certain areas of higher risks or risk where we have seen improvements and decreases; for example, veterans who are in VHA care and diagnosed with PTSD, there has been a 30 percent reduction in suicide rate over the last 20 years. Veterans in VHA care diagnosed with a depressive disorder, there has been a greater than 20 percent reduction.

Senator BLUMENTHAL. Well, those are veterans in VHA care?

Dr. MILLER. Mm-hmm. And veterans——

Senator BLUMENTHAL. What about the total number?

Dr. MILLER. And veterans not in the——

Senator BLUMENTHAL. I think our Nation is judged, not by the numbers who are in VHA care, they are bound to be lower, I would hope they would be lower, but the numbers overall. If you were judging our Nation, those numbers are unchanged. I mean, I think we need to face the fact, and I am encountering constituents every day who say: Why can't we make progress?

Dr. MILLER. My answer to that sir, it is the "how", 70 percent of veterans die by firearms. That is the number that hasn't changed, and has only gone up. And until we make a significant improvement in that area, we probably will not see a significant decrease in veteran suicide.

Senator BLUMENTHAL. So my time is expiring, but have you advised the leadership of the VA that it should issue a warning to veterans and their families that firearms should be removed from their homes. And they should support red-flag statutes, and emergency risk protection orders in States where they are not now? And I have been probably one of the leading advocates in the Senate for separating people from guns when they say they are going to kill themselves and kill others? Shouldn't the VA be much more aggressive in advocating for those statutes?

Dr. MILLER. We provide technical consultation on everything that comes our way from you and back up through the chain. I just flew here from Denver where I was partnered with someone from your State, sir, and the President of NSSF, to address firearm manufacturing industry regarding what we can do together and collaboratively, to message exactly what you are saying.

Senator BLUMENTHAL. My time has expired. Thank you, Chairman.

Chairman TESTER. Yes. Thank you. Before I get to Senator Tillis, I would just say that, I believe you are on Armed Services, I think Senator King is Armed Services, and Senator King knows this because we have talked about it, the transition between active military and the VA, we need to do some work on, because I really think that is a huge driver for the suicides.

Senator Tillis.

SENATOR THOM TILLIS

Senator TILLIS. Yes, starting with the fact that two-thirds of those who are taking their lives every day are not connected to the VA, we have got to figure out a way to get them better connected.

Dr. Miller, and Dr. Black, thank you both for being here. You know, the exchange that you had with Senator Cassidy about, maybe a mistake, and it may very well be that somebody who was in a position to where they could have gotten the consult done, intervene, save a life. But it could have also, and more likely be related to a breakdown of a process and staffing, and a number of other things. I just can't imagine that somebody working in that position would actually not care about trying to save that veteran's life.

Dr. MILLER. Senator——

Senator TILLIS. But it is what it is. And to the extent that they failed to follow processes they obviously need to be disciplined.

Dr. MILLER. Yes, sir.

Senator TILLIS. I just believe in my heart of hearts it has got to be something more fundamental. The OIG analyzed, I guess, the analysis of consults for PTSD, military sexual trauma, or couples therapy, submitted from November 1st, 2020, through June 2022. They found 39.3 percent of psychotherapy, 39.5 percent of PTSD, 27 percent of military sexual assault, and 67, almost 68 percent of couples therapy consults, did not meet the required time of 30 days from the patient indicated date.

This sounds to me like a—and I guess as a part of the OIG Report, they said it looked like staffing issues, backlogs, the Clinical Research Hub no longer available to Hub staffing concerns. Do you agree with the OIG's assessment, or the information they receive from mental health leaders that you do have staffing backlog issues that are a problem? And if you do, how are they being addressed?

Dr. MILLER. Yes, sir. To answer your question accurately, to make sure I am thinking of the same OIG Report, are you referring to the one from North Carolina and Asheville?

Senator TILLIS. Yes.

Dr. MILLER. Yes. Okay. Yes. From my review of what I know of that OIG Report, there was concurrence to all the recommendations that were provided. I also believe that if we were to look at it today, that that facility has made some meaningful progress regarding mental health hiring. I do know that the Chief of Mental Health is today sitting at a training program for BHIP, which was also mentioned in that particular report, so they are making advancements on that as well.

Senator TILLIS. Just moving on to other information that was included in the OIG Report, one thing that stuck out at me is—look, I know I talk with a lot of veterans, I talk with a lot of veterans service organizations, and they all like the brick-and-mortar presence of the VA, about when they can get an appointment, and when they can get the care they need. In the behavioral health space, we do not have enough in the VA or in the general community of the general population.

But can you speak to some of the passages in the OIG Report that said that people within the VA were really discouraging community care referrals for behavioral health; why they would do that?

Dr. MILLER. So I think that from that, and specific to the situation, from my understanding of it, there were discussions about exactly what we have said in here, which is VA care works, and let us capture as much of that as we can through appropriate mental health staffing. I think that there may have been interpretations of that that led to then believing that it was a black and white and then discouraging community referrals. I believe in the response to that OIG, the facility attempted to clarify that, and one of the recommendations that they are engaging is staff-wide training on that very issue, sir.

Senator TILLIS. Yes. I think it is critically important——

Dr. MILLER. Yes.

Senator TILLIS [continuing]. For anyone in the VA. And I am a big supporter of the VA. I like to think of myself as a cheerleader, I very seldom flog you all in these open hearings but—very sel-

dom—but for something like this, we have got to have balance. This is about providing care.

Dr. MILLER. Mm-hmm.

Senator TILLIS. And unless you think you are knowingly providing a community care referral to somebody who is not competent to provide the care, refer the case.

Dr. MILLER. Yes.

Senator TILLIS. And then build a capability and serve more within the VA, but that particularly in behavioral health crisis situations, days and minutes matter.

Dr. MILLER. Yes.

Senator TILLIS. And I think that anyone who, in the VA, is guilty of saying: Well, you know, we just need to keep them in the mix, a few more days, a few more weeks. First, you are playing, potentially, with somebody's life, and you are—the person who is saying that is running counter to what I have heard from everybody in the VA: Get the care, quality care as quickly as possible, in the VA if possible, but in the community when necessary.

Dr. MILLER. That is all that matters. I agree with you 100 percent. You would know this better than I do, sir, but I believe specific to that region and your constituents, community care, mental health care is in short supply. It seems difficult to come by.

Senator TILLIS. It is, and that is why we are—And Mr. Chair, I just want to mention this for future consideration. I met with Secretary McDonough when he was in Charlotte, about a month ago, and I was talking to him about the Bipartisan Safer Communities Act, and so it made me think about it when Senator Blumenthal spoke up, that is one of the single largest investments in behavioral health that this Congress has made in modern history.

One of the things I asked Secretary McDonough is, have we tuned it right to where—if you think about Eastern North Carolina, think about between Fort Bragg and Camp Lejeune, is there someplace down there where maybe we have something that we haven't had before? Collaboration with the VA, collaboration with the Army, collaboration with the private sector, to stand up a behavioral health capability that does really exist, it is scaled down in that area.

So I would like for us, if we could, I have talked to Denis about it, but I would like to see if the plain text as we passed it, facilitates that sort of thinking. Or if we need to open it up and potentially consider that in areas where I think it could be helpful.

Dr. MILLER. And improve telehealth in those areas. Yes, sir.

Senator TILLIS. Yes. Thank you. Thank you, Mr. Chair.

Chairman TESTER. Senator King.

SENATOR ANGUS S. KING, JR.

Senator KING. Thank you, Mr. Chairman.

Dr. Miller, nice to see you in person, we talked last week. One of the main issues that seem to be motivating suicides is financial, and financial distress, and I think the data is four times—veterans with incomes below $50,000 who have financial problems are four times as likely to have ideation of suicide. What about a pilot in the helpline, of the Crisis Line, of having some financial expertise

that could be referred? Are you having a financial problem, here is somebody you can talk to.

Dr. MILLER. Yes.

Senator KING. Is that something we could work on?

Dr. MILLER. Yes, is the short answer. What you are getting at though, sir, is an important point in terms of instead of having maybe the referral from the Veterans Crisis Line go to mental health, maybe it would be more appropriate for it to go to a financial counselor, in which case then there is a ripple effect in capacity with mental health. You save by putting people in the right place at the right time. Yes.

Senator KING. So is this something that you don't need legislation; is this something you could pilot for, in one VISN, for example?

Dr. MILLER. Yes. What we can pilot is, we are starting a new Veteran Center for Financial Empowerment. That center will offer, through VBA, and services that are available with VBA, referral to free consultation for financial issues. That will allow us to get some initial data on demand and need and be able to report that back to you for next steps.

Senator KING. I would appreciate it. I think that is an important step. Let us see what the data shows us because it does appear to be one of the causation factors. Workforce, it seems like every hearing that we are at, we talk about workforce, and I keep hearing about the difficulty of onboarding people.

For example, if you want to bring on a new therapist, it may be a therapist, it may be a clinical social worker, it may be a psychologist, you have got to do three different—three different job descriptions and go through a long process. And in fact, I have heard of mental health directors who are spending 20 hours a week on administrative functions of onboarding people. How do we crack that problem? It just seems to be a problem throughout the agency.

Dr. MILLER. Yes. I feel your pain and theirs. We hired 900 Veterans Crisis Line responders in the last year, a-year-and-a-half, and a significant portion of my time is paperwork to help move those issues in hirings along. I think that we are taking a good step in this area through the Under Secretary's initiatives that are informally called "Tiger Teams". There are at least six key areas, suicide prevention is one, but another one is hiring and retention and workforce management optimization. Watching how that group is able to progress with the targeted goals and outcomes will be important.

Senator KING. Well, I would hope something, and this isn't for you necessarily, but for the VA generally, instead of this iron hand of control from Washington, why shouldn't the local VA facility be able to hire the people they need? Washington can give them guidelines; here are the standards, here are the minimum standards, and those kinds of things. But somebody in Maine, if they need somebody, they ought to be able to reach out into the community and try to find them, and not go through all the steps that appear to be in this process.

I don't expect you to answer that, but I think that is something, Mr. Chairman, we ought to talk to the Agency about. There are

just—I keep hearing about the administrative burden of bringing people on board, and then we just—we need them.

Final question, I think it was the Chairman who used the term "better connected", about getting people connected into the system. One of the ideas that I am working on is that an active-duty service member can pre-enroll in the VA while still in active duty as part of the TAP process. Do you have a reaction to that?

Dr. MILLER. Yes. I think that would—personally, I think that would be extremely helpful in terms of streamlining the process. Currently, what can be done is a transitioning service member can preregister; they cannot pre-enroll. The reason why they cannot pre-enroll is because, by law, they have to be a veteran by the legal definition of a veteran to enroll.

Senator KING. Fortunately, laws are the business that we are in here.

Dr. MILLER. Yes, sir.

Senator KING. Great. Well, I think that is something I would like to see us work on. Thank you, Mr. Chairman.

Chairman TESTER. Senator Boozman.

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Mr. Chairman. And thank you and Senator Moran for having such an important hearing. You know, with all the rancor that is going on around here, but this Committee really does work in a very, very bipartisan way, and because of that, in the last couple of congresses we got an awful lot done.

We all know that suicide is really complex; it is a complicated crisis, there is no single solution. We also know that if people are in the VA system, they are less likely to commit suicide. Most of the people that are committing suicide are outside of the system.

So one of the things that we have worked on, and most of the Committee has worked on, is trying to make it such that we could capture those folks that are outside of the system, get them some help in the community, and then ultimately bring them into the VA where they can get even additional help.

Dr. MILLER. Mm-hmm.

Senator BOOZMAN. Dr. Miller, I appreciate you highlighting the Staff Sergeant Parker Gordon Fox Suicide Grant Program in your testimony. When we wrote the grant program, we intended to provide Federal resources to organizations in the community that coordinate Suicide Prevention Services outside of a clinical setting. I have met with many grant recipients and heard incredibly positive feedback on the program.

After one year of this program being in effect, what are the biggest lessons that you have learned? And have you identified ways to improve for the future? So this has been going on for a while; you have got these grant programs out there. What are you finding with them?

Dr. MILLER. Yes. I think one thing that we are learning is, it is written into the law the importance of screening for risk, and ensuring that the services are going to those who are at higher risk. But we are learning, as part of that process, that one of the many beauties of this grant is the services that a lot of the grantees are

providing, are what we may call "upstream" in nature. So it is a bit contradictory for them to be, necessarily, screening for risk, and screening out those who aren't high risk, when a lot of the work they are doing is moving upstream before these individuals become high risk.

So resolving that I think—discrepancy, I think is a challenge for us that we are committed to working with you and this Committee together. I think the second thing I would say is we are learning a lot about how to screen for risk in ways when you are not a licensed mental health professional, and it just feels out of your normal flow of what you do to pull out a survey, a questionnaire, and say: I have some questions here that I need to ask you.

So I think we are taking a close look at the screener tool that we have implemented as part of this, and wanting to take a look at: is there a better way to meet the requirements of the screen without necessarily asking grantees to slip into a role that feels very unnatural for them as part of their service.

Senator BOOZMAN. Yes. And this follows up on your comments, and then question—comments that Senator Moran had, but it does appear that when you visit with people, you know, that are involved, that there is just something about government that makes things pretty complex. And I am part of government; I understand that. But, you know, providing increased flexibility in that area, and, you know, the whole process, I think, would really be helpful.

Dr. MILLER. Absolutely; I think that would—I would want that to be an open discussion between us, because how I may define increased flexibility, I may have a blind spot then in terms of what you were intending with the law and the applications of the law. So I think it is really important we continue our open and collaborative dialogue so that we are fully capturing your intentions with the law.

Senator BOOZMAN. No. I agree, and I think something would be helpful if we could discuss with you, but also get some providers in, you know, to help us realize some of the unintended consequences. We all want the same thing.

Dr. MILLER. Mm-hmm.

Senator BOOZMAN. That may be, you know, a requirement, or whatever; just makes it a little bit more difficult.

Dr. MILLER. Yes. I am looking forward to Panel Two. I think it will give us some good insights and steps forward.

Senator BOOZMAN. Thank you.

Dr. MILLER. Thank you.

Chairman TESTER. Senator Sinema.

SENATOR KYRSTEN SINEMA

Senator SINEMA. Well, thank you, Chairman Tester, for holding this hearing. And thank you to our panelists for being here, and for the critical services you provide for America's veterans. I will focus my questions on mental health resilience for veterans and for their community. But first I want to address a time-sensitive issue.

Much of what we discussed today centers around access to care for veterans, and part of that access is transportation to the point of care, like a VA hospital or a clinic. The VA is currently implementing a rule that decreases veterans' access to ambulance serv-

ices, particularly in rural parts of the country, like Northern Arizona.

So I commend Senators Tester and Moran for their quick bipartisan work drafting and introducing the VA Emergency Transportation Access Act to address this issue, as well as a related amendment to the appropriations bill that I hope to vote on in the near future. I look forward to working with the Committee and the VA to protect veterans' access to life-saving ambulance services.

Since coming to the Senate, I have led bipartisan efforts to help service members and veterans build supportive resilient communities; first, by earning broad support and passing my Sergeant Daniel Somers Veterans Network Act into law, and more recently by introducing the Military Suicide Prevention in the 21st Century Act. As we know, networks of support for our veterans are vital to their well-being.

So my first question is for you, Director Miller. National Community Health Partners, which is based in Southern Arizona, has recently launched a project called "The Best Is Yet to Come" funded through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program; one of three such grantees in Arizona. Can you speak to the importance of these grants to community organizations?

Dr. MILLER. Yes. Absolutely, I think there is a few things that come together under the heading of our community-based Suicide Prevention Plan that reinforce your points exactly. The community-based Suicide Prevention Plan focuses on the fact that suicide prevention is not just clinical; it does not just occur in the room between a patient and provider, it occurs in the community. And as such, we have the Governor's Challenge, we have the development of community coalitions and collaborations, and then we have the Fox Grants.

Arizona is leaning forward in each of these areas, and what we have seen out of States like, and such as Arizona is the importance of, at the State level, at the county level, forming veteran suicide prevention plans for the community that are informed and built by the community. And then we are able to come in and support, through the Governor's Challenge, we are able to come in and support through the Fox Grants. The fact that you see that with the Fox Grants is evidence of the strength of that in Arizona.

Senator SINEMA. Mm-hmm. Thank you. I still hear from my Veterans Advisory Committee in Arizona that the lack of a cohesive network creates challenges for veterans. So what additional resources do veterans have to find a community after their service?

Dr. MILLER. I think that that is a critically important consideration because one thing that we know, and I think we are going to see this more and more in the data, there is a relationship between connection, lack of connection, and suicide, particularly for veterans. So in terms of creating a community, I think one important step is the Solid Start. To that I will defer to Dr. Black.

Dr. BLACK. And thank you, Senator. Yes, the Solid Start Program is that first critical year after separation from the Military. So those calls at 90, 180, and 365 days it is helping to connect to the community, so when our Solid Start representatives are making that call that is some of those questions as asked, and helping

connect them to their local VSOs, is one of the things that they will do.

If that is something that is an issue for the veteran it is based—those calls are based on the veteran need. So if they are saying: Yes, I am having a hard time, you know, finding community connections. That is something that will be addressed in those calls.

Senator SINEMA. And are there any metrics that we can use to gauge the growth and strength of these types of support networks?

Dr. MILLER. I think that the metrics that are associated—the first thing that comes to mind is the metrics that are associated with the Governor's challenge and the work that we are doing there. So the practical application of that would be: What is Arizona seeing in terms of the number of community collaborations that have been built, implemented, maintained. That would be an important indicator. Nationwide we just reached 1,500. How is that relative in Arizona? Is it growing? What lessons are we learning?

Senator SINEMA. I see my time has expired. Thank you, Mr. Chairman, for holding this hearing on such an important topic.

Chairman TESTER. Thank you, Senator Sinema.

So you heard my opening statement, and I think you are fully aware that 60 percent of the veterans who commit suicide don't have any engagement with the VA. Senator King has a bill that will enroll the service member before they get out of the service, in the VA. I want your opinion. Is that a solution?

Dr. MILLER. So there is the answer that I could give which is, we will review that through our Technical Consultation Team and experts and we would happy——

Chairman TESTER. Except I want your opinion.

Dr. MILLER. My opinion is that when you look at engaging preregistration, and the percent that we are able to do with that, and then you look at how that converts to pre—or how that converts to enroll enrollment, there is a gap. So the short answer is, if you can cut that gap down between preregistration and enrollment, and make it all the same, that just makes sense to me. But that is just Matt Miller talking.

Chairman TESTER. Well that is right—we are in front of this Committee though. Okay? If you were a "nobody" you wouldn't be here, all right. So Dr. Miller the STRONG Veterans Act includes the silent monitoring requirements of the Veterans Crisis lines.

Dr. MILLER. Yes.

Chairman TESTER. The IG was critical of that too in his report. What assurances can the VA—can you provide—can the VA provide to this Committee that Veterans Crisis Line responders are receiving the appropriate amount of silent monitoring today?

Dr. MILLER. Yes. A few things; and I think that is really important, because that is one of the keys to rebuilding trust, I think, in this situation. Number one, if you look at our staffing levels in January of '21 when this tragedy occurred, we were about 550 responders. We have since added 900-plus responders.

Why does that matter? That matters because the context of this situation is we were using someone in an overtime role who wasn't regularly a responder. My point is, we don't have to do that anymore to answer any call. So that is one step that has been necessary here.

The second step is, two forms of silent monitoring that must occur on a monthly base and be reported, 90 percent supervision, or supervisor performance monitoring, 80 percent silent monitoring. We report that on a monthly basis, as I said, and as part of the OIG recommendations we are going to be reporting that and our progress to OIG. We will not be able to close that recommendation until we reach a level that they are satisfied with.

That said, I know for a fact, because I looked at it today, we are at over 90 percent for both the supervision silent monitoring, and the silent monitor silent monitoring, two forms.

Chairman TESTER. All right; you answered my second question with that answer. So in Section 701 of the Hannon Act, and by the way this law was passed—was signed in a law in 2020; it implements new telehealth access grants, the VA doesn't expect to be able to give awards out until 2025, not to beat this, but 2020 is when it was signed into law, we are not going to get any grants after 2025, telehealth is really important in a rural State, I think it is important in an urban State too, quite frankly. What can you guys do to expedite that roll out? Or are you happy with that timeline?

Dr. MILLER. We are not happy with that timeline.

Chairman TESTER. Okay.

Dr. MILLER. I think that in talking to those who are leading this particular effort my understanding and perception is that we are not happy, we have looked at options to expedite, there has been some consultation that is needed to occur with OGC, and OGC has found themselves needing to fill in some details toward enactment. And the impression that I got in talking with them is, it is better to measure twice, cut once, than to do it wrongly, legally.

Chairman TESTER. I got it.

Senator KING [continuing]. In months.

Chairman TESTER. Yes.

Senator KING. That is a standard I——

Chairman TESTER. That is a very good point, Senator King. I would also point out that that we are—if it takes us 5 years to do a telehealth grant to get them out the door, we have got no hope to ever get electronic medical records done. We have just got no hope.

Dr. MILLER. We were, I think, very quick and efficient with Staff Sergeant Parker Gordon Fox, so I think there is hope.

Chairman TESTER. Okay. The last question, because we have got another panel, though I will defer to the Ranking Member if he has another question; and maybe even to Senator King, but it had better be a damn good one.

Recently, we introduced the bipartisan Not Just a Number Act, Senator Boozman was just here, we introduced it together, it requires a VA to examine association between veterans' use of VA benefits and suicide. I think you could also bring in the point that Senator King talked about, about financial difficulties.

Dr. MILLER. Mm-hmm.

Chairman TESTER. Dr. Miller, how could Outreach do an analysis of veterans who use VBA programs help? Do you think it would?

Dr. MILLER. Let me give you——

Chairman TESTER. Do you think it would be worth the time spent to look at them?

Dr. MILLER. Yes, sir. Let me give you an example to illustrate. REACH VET is considered a leader, nationwide and internationally, in risk prediction for suicide. REACH VET is based primarily on clinical factors pulled from the medical chart. We know that from looking at the data the majority of veterans who die by suicide by firearm don't show up in the top 50 percent of risk for REACH VET. They show up in other areas that are outside of the clinical. So then the short answer founded upon that is, yes, sir.

Chairman TESTER. Okay. Senator Moran.

Senator MORAN. Thank you, Chairman. I will use my time of my opening statement that I didn't give, to just ask a couple of clarifying questions. First of all, Senator Tillis, in Asheville, your answer to him involved that—and the question that I want to raise is about the lack of suggestion, or recommendation, or appointment to community care. And your answer was that we think that there was a policy in place that we were trying to keep our patients within the VA, we believe we provide better service. And you indicated, I think, Dr. Miller, that the Asheville staff was being retrained or trained to get this right; is that—did I make that up, or that is what you said?

Dr. MILLER. I think the only thing that I would suggest modification on, is I don't know that there was a policy in place. I think that there was a communication about the general spirit of VA provides great care, let us provide great care.

Senator MORAN. And the point I was—that is what you said. The point I want to make is that the directions, though, were given to the hospital at Asheville, not more broadly within the VA?

Dr. MILLER. Yes. In this particular OIG, all——

Senator MORAN. Because OIG pointed this out?

Dr. MILLER. Yes.

Senator MORAN. I would say that it is happening across the country, that that is not a policy, but this belief that the VA provides the best service, and therefore community care is often not suggested to a veteran. I hear about it consistently at home, I hear about it from my colleagues, and it is not what the MISSION Act says. The issue there is that you can have community care, if your wait time is too long, or if it is in the best interest of the patient, the veteran, determined not by the VA, but by the veteran and his or her provider.

Dr. MILLER. Yes. Well——

Senator MORAN. I am restating what the law is, but it is not, ever been clear to me that the VA is interested in making community care that widely available, and I think it is particular important in this hearing, where mental health services are rare, hard to find, within the VA, and sometimes outside the VA, we don't have enough providers anyplace. But it is also important because it can be a life and death circumstances, and the failure to suggest community care is one of those life and death circumstances.

It, again, is not in compliance with the law as we wrote it and I wish that your answer would have been, the VA is now providing direction to all VAs, all VISNs, all hospitals, all providers that com-

munity care is an option in the circumstance, particularly when a veteran cannot get an appointment within the VA.

Let me ask a more technical question. I think you have said that if you are suggesting ideation of suicide, you can get an appointment within 24 hours; did I hear that? Or is that true?

Dr. MILLER. That is not what I meant to say in that particular context. What I think I was talking about was same-day access that any veteran should be able to request and there should be an option for it at the VA facility, or the community-based outpatient clinic. Now, with that said, yes, there should be immediate access for any veteran who is experiencing suicidal thoughts.

Senator MORAN. The point I want to try to make sure I understand is, I think you said: we could get an appointment within that time frame. And does "get an appointment" mean you are seen by a provider? Or does "get an appointment" mean you are scheduled to be seen by a provider?

Dr. MILLER. No. In this case, in a crisis, if we are talking about— and we are not even talking about an appointment; let us say we are talking about an encounter, an engagement, you go and do the appointment after the fact, just to make sure that it is logged into the system. That is what should occur with same-day access, and with the certain——

Senator MORAN. Same-day access is different than getting an appointment. Same-day access is same day access, getting an appointment is something that is written on a piece of paper and——

Dr. MILLER. Yes.

Senator MORAN. All right.

Dr. MILLER. What you are highlighting is a nuance that I think is important, and that is that there are different dimensions of access. There is emergency access, there is routine first appointment, and there is follow-up episode of care. What we need to do in the VA, is be carefully watching, providing for, and monitoring all three types of access.

Senator MORAN. You are talking VA health care broadly; or VA health care as it relates to mental health and suicide?

Dr. MILLER. Well, I would argue broadly. However, mental health specifically is unique somewhat in that you commonly see the need for emergency first appointment routine follow-for episode of care.

CLOSING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. And now for my closing statement Mr. President—Mr. Chairman, which was the opening statement: I had a veteran from Kansas visit my office today, this morning, and this is her story, she shared that after the beginning of mental health treatment at a Kansas VA Medical Center. She was referred to a local Vet Center because of staffing shortages at the VA Health Center. When she reached out for an initial appointment with the counselor at the Vet Center she was told their case load was already full, unless she was experiencing suicide ideation they would not be able to prioritize her.

Six weeks later the veteran received a follow-up call from the Vet Center saying: We will not be able to help you at all. We don't have the staff. I think was the point. That is now months ago, and she

has had no follow up, no effort to re-engage, never met with a counselor.

And unfortunately, I don't think this is an isolated circumstance. And so this is an example, and I heard this with Senator Murray in her conversations about the number of days. I heard it with Senator Blackwell. And the number of days for care and treatment for an appointment, for attention for—and so the other point that I make is not one time, this veteran said, did she ever hear anything about the possibility of going to the community, because both the hospital and the Vet Center failed her for lack of capability of seeing her due to staffing shortages.

It is why my support for community care is not at all based upon any bias against the VA, it is that too many veterans fall through the cracks when there is, the reason that we created community care in the MISSION Act, was a result of their lack of capabilities of a hospital in Phoenix meeting the needs of our veterans, and so we gave all—initially Choice and then the MISSION Act, we gave an option to try to solve the staffing shortages.

They still exist, and the law says a veteran is entitled to, in many circumstances, care in the community but they don't know it if the VA doesn't tell them, and if the VA doesn't make it available for them. What am I missing?

Dr. MILLER. Nothing, sir. Message heard.

Senator MORAN. Thank you.

Chairman TESTER. And that was at a CBOC in Wichita?

Senator MORAN. It was at a hospital in Kansas.

Chairman TESTER. A VA hospital?

Senator MORAN. A VA hospital in Kansas.

Chairman TESTER. Okay. Yes. Look, thank you guys very, very much. I appreciate you being here Dr. Miller. I wished to let Dr. Black speak more, but you did—you did a fine job answering the questions. We appreciate you both being here.

I think as the Ranking Member said to me a bit ago, we have had so damn many hearings on mental health, and it doesn't seem like anything has changed. And there is no doubt in my mind that you want to do the best for our veterans, and you are trying to do the best for your veterans, and this was really frustrating for me to say, but we have got to do better. We have just got to do better.

This is just—this isn't saleable. It is keeping people out of our military when we need more people in our military. It is ruining lives. It is ruining families. And so we all need to work together to make sure this happens, and please know that this Committee would probably give you anything you ask for when it comes to mental health. We just need to make sure that what you are asking for is something that actually will make a difference. Thank you.

Senator MORAN. Mr. Chairman, the legislation that we are talking about, John Hannon——

Chairman TESTER. Yes.

Senator MORAN [continuing]. It is a result of your leadership. I chaired the Committee when this legislation was passed. It was your piece of legislation named after a veteran in Montana.

Chairman TESTER. That is correct.

Senator MORAN. This matters to you, it matters to me.

Chairman TESTER. Yes.

Senator MORAN. And I want to be helpful to you. This Committee does want to work together with the Department of Veterans Affairs to save lives.

Chairman TESTER. Yes. Amen. And so we are all on the same page here. Okay. Thank you for your time. We are going to get the next panel going. Thank you.

I will start by welcoming our witnesses to the second panel. First up is going to be John Eaton, who is the Vice President of Complex Care at the Wounded Warrior Project.

John, I will tell you, earlier today I got to meet with some women from the Wounded Warrior's Project, and I will tell you that it was enlightening and beneficial for me, and I am glad you sent them over, if you did, or somebody did, but it was a nice conversation.

Then we are going to hear from Gilly Cantor. And I am going to tell you, Gilly, you are the first "Gilly" I ever met. Okay. And it is good to have you here. You are the Director of Evaluation and Capacity Building for the D—D'Anielo—better yet—Institute for Veterans and Military Families, at the great University of New York, Syracuse. And it is good to have you here.

I would ask you to keep your comments to 5 minutes as with the previous panel. Please know that you are full written statement will be a part of the record.

We will start with you Mr. Eaton.

PANEL II

STATEMENT OF JOHN EATON

Mr. EATON. Thank you, Chairman Tester, Ranking Member Moran, and the distinguished Committee members, for this opportunity to speak.

Since 2003, Wounded Warrior Project has been working to transform the way America's injured Post-9/11 veterans are empowered, employed, and engaged in their communities. For the past 20 years, we have supported warriors through and beyond their transition to civilian life with services in mental health, physical health, peer connection, career counseling, and financial wellness. We currently offer these services to over 195,000 veterans across the country, and we are welcoming hundreds more every month.

Our vision to foster the most successful, well-adjusted generation of wounded service members in our Nation's history brings with it the responsibility to identify, address, and serve the mental health needs of the veterans who reach out for help. In our 2022 Annual Warrior Survey, nearly all respondents reported experiencing post-traumatic stress, traumatic brain injury, or other mental health injuries during their military service, 83 percent reported experiencing more than one.

Outreach and awareness-building have been critical parts of our mission because, sadly, many veterans don't seek the help they need due to fear of being negatively labeled, or they don't know the programs and services that are available to them. Wounded Warrior Project is here to help them, at no cost, get the specific type

of mental health help they need to take the next step on their journeys to recovery.

Of course, we believe no single organization can meet the needs of our injured veterans. We also believe that evidence-based mental health treatment works when it is available and when it is pursued. However, the best results will be found when we embrace a public health approach focused on increasing resilience, improving psychological well-being, and building an aggressive prevention strategy. VA is our biggest and most important partner in that pursuit, and it is critical that we give them the tools they need to succeed.

Our written statement outlines several ways that Congress can help. But this afternoon, I will focus on five important steps that this Committee can take to help take the veterans suffering from the invisible wounds related to their service of our Nation.

First, we have to reduce wait times for accessing mental health. VA's access standard is reasonable on paper, but the practical experience for many veterans who ultimately seek care through Wounded Warrior Project indicates that many of them are being offered appointments well beyond the target, without any clear discussion with their provider about how care may be found more quickly in the community.

In addition, the lack of a consistently applied access standard for residential rehabilitation care for mental health, has essentially resulted in no true access standard for care. Fortunately, both the Making Community Care Work for Veterans Act, and the Veterans Health Act offer solutions to both of these problems and improvements over the status quo.

Second, we have to acknowledge and respond to the fact that access to care issues at the VA are a symptom of a larger challenge of needing more mental health providers. Recent HHS research indicates that 164 million Americans live in areas with mental health professional shortages, and so it is no surprise that VA is facing several shortages in psychology, psychiatry, and social work in many of its facilities.

To address these problems, we call on Congress to pass the VA Careers Act and the Mental Health Professionals Workforce Shortage Loan Repayment Act, the first of which would help VA recruit and retain more mental health providers, while the latter would address the fact that mental health isn't just a veteran problem; it is an American problem, and we simply need to get more providers in the field.

Third, we should to continue encouraging VA to leverage telehealth as a means of making care more accessible. Veterans who share their stories with us through surveys and action, often prefer telehealth for its convenience; however, those preferences should not be assumed, and veterans should be provided with clarity and transparency when telehealth is available as an alternative to in-person care. We believe that telehealth should satisfy access standards only when a veteran has agreed to it, with a clear understanding of their options.

Fourth, we continue to support investment in VA grants and partnerships within the community to provide upstream suicide prevention services. We remain hopeful that the Fox Grant Pro-

gram will become a permanent fixture in VA's public health strategy. However, we believe that attention should be given to how service eligibility determinations are made and how clinical care can be responsibly provided before the program is made permanent.

Fifth, and finally, we encourage this Committee to take care in understanding that brain health is not always synonymous with mental health, and that there are steps we can take to improve the quality of life and mitigate factors for suicide among those who have suffered traumatic brain injury. A growing body of research is showing a greater association between TBI and suicide. And while TBI often co-occurs with a mental health diagnosis, we encourage stronger support and long-term care to address the care and financial stressors that can affect those with moderate to severe TBI.

To that end, we urge Congress to pass the Elizabeth Dole Home Care Act, and Expanding Veterans' Options for Long-Term Care Act, which would collectively serve the long-term needs of younger veterans who need this care earlier in life.

In closing, I want to thank this Committee for the invitation to testify. And welcome your questions.

[The prepared statement of Mr. Eaton appears on page 54 of the Appendix.]

Senator MORAN. Thank you. Gilly Cantor.

STATEMENT OF GILLY CANTOR

Ms. CANTOR. Thank you, Mr. Chairman, Ranking Member Moran, and Members of the Committee. Thank you for this opportunity to testify.

I am Gilly Cantor. I serve as the Director of Evaluation and Capacity Building at the D'Aniello Institute for Veterans and Military Families at Syracuse University.

Our contribution to this conversation is rooted in upstream approaches to suicide prevention. For 10 years, we played a key role in building and evaluating networks of health and community-based social service organizations, originally those are part of our AmericaServes Initiative, which is in 18 communities across the country.

These collaborative models have demonstrated that helping veterans navigate to the full scope of services and resources they need beyond clinical interventions alone is an integral component of suicide prevention. At the same time, we have witnessed unprecedented effort from this Committee, and Congress, and the VA, to better integrate communities into suicide prevention strategies. It is the strong belief of the IVMF, and on behalf of our partners, that we must not give up on the promise of these efforts, but rather ensure that they live up to their potential.

So today, I would like to reinforce why communities remain essential to effective suicide prevention, and I would like to demonstrate that establishing transparency and accountability between the VA and communities, at scale, is both achievable and necessary.

There are three findings I want to highlight from a study that we did with the VA Center for Health Equity Research and Promotion. We looked at collaboration between AmericaServes networks, and VA medical centers and their communities.

First, we found high overlap between AmericaServes and VA data, even in communities with low levels of partnership. In other words, many veterans enrolled at the VA are, unquestionably, also receiving services in their communities.

Second, veterans served by both the VA and the community were comparatively younger. They included more Black, Hispanic, and women veterans, and they had more health-related social needs, like housing and food security. So in other words, communities are reaching the most marginalized veterans experiencing the most hardship.

And third, when partnerships were strong, veterans receiving healthcare from the VA and services in the community, were more likely to have those needs successfully met. So when we work together, the stressors impacting veterans' well-being can be more effectively addressed.

Broader research shows, and this was talked about earlier, that these economic, social, and interpersonal circumstances increase the risk of suicide. Imagine what more we could do if non-health data like this was examined regularly and shared. We must support legislation like the Not Just a Number Act, and bring all the data the VA and communities have to bear on this issue.

Additionally, we know from our own evaluation of AmericaServes in Pittsburgh, that hundreds of veterans are formally referred between the VA and the community each year, because this data is meticulously tracked, the VA has full access to this information. This level of transparency is also happening in other places, such as North Carolina and Texas, but it is not happening everywhere.

Finally, I would like to share opposing accounts we heard during our roundtable with 11 of our partners who are recipients of the Staff Sergeant Fox Suicide Prevention Grant Program. In one community, the Suicide prevention coordinator sat shoulder-to-shoulder with the grantee. They streamlined enrollment into the VA for those who screened eligible due to the risk.

In other communities, suicide prevention coordinators were hardly aware of the program, and the ability to facilitate that enrollment was not happening. We need to make these successful communities the rule and not the exception.

We have submitted a full brief as a statement for the record on that roundtable, and encourage the Committee and the VA to consider its findings. And we are happy to talk about it as much as they would like.

If there is one message that I would like to leave you with, in light of some of the tragic things that have happened, again, focusing upstream, it is this: We think there is more to be hopeful about than there is to criticize. We are all here because the stakes remain high and the consequences of failure are quite, literally, existential. But we have collectively taken meaningful action and effective steps toward our shared goal.

We simply need to monitor our progress and have the courage to adjust course along the way if necessary. Thank you.

[The prepared statement of Ms. Cantor appears on page 70 of the Appendix.]

Chairman TESTER. I want to thank you both for your testimony, and I want to start by commending you both for the work that you and your organizations do. I will tell you, I like the optimism of saying that we have more to be thankful for than we do to be critical of. You know, if this was an easy issue, we would have had it settled a long, long time ago. The human mind is a hard thing to try to figure out how it works, and there is proof around this place all the time, so it is an interesting situation.

I am going to start with you, Mr. Eaton. As I indicated in my introduction of you, this morning some women from the Wounded Warrior's Project came to my office, and I talked about a lot of things, including a survey that Wounded Warrior's Project just did about women veterans. Could you give me an idea on what that survey said about mental health, if it said any—I haven't had a chance to read the documents they gave me, okay, but if it said anything about mental health, could you talk about that? And if there are solutions, talk about those too?

Mr. EATON. Yes, thank you, Mr. Chairman. And thank you for meeting with the women warriors from Wounded Warrior Project. Just yesterday, we released the report, so the 2023 Women's Warrior Report; and it was based on surveys, as you mentioned, from 5,000 women warriors from our alumni, as well as in-person focus groups across the country, to really collect qualitative and quantitative data.

The findings across multiple areas, you know. To name a few: access to care, transition from military to civilian life, as well as financial wellness. With respect to the mental health area, anxiety and depression were the top two health challenges reported by women warriors. And research shows that women are more likely to show moderate to severe symptoms, as well as PTSD symptoms, than our male warriors.

Also, a higher percentage experienced loneliness and isolation compared to men as well, which is hugely detrimental, as we know and have discussed today, to our overall mental health.

There is good news that came out, one of which women were found to score higher on resiliency measures, and eight out of ten women warriors reported—have accessing professional help at least 12 times over the last year. So we are, as a population, very resilient and engaged in their mental health and wellness, which is a really good finding.

And so what can we do? You know, what we have taken away is really the opportunity to focus on transition, and how do we ease the stress and foster better connections to other veterans and support networks and after service, as well as making the VA a more desirable place for care by making it easier to access with appointment times and gender-specific care; and finally, additional research that can be done to understand the whys behind how men and women are experiencing trauma, and thus, seeing the results of the survey.

Chairman TESTER. Was there any sort of conversation around how well the VA is doing?

Mr. EATON. So that is a topic we discussed with veterans across all of our alumni, and over 90 percent of our alumni report using the VA for their services. When we think about access to care, we hear the same feedback from our female warriors as we do male warriors, and you know, long wait times perhaps, and how that affects, you know, it is really important when we are at the moment of readiness to really capture that momentum, and oftentimes without that, we are seeing poor health outcomes, both mental, physical, family, and relational issues as well.

Chairman TESTER. So Gilly, this next question is for you. The Not Just a Number Act is a bill that we have—and Senator Boozman, I appreciate your mention of it—because I think suicide goes way beyond just mental health practices. This bill would also look at things like disability compensation, education, employment benefits, home loans, foreclosure assistance, housing assistance programs.

From your seat, how could you—from your seat, tell me your analysis of veterans who use VBA programs and how this bill could improve VA suicide prevention efforts?

Ms. CANTOR. Sure, I don't know a lot about exact likelihoods, or things like that, but I do know of a recent Brown University Study that looked at Vietnam veterans, specifically, and their usage of disability compensation, and it was directly associated with certain improved health outcomes, which just tells you that there is a lot more to look at there.

And I think that if we can't look at that data regularly, then we are doing something wrong. And I think that in order to make that possible, it wouldn't surprise me if it there is sort of some underlying infrastructure problems, technology-wise, and gets into the weeds, and it is boring data stuff. But I really think that part of it has to do with how different agencies, including within the VA, track data, and it doesn't line up.

We have seen it between DoD and VA, it is even within VBA to VHA. It is really hard to match things up and to look at things really clearly and get an understanding of what is going on without taking years to do a research project. And that is a problem.

Chairman TESTER. Okay. Thank you both very, very much.

Senator MORAN.

Senator MORAN. Senator King, I would be happy if you would like to go next.

Senator KING. I will go after you.

Senator MORAN. Let me start with you, Mr. Eaton. Thank you very much for being here today. Thank you for your work on behalf of Wounded Warrior's Project. I appreciate very much your remarks in your testimony, and your written testimony about the Veterans Health Act. It reflects an effort by Senator Sinema and I on a topic that we have been trying to be prevalent on and relevant on today.

Could you discuss in detail, more detail how the VA's current misinterpretation of access standards set forth in the MISSION Act are having a consequence on veterans' access to care?

Mr. EATON. Yes. And thank you for the question. You know, we discussed in our written statement, so the VA's MISSION Act, you know, standards that do not exist around the critical mental health

rehabilitation programs. So instead, veterans and advocates are left to really interpret that VHA directive, and in our experience, it provides little predictability on acceptance of referrals, length until a decision; and other really important factors when we know that time is of the essence.

What we are seeing in our C3, our Complex Case Coordination Program, works with the most in-need warriors who are experiencing mental health concerns, and oftentimes an RRTP is an indicator for their care. And so what we are seeing, though, you know, local policy variations that are, again, unpredictable referrals, lengthy wait times, and really not a formally calculated way to be consistent about how we are understanding those options so we can advocate for the veteran. And what also comes as a result is that alternative treatment options that could result in a community referral or an inter-VA referral aren't taking place.

And so, you know, in totality, that really just shows that, you know, what we are seeing is veterans are not accessing the care they need when they need it, and delays in finding that appropriate care really enable our opportunity to capitalize on the momentum and the willingness to get that treatment, which oftentimes is years in the making and really important.

Senator MORAN. Mr. Eaton, from time to time I am told that the reason that the VA is not making referrals for community care is the lengthy wait times in the community. Is that anything that you hear, and what is the reality there when we know there are wait times also at the VA?

Mr. EATON. Sure. And that is a great point. I think as we talk about mental health shortage, it is obviously something that is not only seen within the VA. And so it is very regional-specific, and that is why our team looks at all options, the primary, working with the VA within that program to establish their holistic care within that system of care. What I know is that we have a very cultivated group of partners from RRTP programs that are part of the Community Care Network, and it would be our experience that we have very quick response times for when those needs arise.

For example, we serve over 6,000 warriors a year with outpatient mental health services, with wait times less than 14 days for a first appointment, and generally in most cases. And so I think, depending on the region, it could be a better choice, whether it is VA or a Community Care Network. But ultimately, we really feel the veteran should have more visibility into that conversation.

Senator MORAN. Thank you for that answer.

Ms. Cantor, you, in your testimony, talk about the recent convening of 11 organizations who are Hannon Fox grantees. This takes me back to my first question earlier: Would you elaborate on the need for the VA? You talk about the screening issues remain a barrier, elaborate on the need, or what the VA could do to open up the eligibility standards to meet the needs of veterans who we are trying to reach and better serve.

Ms. CANTOR. Sure. So one of the issues that came up was around who is eligible, and then also on which services are eligible at which points. And I really appreciated how Dr. Miller described the tension that is going on between trying to get it to be the right people and the right things. And I think that what we are seeing and

what the communities are saying is that depending on which screeners—individuals screen for risk, some, not others, and it depends on the person, that that can cause people to screen ineligible.

And so they are looking for more flexibility in which screeners they use, or the possibility of making sure that as long as they are screening on one, even if not the other, that that constitutes enough of a risk for someone to get—to be eligible to be enrolled. They are also hoping that they can increase which services are eligible for coverage under the program so that they can try to do better outreach and get more people in the door in the first place, access to transportation, being able to provide food, making it a more welcoming environment for people to come in and connect with others, and address isolation, and then hopefully ask for help.

Senator MORAN. Any ways for the screening—to streamline the screening and make it more friendly?

Ms. CANTOR. They expressed a need to make it more conversational, that was one thing that came up repeatedly, and that the forms that accompany the screeners that they have to fill out would also need to be tailored to accommodate that style where, right now, it is difficult for them to do those intake screenings and then have to populate other things. And so there is sort of this extra barrier during the screening process, just for them to make sure that those conversations Dr. Miller referred to, as trying to ensure that they are not clinical conversations because the goal of this is to take the clinical element out and get more people, get more of the ten people who die by suicide that are not connected to the VA, comfortable, screened, and connected.

Senator MORAN. Any suggestion that this help from these organizations that receive the Hannon Fox grants that that would help us get to those who are not engaged with the VA?

Ms. CANTOR. I think—this is me speaking—I think it would. I think that most of them—you know, I mentioned the study we did, 70 percent of this doesn't apply to all those partners, but for those that it does apply to, 70 percent of the people that are veterans that they work with showed up in VA data. But that means that 30 percent didn't. And that is just from the veterans, they also serve family members, they also serve caregivers, et cetera. So there is—I see at least a 30 percent opportunity there for people that they are talking to every single day.

Senator MORAN. Ms. Cantor, I never thought about, when we wrote the Hannon Act that these grants to community organizations might increase the population of who is served. But your testimony, your conversation with me, that kind of a light bulb went off that, I don't know whether it is true, but it sure seems kind of commonsense to me that one way to serve more veterans, those veterans who are not engaged in the VA today, can be through a community organization.

Ms. CANTOR. Thank you for that comment. I fully agree.

Senator MORAN. Okay. Senator King.

Senator KING. I want to start with two general comments. Number one, you may wonder where everybody is. At this very moment; there is a Classified All-Senators Briefing on the conflict in Ukraine. And that this is one of the most dedicated committees in the Senate. But I just want you to understand that sometimes we

have these inevitable conflicts in terms of time. So that is what—that is where everybody is right now.

Senator MORAN. Senator King is pointing out that he and I are supposed to go as well.

[Laughter.]

Senator KING. Yes. Yes. Okay, second, in these hearings we always are talking about how we can improve things, we can do better, and they often turn into somewhat negative about the VA. I think I can tell you from the point of view of what I hear from my veterans in Maine, they really like the care that they are getting from the VA. They are impressed by the personal qualities of the people that they meet with, and they get—they get great care.

Now, one of the issues is access. The question is when do you get the care? And that is a larger issue. We have got an enormous shortage in this country of mental health professionals. In fact, we have got an enormous shortage of just about everything. One of our major hospitals just told me recently they are short 800 nurses. I mean, that is what we are up against.

So I think we need to understand that it is not for lack of trying that the VA is short-staffed, that this is a nationwide problem, in and around the VA, but just generally.

So the question is, I think, what tools can we provide to the VA that they can more effectively compete in the workforce market? And I don't expect you to answer that, but if you have any thoughts, Ms. Cantor? I want to get this——

Ms. CANTOR. That is a really—no, that is a really hard—I mean, that is a great, that is a great idea, Senator. I think one of the things that this is not necessarily helping with mental health specifically, but it is a model that could be applied. There is a great program out of New York City called "PROVE", that is a peer-to-peer model, and they train their social workers in their social work program through—to work with veterans. And thereby, in addition to helping a peer-to-peer model, which can, again, be upstream from other challenges and help people feel connected on campuses.

It is training a new workforce of culturally competent social workers. And I think that models like that could be applied outside of the social work space. It is something that could be done. I know that—I don't know the number, but it is my understanding that a huge percentage of physicians are partially trained at the VA because of the high-quality care that—and program and education that can be offered there.

It is surprising to me that it is not a more competitive and interest—and place to work that people would be interested in working.

Senator KING. Well, I do think this is something we need to think about.

Ms. CANTOR. Yes.

Senator KING. If this is a competitive marketplace, we are going to have to—for example, I learned recently, no one in the Federal Government is allowed to be paid more than the President. That is $400,000 a year. Try hiring a cardiologist for $400,000. I mean, that is the kind of thing that we need to discuss, we need to talk about waivers, and to be sure that we have access to the professionals that we need.

Telehealth, Mr. Eaton, you mentioned that, and I don't know if you are aware of the answer to this question. I probably should have asked it of the prior panel, but do we have licensure issues with telehealth? If you have got a VA facility in Augusta, Maine, can a veteran go there and get counseling from a counselor in Kentucky? Do you know?

Mr. EATON. I am not aware of the VA's approach and what they are able to do across State lines, but I do know through PSYPACT, there is a growing number, an overwhelming majority of States that are able to have cross-state service through psychology. And we leverage that within our Warrior Care Network as well as our outpatient.

Senator KING. Clearly, that is something we need to do. And in my talking with veterans and others, mental health, and behavioral health lends itself to telehealth. A lot of people are even more comfortable talking to a screen, and they don't have to wait in a doctor's office and worry about stigma, and who is in the—who is sitting in the chair next to them. And you mentioned they have got to understand their options, but I think telehealth is an opportunity to provide the care nationwide that perhaps might not be available, particularly in a rural area.

Mr. EATON. Well, a hundred percent agree. And that is what we have seen, you know, when we——

Senator KING. I like that on the record. "A hundred percent agree." I appreciate that.

Mr. EATON. During our survey with our warriors, of those that were offered telehealth services, 90 percent accepted that. And those that were not offered, only 40 percent said that if they were offered, they would not have elected that service. So we see it as, again, increasing access, increasing capacity, and it is a positive experience for veterans.

Senator KING. And one of the other, in terms of the providers, what I am told is, there is a much lower level of missed appointments; there is a better—they are getting to the appointments, which is better for the providers. So I do think that is something that we have got to—we have got to work on.

Ms. Cantor, your thoughts on telehealth?

Ms. CANTOR. I agree. I think that it makes sense for many people. I think that, similar to what we were talking about with community care, that it comes down to patient choice; and that if that is something that they are willing to do, that that makes a lot of sense. And I think, missed appointments, in particular, is a missed opportunity, and it also, with telehealth, addresses the transportation problem that is a huge cause of that for in-person visits.

Senator KING. Particularly in rural areas?

Ms. CANTOR. Particularly in the rural areas.

Senator KING. Great. Well, thank you all very much for your testimony, and I appreciate the work that you are doing. And we are in a learning mode here, so if there are suggestions, ideas, that is what we want to hear, ways that we can try to fix things, whether it is—it could be a law change, but it could also be something that we can work with the VA administratively, that doesn't involve a law change.

If there are things, and we have talked about earlier, you heard us talking about the onboarding, and the barriers to bringing new people in. So share your thoughts; we are in the idea business around here. Thank you.

Thank you, Mr. Chairman.

Senator MORAN. Senator King, thank you. Thank you for your full, lengthy participation today.

Senator KING. Sure.

Senator MORAN. Mr. Eaton, Ms. Cantor, thank you very much for your testimony. Thanks for joining us today.

The Members of the Committee will have one week to submit written questions, and we would ask the witnesses to respond to them as quickly as possible.

The Committee is now adjourned.

[Whereupon, at 5:42 p.m., the hearing was adjourned.]

APPENDIX

Prepared Statements

**STATEMENT OF DR. MATTHEW MILLER, Ph.D., MPH,
EXECUTIVE DIRECTOR, SUICIDE PREVENTION,
OFFICE OF MENTAL HEALTH AND SUICIDE PREVENTION
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE**

"INVISIBLE WOUNDS OF WAR: IMPROVING MENTAL HEALTH AND SUICIDE PREVENTION MEASURES FOR OUR NATION'S VETERANS"

SEPTEMBER 20, 2023

Good morning, Chairman Tester, Ranking Member Moran and distinguished Members of the Committee. Thank you for the opportunity today to discuss the Department's efforts to implement recently enacted laws related to Veterans' mental health care and suicide prevention, including P. L. 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) and Division V of P.L. 117-328, the STRONG Veterans Act of 2022 (the STRONG Act) included in the Consolidated Appropriations Act, 2023. Accompanying me today is Dr. Susan Black, Suicide Prevention Officer, with the Outreach, Transition and Economic Development Service in the Veterans Benefits Administration.

In 2020, 44,298 adult Americans died by suicide. Of those, 6,146 were Veterans. These numbers are more than statistics—they reflect individual lives prematurely ended and they continue to be grieved by family members, loved ones and the Nation as a whole. More work remains to amplify Veteran suicide prevention efforts alongside each of you at the national, state and local levels.

Suicide is a complex problem with a multifaceted interweaving of potential contributing factors. In addition to mental health risk factors for suicide, we must look at a broader array of other contributing factors such as sociocultural risk factors and health related social needs that are also associated with suicide ideation and attempts. Unemployment, chronic pain, insomnia, relationship strain and the death of a loved one are examples of individual factors outside the specific frame of mental health which may play a role in suicide. International, national, community and relational factors also impact suicide risk (e.g., inadequate access to care, global health concerns, war, economic crises or homelessness).[1] With no single cause, there is no single solution, and we must be comprehensive in our approach to prevent Veteran suicide.[2]

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[1] Turecki, G., & Brent, D. A. (2016) Suicide and suicidal behavior. *Lancet, 387*, 12271,227–39.
[2] Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V.,

Every death by suicide is a tragedy and we will not relent in our efforts to end Veteran suicide. We know that suicide is preventable. It is a national public health issue that affects people from all walks of life, not just Veterans. Eliminating Veteran suicide is a top VA priority, and we continue to work diligently across the Department and with Federal, tribal, state and local governments to advance a public health approach to suicide prevention. The VA suicide prevention strategy is guided by the National Strategy for Preventing Veteran Suicide 2018-2028 and is in full alignment with the President's 2021 National Strategy for Reducing Military and Veteran Suicide.[3] More specifically, the VA suicide prevention strategy advances a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety (LMS); crisis care and care transition enhancements; increased access to effective care; addressing upstream risk and protective factors; enhanced research coordination; data sharing; and program evaluation efforts.

VA's public health approach requires a focus on evidence informed clinical and community initiatives. This means maximizing prevention efforts that cut across all sectors in which Veterans may interact and collaborating with Veterans Service Organizations, state and local leaders, medical professionals, criminal justice officials, private employers and many other stakeholders. VA's public health strategy combines collaborations with communities to implement tailored, local prevention plans while also focusing on evidence-based clinical strategies for intervention. We focus on both what we can do now, in the short term and over the long term, to implement VA's National Strategy for Preventing Veteran Suicide, through the following:

- Suicide Prevention (SP-2.0) Community-Based Intervention for Suicide Prevention (CBI-SP) model; and
- SP 2.0 Clinical Telehealth model which is a clinical approach focusing on broad dissemination of evidence-based psychotherapies.

The Suicide Prevention Now Plan (NOW) aims to develop and deploy interventions that are deemed to reach Veterans at high risk for suicide within 1 year. Led by staff in VA's Suicide Prevention Program and key VA partners, the plan includes targeted mental health and suicide prevention strategies to support Veterans, Veterans Health Administration (VHA) providers and the community. The five priority areas of the Now plan are as follows: (1) LMS, which promotes secure storage of firearms so that someone at elevated risk for suicide is less likely to use the firearm to attempt suicide; (2) suicide prevention in at-risk medical populations; (3) outreach to and understanding of prior VHA users; (4) suicide prevention program enhancements; and (5) educational media campaigns.

Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., Sáiz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. Lancet Psychiatry, 3(7), 646–659.

[3] Department of Veterans Affairs (2018). National Strategy for Preventing Veteran Suicide. https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

Through CBI-SP, 50 States and 5 territories are participating in the VA Substance Abuse and Mental Health Services Administration Governor's Challenge and more than 1,500 community coalitions have been formed across the country, working together towards ending Veteran suicide. The goal is to equip communities to help Veterans get the right care delivered whenever, wherever and however they need it.

The SP 2.0 Clinic Telehealth Program was implemented through a partnership between VA's Suicide Prevention and the VHA National Clinical Resource Hub leadership team to stand up national telehealth capability to provide the following evidence-based practice treatments (EBP):

- Cognitive Behavioral Therapy for Suicide Prevention;
- Problem-Solving Therapy for Suicide Prevention; and
- Dialectical Behavior Therapy, as well as the Safety Planning Intervention.

Currently, there are over 100 clinical staff serving through SP 2.0 Clinical Telehealth. These providers are trained to offer EBPs for suicide prevention to Veterans with a recent history of suicidal self-directed violence. This service is available through all 18 Veteran Integrated Service Networks. As of September 18, 2023, since the program launched in April 2021, SP 2.0 Clinic Telehealth Program has completed over 7,000 mental health intake sessions.

According to the 2022 National Veteran Suicide Prevention Annual Report, when it comes to comparing Veterans and U.S. adults who died from suicide in 2020, guns were more commonly involved among Veterans (71.0%) than non-Veterans (50.3%). The NOW Plan facilitated the Keep It Secure LMS media campaign, which launched in September 2021 and ended in June 2023 and garnered over 2.8 billion impressions, over 1.7 billion video completions and over 26 million website visits. This campaign targeted and reached a diverse audience of Veterans and their concerned others. By increasing time and space between lethal means and individuals at risk for suicide, suicide is reduced.

VA continues to innovate in this area and in February of 2023 VA announced the 10 winners of Mission Daybreak, a $20 million grant challenge aimed at developing innovations to reduce Veteran suicide. During this challenge, VA received more than 1,300 innovation submissions from Veterans, Veteran Service Organizations, community-based organizations, health technology companies, startups and universities – with solutions ranging from lethal means safety concepts and targeted virtual care programs to other promising suicide prevention solutions that offer healing and recovery to Veterans. Mission Daybreak is the largest cash Federal incentive prize since the establishment of the Prize Authority.[4]

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[4] Department of Veterans Affairs (2023). Winners Revealed in VA's $20M Mission Daybreak Grand Challenge to Reduce Veteran Suicide*s*. https://news.va.gov/press-room/winners-revealed-in-vas-20m-mission-daybreak-grand-challenge-to-reduce-veteran-suicides/

Hannon Act

The Hannon Act was built upon this comprehensive approach, and we are pleased to report on VA's progress in implementing the Hannon Act since our last hearing on this topic in 2020. Broadly, the Hannon Act prioritized staffing expansion, targeted suicide prevention efforts, and research, establishing best practice models for mental health care delivery and providing critical oversight and accountability for mental health programs. We look forward to discussing VA progress in these areas.

Suicide Prevention

Regarding suicide prevention efforts, the Hannon Act has expanded access to critical mental health care resources. Section 201 of the Hannon Act established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), allowing VA to provide grants to eligible entities to expand suicide prevention services to eligible individuals and their families to reduce the risk of suicide. In September 2022, VA awarded $52.5 million to 80 community-based organizations in 43 States, the District of Columbia and American Samoa. These organizations provide or coordinate the provision of suicide prevention services, thereby significantly expanding services provided to Veterans in the community. In March 2023, VA prepared for the second round of grant awards by publishing a Notice of Funding Opportunity for renewal grants and new organizations to apply for grants worth up to $750,000. The application period opened March 2, 2023, and closed May 19, 2023. The review and award process are underway. Awards will be announced by September 30, 2023, for services in fiscal year 2024. In July 2023, VA held its third in-person technical assistance event for the SSG Fox SPGP grantees. This two-day event included: LMS training; program guidance and implementation strategies; and the opportunity to share grantee success stories and examples of innovative suicide prevention services from among the cohort.

The Hannon Act provided VA the opportunity to review established suicide prevention processes to identify opportunities to enhance implementation. Several clinical initiatives identified in the Hannon Act have also been implemented across VHA as part of the SP Now plan. A few examples of these initiatives include increased hiring of mental health staff in Specialty Care clinics with Veterans at high risk for suicide, the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) Program and Safety Planning in the Emergency Department (SPED).

These initiatives are having a significant impact on patient safety. As of August 8, 2023, more than 54,500 VHA prescribers, representing all VHA facilities, have prescribed naloxone to over 477,500 Veterans with over 4,210 reported opioid overdose reversals. VA also implemented REACH-VET, which uses predictive modeling to identify Veterans at highest risk for suicide and then works to outreach and engage Veterans in care. REACH-VET has been associated with increased attendance at outpatient appointments, a greater proportion of individuals with new safety plans and

reductions in mental health admissions and emergency department visits and reduction in suicide attempts. VA is exceeding benchmarks for all five REACH-VET metrics.

SPED is an evidence-based practice shown to reduce suicidal behaviors by 45%.[5] SPED promotes safety planning with Veterans who present to the emergency department with suicidal ideation, providing follow-up contact until treatment engagement occurs. Through technical assistance and individualized consultation, VA is exceeding SPED performance expectations, and the new White House strategy focused on reducing military and Veteran suicide is now looking to implement the practice in non-VA community hospitals.

Mental Health Services

VA provides mental health care services through a stepped-care model to promote mental health treatment at the least intensive level of care appropriate. Services include a full range of inpatient, residential and outpatient specialty and general mental health services available in VA and through community partners. Veterans may receive mental health care through primary care, self-directed options such as mobile apps and online programming, or through tele-mental health services.

The demand for mental health care continues to grow. The number of Veterans seen by mental health providers has doubled since 2006. VA employs 17,000 licensed mental health providers to address ongoing demand and expanding health care eligibilities; ensuring appropriate staffing levels are maintained is essential. VA is committed to not only hiring critical mental health staff, but also enhancing opportunities to train and develop mental health care professionals to address the national shortage. VA is committed to the mental health staffing model outlined in Section 501 of the Hannon Act. The VA has experienced tremendous mental health staff growth over the last 2 years. The Secretary and Undersecretary for Health are committed to hiring efforts targeting mental health staff and leveraging the staffing model developed in response to the Hannon Act. While at the early stages of the initiative, VA recognizes staffing efforts must continue to enhance access to care for underserved and rural areas of the Nation. To enhance hiring opportunities, VA continues to build on the occupational series for Licensed Professional Mental Health Counselors and Marriage (LPMHC) and Marriage Family Therapists (MFT). Since 2019, the number of LPMHCs and MFTs working in VA has more than doubled, and we are excited to continue to expand staffing across the enterprise.

Finally, recognizing the availability of mental health staff across the Nation is limited, the Hannon Act created opportunities to "grow our own" through educational

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[5] Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., Chaudhury, S. R., Bush, A. L., & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*, *75*(9), 894–900.

scholarships. Hannon Act Section 502 authorizes Readjustment Counseling Services (RCS) to provide scholarships to individuals seeking mental health related advanced degrees in psychology, professional counseling (LPMHC), marriage and family therapy (MFT) and social work (MSW). The individual recipients will be required to work at a Vet Center for 6 years after graduation. RCS has completed the required regulatory process and partnered with the associated VA scholarship program offices have awarded the initial 29 scholarships for the fall semester 2023. These scholarships include tuition, book vouchers and monthly stipends and priority was given to Veteran applicants (17 awards). RCS is moving to a rolling application period with ongoing review and award for future semesters. RCS is continuing targeted outreach to universities in hard to recruit areas including rural and tribal communities. In addition, RCS is also engaging with professional organizations such as the American Psychological Association. These actions are designed to increase application submission from all professions.

Mental Health and Suicide Prevention Research

Opportunities to expand research to increase our understanding of suicide risk factors is a critical component of the Hannon Act. For example, VA is funding a study of the relationship between altitude and suicide among Veterans. This work is being led by a team of investigators from the Durham VA Medical Center in North Carolina working in collaboratively with investigators from the Department of Energy and using the supercomputer resources of the Department of Energy. The study began June 1, 2021, and is on track for completion within the Congressional timeline.

To expand our understanding of medical risk factors associated with suicide risk and increased mortality, VA initiated a contract with the National Academies of Sciences Engineering and Medicine (NASEM) in September 2022 that will continue through September 2024. The purpose of the contract is for NASEM to "to evaluate the effects of opioids and benzodiazepine on all-cause mortality of Veterans, including suicide." In the coming months, we anticipate the investigators will be presenting their independent analyses to the NASEM Committee, and the Committee will continue to meet in 2024, review the data analyses and prepare their final report.

The Hannon Act addressed opportunities to enhance health care practices through new and updated systematic practice reviews and in establishing tool kits for VA and community health care providers. Recognizing the critical importance of Clinical Practice Guidelines (CPG) for the treatment of serious mental illness, VA established two distinct workgroups of national experts to review best practices in the management of bipolar disorder and in psychosis. In 2023, VA and the Department of Defense (DoD) published new CPGs for bipolar disorder and for first-episode psychosis and schizophrenia. Additionally, the workgroup updating the VA/DoD CPG for Assessment

and Management of Patients at Risk for Suicide (2019)[6] is actively engaged and on track for publishing the updated CPG in 2024. The Hannon Act also directed VA to assemble a provider toolkit and training materials for treating mental health comorbidities in collaboration with DoD. This toolkit is an assembly of publicly accessible resources for managing a wide array of mental health conditions, including violence and anger, cognitive disorders, moral injury, obsessive compulsive disorder and mood disorders, among others.

STRONG Act

The STRONG Act contains more than two dozen sections that bolster VA's efforts to support Veterans' mental health and supports Veterans' equitable access to VA's life-saving resources by expanding mental health outreach to traditionally underserved Veterans, developing and delivering the most effective treatments, better equipping VA's workforce to provide care and further strengthening VA's Veterans Crisis Line (VCL). The STRONG Act requires VA to update training for the VA workforce and VCL staff, implement pilot programs, expand access to mental health care, conduct analysis and research and provide outreach to Veterans regarding mental health resources.

The STRONG Act aligns with VA's top clinical priority of preventing Veteran suicide and connecting Veterans with the best care through the expansion of culturally competent mental health and suicide prevention services to traditionally underserved Veterans and increased staffing and staffing across mental health disciplines.

VA has already successfully met the requirements of 3 of the 27 substantive sections contained in the law. Two of the completed sections are in title II of the Act, which focuses on VCL quality improvement action. The VCL is a national call center with trained responders available to any Veteran, Service member, or their loved ones 24/7/365. Launched in 2007, the VCL started with 14 trained responders working out of a call center in Canandaigua, N.Y. To date the VCL has responded to over 6 million calls, chats and texts and issued over 1 million referrals to local Suicide Prevention Coordinators. Beyond the call, VCL initiates the follow-up with caring letters, an evidence-based intervention found to reduce the rate of suicide death, attempts and ideation (Reger, et al. 2019). VCL services are enhanced by the Peer Support Outreach Call Center, providing outreach by certified peer specialists to support hope and recovery-oriented services after the initial call to VCL.

Through Congressional legislation and a Federal Communications Commission directive, VCL partnered with the Substance Abuse and Mental Health Services

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[6] Use Department of Veterans Affairs (2019). VA/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide, https://www.healthquality.va.gov/guidelines/mh/srb/

Administration and the 988 Suicide and Crisis Lifeline to establish 988. After the 988 roll out July 2022 through September 7, 2023, VCL demand has increased by the following amounts across phone, text, and chat services:

- Phone-based demand increased by 12.77% compared to the same time from the previous year.
- Text-based demand increased by 43.34% compared to the same time from the previous year.
- Chat-based demand increased by 10.78% compared to the same time from the previous year.

VCL is actively expanding operations to maintain the quality crisis intervention and mental health support services it provides. Since February 2021, VCL has grown from 877 full time employees (FTEE) to 1,812 FTEEs. In addition, VCL currently has 1,082 FTEE crisis responders, compared to 541 FTEEs in February 2021 . The implementation of title II and all the remaining sections is ongoing through collaboration with internal and external stakeholders.

Economic Factors Related to Veteran Suicide

Some Veterans report difficulty in transitioning to civilian positions and difficulty translating military-related skills to higher-paying civilian jobs. Unemployment and poverty are correlated with homelessness among Veterans. Financial hardship and economic stressors are major predictors of Veteran suicide. The Veterans Benefits Administration (VBA) provides a variety of benefits and services upstream which can help reduce or eliminate risk factors associated with suicide and promote protective factors for some Veterans. Programs such as Solid Start, Disability Compensation, Pension, Veteran Readiness and Employment and Education/GI Bill assist Veterans with transitioning to civilian life, connecting with benefits, establishing and achieving educational, vocational and career goals and supporting financial well-being.

VA Solid Start (VASS)

The first year after separation from military service poses challenges for recently separated Veterans that can make it difficult to adjust to civilian life and, for some, increase their risk of suicide. To provide added support during this critical period and to support VA's efforts to address Executive Order 13822, Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life, VBA launched VASS in December 2019. VASS provides early and consistent caring contact to newly separated Veterans at least three times during their critical first year of transition from the military (0-90 days, 91-180 days and 181-365 days post-discharge from active duty). Specially trained VA representatives address issues or challenges identified by Veterans during these calls and assist them with accessing benefits, services, health care (including mental health care), education and employment opportunities. After each successful connection, the Veteran receives a comprehensive follow-up email from the VASS representative that provides information on all issues discussed and lists connections

for additional support and assistance. This email specifically provides contact information for service organizations and connections to state Veteran resources, based on information provided by the Veteran as to where they currently or intend to reside. For fiscal year 2023 (through August) VASS has connected with 186,301 (71.3%) eligible Veterans. VASS also provides priority contact to individuals who had a mental health care appointment during the last year of active duty, supporting a successful transition to VA mental health care treatment.

Outreach, Transition and Economic Development (OTED) Service

In addition to VASS, OTED provides the Transition Assistance, Military to Civilian (M2C) Ready Framework, Financial Literacy, Economic Development Initiatives, Outreach and Personalized Career Planning Guidance. The M2C Ready Framework is a joint VA and DoD codified transition period beginning 365 days prior to separation and extending 365 days post-separation. It ensures successful and holistic interagency support for Service members and Veterans as they transition from military to civilian life. These programs also provide understanding of and easy access to VA benefits and resources to ensure Service members have a smooth and successful transition to civilian life. In addition, transitioning Service members, Veterans and their families are educated about employment opportunities, special hiring authorities and career support resources. Financial empowerment information and tools through partnership with the Department of Labor, DOD and Prudential is also offered. Additionally, outreach events focused on raising awareness of suicide prevention and available resources such as information on VCL and the new Dial 988 then Press 1 for the VCL is shared.

Providing support to Service members during their transition, both prior to and following their separation, is critical to preventing suicide in Veterans and transitioning Service members. Collaboratively, VHA and VBA utilize several programs to provide benefits and services aimed at helping reduce or eliminate risk factors associated with suicide while increasing protective factors for Veterans.

Conclusion

We appreciate the Committee's continued support and collaboration in this shared mission. Mr. Chairman, this concludes my statement. My colleague and I are ready to answer any questions you and the committee may have.

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WOUNDED WARRIOR PROJECT

Statement of
John Eaton
Vice President for Complex Care

On

"Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for Our Nation's Veterans"

September 20, 2023

Chairman Tester, Ranking Member Moran, and distinguished members of the Senate Committee on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit this written statement for the record of today's hearing on mental health and suicide prevention. We share your commitment to easing the pain of veterans who are suffering from invisible wounds and appreciate the opportunity to offer our perspective on potential congressional action to improve post-9/11 veterans' access to mental health care and suicide prevention measures.

For 20 years WWP has been dedicated to our mission to honor and empower wounded warriors. In addition to our advocacy before Congress, we offer more than a dozen direct service programs focused on connection, independence, and wellness in every spectrum of a warrior's life. These programs span mental, physical, and financial domains to create a 360-degree model of care and support. This holistic approach empowers warriors to create a life worth living and helps them build resilience, coping skills, and peer connection. Our organization has grown alongside the warriors we serve, and we strive to tailor our programming to the evolving needs of a post-9/11 generation of warriors that has become increasingly diverse. Our reach extends to more than 195,000 veterans who are being served in various ways across the United States.

In this context, assisting warriors with their mental health challenges has consistently been our largest programming investment over the past several years. In Fiscal Year 2022, WWP spent more than $82 million in mental and brain health programs – an investment consistent with the fact that more than 7 in 10 respondents to our 2022 Annual Warrior Survey self-reported at least one mental health condition, and nearly the same amount (66.3%) reported visiting a professional in the past 12 months to help with issues such as stress, emotional, alcohol, drug, or family problems.[1]

[1] WWP's 2022 Annual Warrior Survey can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.

As diagnoses of post-traumatic stress disorder (PTSD), depression, and anxiety have consistently ranked among the top five most self-reported conditions across previous editions of our Annual Warrior Survey, our Mental Health Continuum of Support has matured over the last decade and now allows us to engage each individual based on their unique needs.[2] WWP supports warriors by providing accessible and innovative solutions to mental health support including four programs focused specifically on mental health: Warrior Care Network, WWP Talk, Project Odyssey, and Complex Case Coordination. Each of these programs are designed to support and empower post-9/11 veterans and their families in building resilience and overcoming the challenges before them. Through these four programs in Fiscal Year 2022 alone, WWP provided warriors and their family members with nearly 55,000 hours of treatment for mental health conditions, including PTSD, traumatic brain injury, substance use disorder, and other mental health conditions.

Of course, WWP believes that no one organization can meet the needs of all wounded, injured, or ill veterans alone. Partnerships with and investments in other military and veteran support organizations help guide collaboration that allows WWP to amplify the effects of our efforts. For purposes of today's hearing, we will focus on our largest and most significant partner in meeting the needs of post-9/11 wounded warriors: the Department of Veterans Affairs (VA). The perspectives that follow are intended to identify and discuss what we believe to be among the most critical areas of concern related to mental health and suicide prevention as viewed through access to care, workforce, long-term care, financial wellness, and research perspectives.

Access to Care

- ***Ensure adherence to access standards and promote transparency in community care network wait times***
- ***Improve timely access to residential rehabilitation treatment programs***
- ***Encourage use of telehealth to remove barriers to care***
- ***Prioritize evaluation of SSG Parker Gordon Fox Suicide Prevention Grant Program***

More than 9 in 10 (91%) warriors who responded to the 2022 Annual Warrior Survey use VA for their health care needs. Only a segment of these respondents rely exclusively on VA for care however, and many use a variety of sources for mental health support – to include WWP programs and services. When dealing with stress, emotional challenges, or mental health concerns, WWP warriors report that they most often turn to: talking with family and friends (65.5%), talking with another veteran (60.6%), prescription medication (59.0%), services at VA medical centers (55.3%), and physical activity (54.6%). By offering peer support and a variety of programs tailored to address stressors across physical, mental, and financial domain, WWP is able to capture an informed perspective on why veterans seek care and why they turn to WWP.

Access to Mental Health Care

Currently when a warrior reaches out to WWP for mental health support, their first step to finding care is a conversation with our Triage team. The Triage team conducts screenings of a warrior's mental health history, provides the warrior with information about our various mental

[2] More information on WWP's Mental Health Continuum of Support can be found at the end of the document.

health offerings, and refers the warrior to the most appropriate mental health program within WWP or an external resource. In FY 22, our Triage team received 12,610 referrals to find warriors appropriate treatment, placed 10,634 referrals for mental health support (including 5,630 referrals to external outpatient care providers), and made their first connection with interested warriors an average of 1.04 days later.

A common point of feedback from warriors seeking care and support through WWP is that VA wait times for mental health are offered at future dates that exceed VA's access standard of 20 days for mental health care. Appointments that are many weeks – if not months – away erode trust in VA's ability to provide care at reasonable intervals. Appointment cancellations that result in even more delay can further discourage health seeking behavior or push veterans toward finding care independently. And when group therapy is offered in place of individual counseling to expedite care delivery, a veteran patient may feel that they are getting a lesser service or be turned off by the idea entirely. Options for seeking care in the community are rarely discussed in detail and more often left to the veteran to navigate (and enforce) their path to receiving care sooner. Instances like these allow organizations like WWP to step in and fill the need for rapid access to care that is tailored to meet individual needs and desires.

To this end, WWP supports taking additional congressionally directed measures intended to make community care more accessible for veterans seeking mental health care. WWP is pleased to support both the *Making Community Care Work for Veterans Act* (S. 2649) and the *Veterans' Health Empowerment, Access, Leadership, and Transparency for Our Heroes (HEALTH) Act* (S. 1315) and their respective embrace of addressing disparities on VA's adherence to access standards. While there are distinctions discussed in more detail in the sections that follow, both bills would recognize that the current access standards for mental health have been deemed appropriate across two Administrations – and that the key to success will be ensuring that they are clearly communicated and adhered to.

Access to Residential Rehabilitation Treatment Programs

The access standards contemplated by the *VA MISSION Act* (P.L. 115-182 § 104) and memorialized in the Code of Federal Regulations (38 C.F.R. § 17.4040) do not, in practice, extend to mental or substance use disorder care provided in a residential setting. VA has maintained adherence to access standards for this type of care through Veterans Health Administration (VHA) Directive 1162.02, which establishes a priority admission standard of 72 hours and, for all other cases, 30 days before a veteran must be offered (not necessarily provided) alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening.

Due to this approach, veterans seeking mental or substance use disorder care provided in a residential setting are not subject to the access standard protections assigned under law. VA is not required to inform these veterans of their expected wait time. *See* P.L. 117-328, Div. U, § 122. Veterans are not guaranteed the soonest possible starting time before a community referral must be made. *See* P.L. 117-328, Div. U, § 121; 38 U.S.C. § 1703(d)(4). The access standards used are not applicable to community care network providers who receive referrals for these veterans' care. *See* P.L. 117-328, Div. U, § 125; 38 U.S.C. § 1703B(f).

Most importantly, if appropriate community-based providers are identified and available to provide treatment, veterans waiting beyond VHA's policy-backed access standards have no dependable, clear, and consistent recourse to be referred for that care. VA has presented data suggesting that only 38% of veterans meeting priority admission criteria were admitted to VA within 72 hours, and that the average wait time before admission among all veterans receiving Mental Health Residential Rehabilitation Treatment Program (MH RRTP) care was 24 days – just 6 days less than the 30-day access standard and among a population where 53% were admitted within 14 days. Although information on admissions within 30 days was not provided in the presentation where this data was cited, we believe it reflects that many veterans have waited more than 30 days for admission to care.

We are excited to see a number of bills that are aimed at improving access to mental or substance use disorder care provided in a residential setting or VA's MH RRTP. There are currently three pieces of legislation seeking to address this issue in different ways. The first, the *Making Community Care Work for Veterans Act* (S. 2649) would require VA to update the policies and operational guidance for the MH RRTP program. VA would also be required to standardize the referral, screening, and admission process and complete the screenings and admission decisions within 72 hours for veterans who meet priority admission standards. Additionally, an appeals process would be established for any veteran denied entry to the program or not offered a timely placement and VA would be required to update and conduct training for VA providers and care coordinators regarding these changes.

Next, the *Veterans' HEALTH Act* (S. 1315) would incorporate MH RRTP with the existing extended care services access standard (30-minute average drive time/20 days). This approach would remove the "non-institutional" qualification around extended services but would expressly exclude nursing home care. Lastly, the *Veteran Care Improvement Act* (H.R. 3520) would create a new access standard for alcohol and drug dependence MH RRTP (30-minute average drive time/10 days) and VA would be required to consider a veteran's eligibility within 72 hours of receiving their request.

While each of these bills address the issues we are seeing in terms of access to mental health and substance use disorder care in a residential setting in different ways, we believe they all represent an improvement from the status quo. We believe each approach would enhance accountability, transparency, and oversight on this critical provision of care and ultimately lead to better outcomes for veterans and ensure they are receiving the care they need in a timely manner.

Telehealth

Since the onset of the COVID-19 pandemic, VA has been a leader in embracing and providing telehealth. VA has seen a rapid rise in the numbers of veterans using telehealth to receive their care, and telehealth is similarly popular in the WWP warrior community. Among warriors who were offered a telehealth appointment in the last 12 months, 89.3% reported using telehealth during that period. Among those not offered a telehealth appointment, a majority (63.9%) said they would have used it if presented as an option. Telehealth is a cost-effective

way to improve access to care for many warriors that may face barriers to care, including long driving distances, work schedules, and the need for childcare.

We are pleased to see that telehealth is addressed as an access to care issue in both the *Making Community Care Work for Veterans Act* (S. 2649) and the *Veterans' HEALTH Act* (S. 1315). Section 103 of the *Making Community Care Work for Veterans Act* would allow VA to offer telehealth appointments to veterans as means of satisfying access standards when the telehealth appointment is accepted by the veteran. Section 101(a) of the *Veterans' HEALTH Act* would omit telehealth appointment availability at VA from determinations of eligibility for community care network access; however, Section 105 would require VA to discuss telehealth appointment options with the veteran when it is available, clinically appropriate, and acceptable to the veteran.

While these two approaches are not in complete alignment, both hold potential to deliver better access to care than current practices. Generally speaking, veterans that seek mental health care through WWP express that options for care in the community are not clearly discussed with VA providers. As noted earlier in this section, the VA appointment is often the only option discussed in detail even when offered at a date that exceeds current access standards. Better outcomes can be achieved when options are clearly laid out, and in our experience, telehealth is often a preferred method for those we serve. However, these preferences should not be assumed, and veterans should be provided with more clarity and transparency when weighing their options for care. According to WWP's 2022 Annual Warrior Survey, of those WWP warriors who were not offered a telehealth appointment, 36.1% reported they would have said no to utilizing the appointment even if they were offered it (30.1% for women and 37.1% for male warriors). For that reason, WWP believes telehealth can met the access standards require only when a veteran has agreed to. Additionally, if a veteran choses to stop using telehealth in favor or in-person care, they should not be denied the right for in-person care and community care should be made available if VA is unable to meet the access standards.

Lastly, we should take additional steps to ensure better telehealth connectivity because access to broadband service benefits veterans in several important ways. Like all Americans, veterans benefit from strong and reliable internet access that can foster career opportunities through telework, access to online education, and more opportunities to participate in the digital economy. In addition, as the use of telehealth resources continues to expand, the access to a stable and affordable internet network is increasingly becoming instrumental in maintaining a veteran's physical and mental health and wellness.

Despite these benefits, veteran households subscribe to mobile broadband services at lower rates than households without veterans. 2.2 million veteran households lack either fixed or mobile broadband connections at home. The monthly cost of service or the cost of a computer is often cited as a key barrier to broadband adoption.[3] VA and Census Bureau data show that almost 7% of veterans live below the poverty level leading many to forgo home internet access

[3] *See* JOHN HORRIGAN and MAEVE DUGGAN, PEW RESEARCH CTR., HOME BROADBAND 2015 4 (Dec. 2015), *available at* https://www.pewresearch.org/wp-content/uploads/sites/9/2015/12/Broadband-adoption-full.pdf; Colin Rhinesmith et al., Benton Inst. for Broadband & Society, *The Complexity of 'Relevance' as a Barrier to Broadband Adoption* (Jan. 2016), *available at* https://www.benton.org/blog/complexity-relevance-barrier-broadband-adoption.

and instead seek access in libraries or community centers.[4] This is especially pronounced in rural areas. Of the 4.4 million rural and highly rural veterans, 44% earn less than $35,000 a year and 27% do not access the internet at home.[5]

The Affordable Connectivity Program (ACP) is a Federal Communications Commission benefit program that helps ensure that households can afford the broadband they need for work, school, healthcare and more. The benefit provides a discount of up to $30 per month toward internet service for eligible households and up to $75 per month for households on qualifying Tribal lands. Eligible households can also receive a one-time discount of up to $100 to purchase a laptop, desktop computer, or tablet from participating providers if they contribute more than $10 and less than $50 toward the purchase price. The ACP is limited to one monthly service discount and one device discount per household. To be eligible, a household's income must be at or below 200% of the poverty level ($60,000 a year for a family or $29,000 for an individual) or participating in certain government programs including veterans' pension or VA survivor benefits.

To date, over 600,000 veterans have signed up for the ACP; however, funding for the program is expected to run out by late Fiscal Year 2023 or early Fiscal Year 2024. The ACP was appropriated $14.2 billion in the *Infrastructure and Jobs Act* (P.L. 117-58, Div. J, Title IV) and WWP supports a reauthorization of funding for 1-2 years until the program can be made permanent.

Suicide Prevention Grant Program

Section 201 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116-171) authorized the launch of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, an innovative new approach to bolstering VA partnerships and enhancing collaboration on community-based suicide prevention strategies. In Fiscal Year 2022, the first year of this three-year pilot program, VA awarded $52.5 million to 80 organizations that provide or coordinate a range of suicide prevention programs for veterans and their families.[6] WWP was an early supporter of this initiative, and we remain committed to its success.

While metrics and impact are in the earliest stages of review, our feedback to date is largely anecdotal and based on our organizational experience. We agree that no one organization – and no single agency – can fully meet all veterans' needs. We recognize that empirically supported mental health treatment works when it is available and when it is pursued, but the best results will be found by embracing a public health approach focused on increasing resilience and psychological well-being and building an aggressive prevention strategy. In this context, we offer two important considerations for the Committee.

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[4] *See* U.S. DEP'T OF VET. AFFAIRS, *Veterans Poverty Trends Report* 3 (May 2015), *available at* https://www.va.gov/vetdata/docs/specialreports/veteran_poverty_trends.pdf (noting an 8.7% increase in veterans living in poverty in the 2010-2012 time period, compared to the 2005-2007 time period).
[5] *Rural Veterans*, U.S. DEP'T OF VET. AFFAIRS, https://www.ruralhealth.va.gov/aboutus/ruralvets.asp (last visited Sep. 18, 2023).
[6] Matthew Miller, *VA grant funding helping prevent Veteran suicides*, U.S. DEP'T OF VET. AFFAIRS (Aug. 15, 2023), https://news.va.gov/122642/va-grant-funding-help-prevent-veteran-suicides/.

First, organizations WWP has worked with have expressed concern that the application and compliance requirements can be onerous. Although expectations were clearly laid out by VA[7], some participants have shared with WWP that aligning a veteran's eligibility with delivery of specific services can be challenging. A veteran must meet definitions set out at Section 201(q)(4) of the *Hannon Act*, which includes consideration of a myriad of health, environmental, and historical risk factors for suicide. While acknowledging these predispositions are important in early and direct conversations about suicide, approaching such considerations without a foundation of trust can sometimes discourage veterans from being honest with their responses or willing to accept and engage in services. Allowing some time to foster a relationship enables engagement in difficult conversations that stem from place of care and compassion, rather than obligation. Navigating discussions in such a way can foster more immediate connect to services that mitigate their risk for suicide and reduce emergent needs while also making the delivery of those services ineligible for grant purposes. Others have noted that the high volume of veteran assessments required can induce incentives (like providing small gifts) for completion that may skew the quality of data gathered and what practices are sound under the premises of the grant. We encourage more investigation into how administrative practices can better align with the intended purpose of connecting more veterans with support.

Second, the provision of clinical care under this grant program should be more grounded in practical considerations for delivering veterans evidence-based mental health care. Currently, when grantees are treating eligible individuals at risk of suicide or other mental or behavioral health conditions, the grantee must refer that individual to VA for follow-on care. If they do not, any care given is at the expense of the grantee.[8] However, some veterans are not comfortable receiving care at VA for a variety of reasons. This puts the grantee in a difficult situation where they are forced to stop providing care or provide care at their own expense, something many programs may be unable to afford. Additionally, if a grantee is a part of VA's Community Care Network, they are still required to get additional VA authorization to provide a veteran follow-up care. We would ask the Committee to consider if there are ways this process can be improved so that more veterans at risk of suicide can be connected to care they know and trust as soon as possible.

Mental Health Workforce

- ***Provide support for VA to recruit and retain high quality mental health providers***
- ***Advance policies that promote a stronger mental health and substance use treatment provider base across the United States***

Currently we are facing a dire shortage of mental health providers, both in VA and in the community. The Health Resources & Services Administration estimates that 164 million Americans live in areas with mental health professional shortages.[9] They estimate over 8,000 providers are needed to fill this need.[10] Within VA there is a similar story. While VA has made good progress on filling vacancies, a recent report from the Office of Inspector General (OIG)

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[7] Funding Opportunity: Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, 87 Fed. Reg. 22630 (Apr. 15, 2022).
[8] *Id.*
[9] HEALTH RES. AND SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH WORKFORCE SHORTAGE AREAS (Sep. 18, 2023), https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[10] *Id.*

found severe shortages in a number of critical areas. The OIG found that 91 VHA facilities identified psychology as a severe shortage occupation, 73 VHA facilities identified psychiatry as a severe shortage occupation, and 33 VHA facilities identified inpatient mental health registered nurse (RN) staff as a severe shortage area.[11] These shortages are directly impacting veterans' access to care, increasing wait times for mental health treatment, and putting veterans' lives in danger.

Wounded Warrior Project urges Congress to take urgent action to invest in a more robust mental health workforce. One way to do this is by passing the *VA CAREERS Act* (S. 10). This legislation would help to address the current mental health workforce shortages at VA by giving them additional tools to recruit and retain providers. It would modernize VA's pay system for physicians and high-level clinicians, allow VA to pay for licensure exam costs for future clinicians that are participating in VA scholarship programs, expand eligibility for health care staff that can be reimbursed for professional education costs, and improve VA's workforce data reporting systems so they are able to better track hiring and onboarding. While this legislation's scope exceeds mental health, it can build upon momentum from previous legislation focused on mental health like the *STRONG Veterans Act* (P.L. 117-328, Div. V) which expanded the Vet Center workforce (§ 102), created more paid trainee positions in mental health disciplines (§ 103), and offered more scholarship and loan repayment opportunities for those pursuing degrees or training in mental health fields (§ 104).

To help address the shortage outside of VA and for those veterans who utilize VA's Community Care Network, Congress should pass the *Mental Health Professionals Workforce Shortage Loan Repayment Act* (S. 462/H.R. 4933). This bill would provide up to $250,000 in eligible student loan repayment for mental health professionals in substance use disorder treatment who pursue employment in Mental Health Professional Shortage Areas. With increasing numbers of veterans specifically seeking treatment for substance use disorder, passing this legislation will allow additional providers into this space, resulting in better access to care for veterans and shorter wait times for treatment.

Traumatic Brain Injury and Long-Term Care

- ***Remove barriers to care that can impede quality of life and promote better mental health***

For many post-9/11 veterans, brain health is a crucial factor in overall quality of life. Brain trauma, specifically traumatic brain injury (TBI), has been referred to as a "signature injury" for post-9/11 veterans, and this remains true for many we serve. 37% of WWP warriors self-report experiencing TBI as a result of their military service. Research shows that TBI can have a serious impact on a veteran's mental health. Some of the most common symptoms reported from warriors after a brain injury include feeling anxious or tense, problems with sleep, and irritability. Of warriors who self-reported experiencing TBI, 72% visited a mental health professional within the last 12 months to help with issues such as stress, emotional, alcohol, drug, or family problems and 60% presented with moderate to severe symptoms for two or more mental health conditions. Warriors who self-reported experiencing TBI are also more likely to

[11] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S SEVERE OCCUPATIONAL STAFFING SHORTAGES FISCAL YEAR 2023 (Aug. 2023).

report suicidal thoughts in the past 12 months than warriors who did not report experiencing TBI, more likely to have suicidal ideations, and have a higher rate of needing aid and assistance from another person.

Other research has studied the relationship between TBI and suicide finding that the risk of suicide was 2.19 times higher for those with TBI than those without.[12] The risk was even greater for those with moderate to severe TBI.[13] Due to the elevated risk for this population, it is crucial that we support and create better programs and more options for veterans with moderate to severe TBI that can help to mitigate other compounding factors for this population like financial needs, caregiving needs, and access to care.

One recent success in this area was the passage of the *Long-Term Care Veterans Choice Act* which was included in the *Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act* (P.L. 117-328, Div. U § 165) last year. This law will allow veterans increased flexibility with their health benefits, authorizing VA to cover the cost of medical foster homes for veterans that are otherwise eligible for nursing home care. Not only will this result lower costs for VA, as the cost of a medical foster home is significantly lower than nursing homes, but veterans will also be given an option that allows them more independence and a potentially higher quality of life in a non-institutional setting.

Today, we urge Congress to take additional steps to increase options for care for veterans with TBI. One way to do this is by passing the *Elizabeth Dole Home Care Act* (S. 141/H.R. 542). This legislation would improve veterans' access to long term support services through provisions that would instruct VA to provide informal Geriatrics and Extended Care (GEC) program assessment tools to help veterans and caregivers identify expanded services they are eligible for. Other provisions would codify existing GEC programs and provide assistance to caregivers that are denied or discharged from the Program for Comprehensive Assistance for Family Caregivers into other VA provided support. These provisions will help to provide additional resources to veterans with complex needs, many suffering from the effects of TBI. We also urge you to include the important provision that would increase the non-institutional expenditure cap from 65% to 100% to help ease the economic burden that many of these veterans and their families face.

Another piece of legislation that will improve options for veterans with TBI is the *Expanding Veterans' Options for Long-Term Care Act* (S. 495/H.R. 1815). Like the new law allowing VA to pay for medical foster home lodging (with annual caps), this bill requires VA to implement a three-year pilot program that will assess the effectiveness of providing assisting living services to eligible veterans. This would allow veterans serious needs more flexibility and the option to live more independently. Lastly, the *Innovative Cognitive Care for Veterans Act* (H.R. 5002) would establish a pilot program at VA to partner with private organizations, nonprofit foundations, and other community support entities to provide veterans access to telehealth and other innovative technologies that slow the progression of cognitive disorders through interactive engagement and stimulation solutions. Given that TBI often results in

[12] Trisha A. Hostetter et al., *Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services Between Fiscal Years 2006 and 2015*, 35(5) J. HEAD TRAUMA REHAB. E1, E1-E9 (2019).
[13] *Id.*

cognitive issues, this program will give veterans with TBI access to new, innovative care that we believe will result in overall improved mental health outcomes.

While the above laws primarily focus on long-term care resources and the wellbeing of caregivers, it is not lost on WWP that the stressors impacting family members of those suffering from TBI can negatively impact the mental health wellbeing of the warrior.

Financial Wellness

- ***Foster financial security by advancing legislation that will provide economic empowerment***
- ***Improve the standards for pursuing service-connected disabilities related to military sexual trauma***

Another important factor that can have a considerable effect on a warrior's mental health is their financial well-being. According to our 2022 Annual Warrior Survey, 64% of WWP warriors reported that they did not have enough money to make ends meet at some point in the last 12 months. Amongst these warriors, 64% presented with moderate to severe depression symptoms, 57% presented with PTSD symptoms, 17% reported using recreational drugs within the past year, and 71% reported visiting a mental health professional in the last year.

The link between mental health and financial health is well established. Higher degrees of financial worries are significantly associated with higher levels of psychological distress.[14] Additionally, the Annual Warrior Survey found that warriors who reported moderate and high financial well-being were 4.6 times more likely to report having better mental health than the general U.S. population.

Financial Security Legislation

We believe that there are several important legislative paths Congress can take to improve veterans' financial security and with it, their mental health. The first is by passing the *Major Richard Star Act* (S. 344, H.R. 1282). This legislation would allow Chapter 61 retirees whose disabilities arose from combat-related activities, to receive both their Department of Defense retirement pay and their VA disability compensation concurrently. We believe these are two distinct benefits established by Congress for two different purposes and passing this legislation would give over 50,000 veterans the benefits, and improved financial stability, they have been unfortunately denied until now.

Additionally, we know that meaningful employment not only improves a veteran's financial situation but can also have a powerful impact on their overall mental health. There are currently several pieces of legislation WWP has endorsed to provide additional employment opportunities for veterans, a number of which leverage the vast number of opportunities with the federal government. The *Get Rewarding Outdoor Work (GROW) for our Veterans Act* (H.R. 1786) would establish a two-year pilot program, administered by the Secretary of the Interior, to employ veterans in federal positions that relate to conservation, environmental protection, and

[14] Soomin Ryu & Lu Fan, *The Relationship Between Financial Worries and Psychological Distress Among U.S. Adults*, 44(1) J. FAM. ECON. ISSUES 16, 16-33 (2022).

resource management. The *Veterans Border Patrol Training Act* (S. 774) would establish a pilot program through the Department of Defense's SkillBridge program to train and hire transitioning Service members at the U.S. Customs and Border Patrol (CBP). And finally, the *Employing Veterans to Feed America Act* (H.R. 5014) would establish a pilot program to provide veterans employment at the Department of Agriculture, particularly in positions that would allow veterans access to the outdoors. In addition to the other benefits a veteran may receive from employment, these careers allow for other mental health advantages that have been found from being outdoors. A growing body of research has shown these to include reduced depression, improved physical and psychological well-being, social connection, and resilience.

Within VA jurisdiction, WWP also supports extending an important pilot to prepare veterans for careers in STEM fields. Congress can pass the *VET-TEC Authorization Act* (H.R. 1669) which would fund the Veteran Employment Through Technology Education Courses (VET-TEC) program that offers eligible veterans training in high-demand areas including computer software, computer programming, data processing, information science, and media applications. VET-TEC participants have been more racially and ethnically diverse and more likely to have a service-connected disability when compared to the wider population of working-age veterans in the U.S. population.[15] At a time when wounded veterans continue to have challenges finding and maintaining employment, we believe that extending VET-TEC under this legislation will allow more veterans to prepare for and access better, higher-paying careers, allowing them to have reduced financial stress and improved outcomes.

Service Connection Related to MST

Lastly, Congress should pass the *Servicemembers and Veterans Empowerment and Support (SAVES) Act* (S. 1028/H.R. 2441). According to VA, 1 in 3 women and 1 in 50 men report experiencing military sexual trauma (MST) when they are screened by their VA provider.[16] However, we know that many instances of MST go unreported for a variety of reasons, including feelings of shame, fears of reprisal, and concerns that they won't be believed. Because so many instances of MST go unreported, it can be challenging to provide the necessary evidence when filing claims with VBA. This results in many individuals not being able to receive the benefits that they deserve, putting them in a more challenging financial position. The *SAVES Act* would expand the evidentiary standard for MST survivors applying for VA benefits by requiring VA to consider non-DoD evidence sources when reviewing MST claims. The legislation would also make other improvements to the MST claims process to ensure greater accuracy resulting in survivors having better support and resources moving forward.

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[15] U.S. GOV'T ACCOUNTABILITY OFF., VETERANS EMPLOYMENT: PROMISING VA TECHNOLOGY EDUCATION PILOT WOULD BENEFIT FROM BETTER OUTCOME MEASURES AND PLANS FOR IMPROVEMENT 8 (Oct. 2022)

[16] *Military Sexual Trauma*, U.S. DEP'T OF VET. AFFAIRS, https://www.ptsd.va.gov/understand/types/sexual_trauma_military.asp (last visited Sep. 18, 2023).

<u>Oversight and Research</u>

- ***Protect veterans from the dangers of opioid prescriptions***
- ***Improve reporting on veteran suicide***

Protect warriors from the dangers of opioid prescriptions

Studies have shown that chronic pain is negatively associated with physical and mental health quality of life. Chronic pain may significantly reduce individuals' quality of life by causing functional, social, emotional, and socioeconomic changes, such as changes in sleep patterns, isolation, an increase in depression, and lack of productivity.[17] About three in four (75.8%) WWP warriors responding to the 2022 Annual Warrior Survey scored in a range indicating moderate or severe pain. The overall average Pain, Enjoyment of Life, and General Activity (PEG) scale score among all WWP warriors was 5.3, which indicates moderate pain that interferes with activities and enjoyment of life.

For a number of reasons, it is concerning that over half of warriors (51.5%) responding to the Annual Warrior Survey are managing pain with prescription pain medication. Within an opioid epidemic that has touched countless lives across the country, drug overdose mortality rates among veterans increased by 53% from 2010 to 2019[18] resulting in over 42,000 deaths[19]. According to a 2019 study, nearly half of combat wounded veterans have reported misuse of prescription opioids.[20] VA's annual suicide prevention report revealed that the suicide rate for recent VHA users with a diagnosis of opioid use disorders rose by 35.4% between 2019 and 2020 (the highest rate of increase across all observed health diagnoses).

For these reasons, we encourage the Committee to provide veterans with more options to prevent addiction. First, we recommend oversight of VA's Opioid Safety Initiative. Launched in 2013, this initiative has led to many positive results including fewer veterans prescribed opioid use.[21] However, there may be other consequences worth exploring in consideration of statistics shared above. Second, new laws and approaches pursued outside of the VA health system may reveal best practices and research that can be tailored to VHA. For example, the *Non-Opioids Prevent Addiction In the Nation (NOPAIN) Act* (P.L. 117-328) addressed the prescription of non-opioid treatments used to manage pain in both the hospital outpatient department (HOPD) and the ambulatory surgery center (ASC) settings by expanding non-opioid options for patients. With precedent as a guide, TRICARE may soon follow a similar path and implement a comparable policy.[22] We encourage the Committee to explore the possibility of extrapolating the framework implemented in the *NOPAIN Act* (P.L. 117-328) into VA's system.

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[17] Bruno Saconi et al., *The Influence of Sleep Disturbances and Sleep Disorders on Pain Outcomes Among Veterans: A Systemic Scoping Review*, 56 SLEEP MED. REV. 101411 (2021); ARIEL BARIA ET AL., CHRONIC PAIN IN MILITARY VETERANS, FEATURES AND ASSESSMENTS OF PAIN, ANESTHESIA, AND ANALGESIA 225-234 (Academic Press, 2022).
[18] *Substance Use and Military Life DrugFacts*, NAT'L INST. DRUG ABUSE, SUBSTANCE USE AND MILITARY LIFE DRUGFACTS, https://nida.nih.gov/publications/drugfacts/substance-use-military-life (last visited Sep. 18, 2023).
[19] Mark Begley et al., *Veteran Drug Overdose Mortality, 2010-2019*, 233 DRUG AND ALCOHOL DEPENDENCE 109296 (Apr. 2022).
[20] Michelle Kelley et al., *Opioid and Sedative Misuse Among Veterans Wounded In Combat*, 92 ADDICTIVE BEHAVIORS 168, 168-92 (May 2019).
[21] Press Release, U.S. DEP'T OF VET. AFFAIRS, VA Reduces Prescription Opioid Use By 64% During Past Eight Years (July 30, 2020) (*available at* https://news.va.gov/press-room/va-reduces-prescription-opioid-use-by-64-during-past-eight-years/).
[22] *See* 10 U.S.C. §§ 1079(h), (j)(2).

Reporting on Veteran Suicide

To best address and prevent veteran suicide, it is critical that we have as much data about the issue as possible. The *Not Just a Number Act* (S. 928/H.R. 4157) will improve our understanding of what factors play a role in veteran suicide and what the most affective interventions are. First, the legislation will require submission of the "National Veteran Suicide Prevention Annual Report" before the end of September of each year. The legislation also requires VA to include essential data on not only veteran health care usage but also VA benefits usage such as VA home loans, GI bill benefits, and disability compensation. This will allow all stakeholders insight into not only what mental health practices impact veteran suicide, but also what additional benefits may play a factor. While each year's report includes important and illuminating data points, what is included in one year's report is not always included in the next year's report, which complicates our ability to track the overall issue and what interventions are most beneficial. The *Not Just a Number Act* will help to standardize the data that is collected and presented in each year's report.

Additionally, the legislation will require VA to report on what upstream programs and services at VA have the greatest impact on veteran suicide prevention and to provide recommendations on how these services and benefits may be expanded. It will require VA, along with the Centers for Disease Control and Prevention, to develop a publicly available toolkit for state and local coroners and medical examiners with the best practices for how best to identify and report veteran suicide deaths. Lastly, the bill will require VA to review and provide recommendations on whether the VA's Office of Mental Health and Suicide Prevention should be moved to the Office of Secretary level at VA. WWP believes this legislation will make necessary improvements to the VA's "National Veteran Suicide Prevention Annual Report" and will help the community learn how we can continue to best prevent veteran suicide. We urge Congress to pass this legislation.

CONCLUDING REMARKS

Wounded Warrior Project thanks the Committee and its distinguished members for inviting our organization to submit this statement. We are grateful for your attention and efforts towards addressing the critical issues of mental health and suicide prevention affecting our nation's veterans. We look forward to continuing to work with you on these issues and are standing by to assist in any way we can towards our shared goals of serving those that have served this country.

JOHN EATON

COMPLEX CARE VICE PRESIDENT

John Eaton serves as vice president, Complex Care at Wounded Warrior Project® (WWP). In this role, he is responsible for overseeing WWP's Mental Health Continuum of Support, to include C3 (Complex Case Coordination), Triage, WWP Talk and Project Odyssey.

Additionally, John serves as executive leadership for Warrior Care Network, a partnership between Wounded Warrior Project and four world-renowned academic medical centers, providing veterans and service members living with post-traumatic stress disorder, traumatic brain injury, military sexual trauma and substance use disorder with a path to long-term wellness.

Prior to this role, John has spent the last 18 years serving in healthcare leadership roles, most recently, as vice president of social and behavioral health at Flagler Health +. In this capacity, John was responsible for developing and operationalizing the Flagler Health+ behavioral health service-line to increase access, eliminate stigma and leverage innovation to address behavioral health and social health needs of communities across Northeast Florida.

Under John's leadership at Flagler Health +, Care Connect+ was established and has grown to include a network of more than 200 community-based organizations across Florida, with demonstrated success in advancing key health factors for veterans, such as homelessness, mental health, and social isolation.

MENTAL HEALTH CONTINUUM OF SUPPORT

The Wounded Warrior Project® (WWP) Mental Health Continuum of Support is composed of a series of programs that address mental health care needs of warriors. These programs allow us to engage with warriors based on their unique needs. The continuum is made up of internal resources and programs to assist warriors on their journey to recovery. WWP uses the Connor-Davidson Resilience Scale® (level of resilience), the Rand QoL Scale (psychological well-being), and other validated scales and measurements to determine the appropriate level of care for each warrior.

The continuum of support doesn't define an exact, prescriptive path to recovery, rather the individual needs of each warrior to determine the order and frequency of appropriate program engagement. For example, a warrior in acute psychological distress may be referred to a number of clinical intervention programs. Another warrior with less severe mental health issues may participate in only one or two programs. Subsequently, any warrior who has a setback may be re-evaluated and referred back to one or more programs for additional care. The goal is to provide the appropriate amount of care a warrior may need to get to his or her highest possible level of resilience, psychological well-being, and healing.

INPATIENT CARE
Clinical Intervention

Inpatient care is reserved for warriors in severe psychological distress who have exhausted all other resources. WWP may be able to fund inpatient services in order to stabilize warriors so that they can be engaged with other mental health programs in the continuum. The goal is to sustain and facilitate movement in the continuum through other programs.

WARRIOR CARE NETWORK
Clinical Intervention

To accelerate the development of advanced models of mental health care, WWP partners with four world-renowned academic medical centers to form Warrior Care Network®, leveraging our collective commitment and expertise. The Warrior Care Network treatment model delivers a year's worth of mental health care during a two- to three-week intensive outpatient program (IOP). This unique veteran-centric approach increases access to treatment and improves outcomes. Warrior Care Network provides a path to long-term wellness, improving the way warriors are treated today and for generations to come.

PROJECT ODYSSEY
Engagement Intervention

Project Odyssey is a 12-week mental health program that uses adventure-based learning to help warriors manage and overcome their invisible wounds, enhance their resiliency skills, and empower them to live productive and fulfilling lives. Based on their unique needs, warriors can participate in an all-male, all-female, or couples Project Odyssey. The program starts with a five-day mental health workshop, where warriors are challenged to step outside the comfort of their everyday routines. This opens them up to new experiences that help develop their coping and communication skills. After the workshop, participants work together with WWP to stay engaged, achieve their personal goals, and make lifelong positive changes.

★ PROGRAMS WITH MULTIPLE STAGES OF ENGAGEMENT ★

Within the continuum of support there are additional programs/resources that can be engaged at nearly any point in the continuum. These are WWP Talk and outpatient therapy. The Independence Program, which also encompasses multiple stages of engagement, is a unique component of the continuum. The resources provided by the Independence Program allow the most severely wounded warriors the ability to lead a full life at home instead of a long-term facility.

OUTPATIENT THERAPY • *Engagement and Clinical Intervention*

An additional clinical resource available to warriors across the stages of the continuum is outpatient therapy. Here WWP funds external partners to provide individual, family, or couples therapy delivered by a culturally competent therapist in the closest geographic location to the warriors as possible. With multiple funded clinical partners, warriors are able to engage in traditional outpatient sessions or, if in a remote location, engage in virtual therapy.

WWP TALK • *Engagement and Coordination Intervention*

WWP Talk is a telephonic emotional support program that breaks down the barriers of isolation and helps both warriors and family members plan an individualized path toward their personal growth. Participants work one-on-one with a dedicated team member during weekly emotional-support calls. Together, they set tangible goals and develop skills that lead to positive changes, like increased resilience and improved psychological well-being.

INDEPENDENCE PROGRAM
Engagement, Coordination, and Clinical Intervention

The Independence Program provides long-term support to catastrophically wounded warriors living with injuries such as: a moderate to severe brain injury, spinal cord injury, or neurological condition that impacts independence. The program is designed to support warriors who, without high-touch services, would struggle to live day to day due to the severity of their injuries. The Independence Program increases access to community services, provides rehabilitation through alternative therapies, and empowers warriors to achieve goals leading to a more independent life. Because every journey is different, we work as a team with warriors, their family members, and their caregivers to set goals to live a fulfilling life, at home, with their loved ones.

★ LIVING THE LOGO ★

The WWP logo is much more than a trademark — it is what we see as the ultimate goal for all warriors engaged with the continuum of support to achieve. It is the collective goal of the continuum of support (through resources and teammates) to empower warriors to make it to this final phase and live our logo. The logo, one warrior carrying another warrior, represents a peer assisting a fellow veteran — in essence, carrying him through the recovery process until he can walk of his own accord (through heightened resiliency and psychological well-being). Eventually, as resiliency reaches the highest levels in the continuum, warriors are empowered to help carry fellow veterans, essentially becoming force multipliers as they are engaged as peer mentors.

WRITTEN TESTIMONY OF
Gilly Cantor, M.P.A.
Director of Evaluation and Capacity Building
D'Aniello Institute for Veterans and Military Families at Syracuse University

BEFORE THE
Senate Committee on Veterans' Affairs

September 20, 2023

Mr. Chairman, Ranking Member Moran, and Members of the Committee, thank you for the opportunity to testify on the topic of improving mental health and suicide prevention measures for our nation's veterans. My name is Gilly Cantor and I serve as the Director of Evaluation and Capacity Building at the D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University.

The IVMF's contribution to this conversation is rooted in the research and practice related to upstream approaches to suicide prevention. For ten years, our institute has played a key role in creating, sustaining, and evaluating networks of health and social service organizations – originally as part of our AmericaServes initiative working alongside 18 communities across the country.

Mirroring a growing body of evidence in healthcare more broadly, these models have demonstrated that helping veterans navigate to the full scope of services and resources they need – beyond clinical interventions alone – is an integral component of suicide prevention efforts.

At the same time, we have witnessed unprecedented effort in recent years from Congress, the VA, and DoD through bipartisan legislation that better integrates communities into suicide prevention strategies, and we have observed both evidence of their success and opportunities to improve.

It is the strong belief of the IVMF and our partners that we must remain committed to bridging the gap between the VA and communities – between health and social needs. We must not give up on the promise of these efforts but rather ensure they live up to their potential.

To start, I'd like to make it clear why communities and accountable partnerships remain essential to effective suicide prevention solutions.

There are three findings I want to highlight from a recent VA-funded pilot study we conducted with the VA Center for Health Equity Research and Promotion. The study explored the extent and potential effects of collaboration between AmericaServes networks and local VA Medical Centers.

- First, we found a high percentage of overlap between AmericaServes and VA data, *even in communities with lower levels of formal partnership*. **In other words, many veterans enrolled at the VA are unquestionably receiving services in their communities.**
- Second, veterans served by both the VA and the community were comparatively younger; included more women, Black, and Hispanic veterans; and had more health-related social needs (such as stable housing, access to healthy food, etc.). **In other words, communities are part of the system of care for *the most marginalized veterans experiencing the most hardship*.**
- And third, when partnerships were strong, veterans receiving healthcare from the VA *and* social services in the community were more likely to have those needs successfully met. **In other words, *when we work together*, the stressors impacting veterans' wellbeing are more effectively addressed.**

Further, we know from research and data that establishing accountability and transparency between the VA and communities is both achievable and necessary if we want veterans to thrive.

- We know from research that economic, social, and interpersonal circumstances increase risk of suicide. Imagine what more we could learn and act upon if non-health data was examined regularly and transparently shared. We must support legislation like the Not Just A Number Act to bring *all* the data the VA has to bear on this issue. In fact, we should be looking beyond VA to DHHS, DoD, other health systems, and communities to ensure we have the fullest possible picture of veterans not currently served by the VA.
- From our evaluation of AmericaServes data in Pittsburgh, we know that hundreds of veterans are referred between the VA and the community annually. Because these cases are meticulously tracked, we know that individuals referred by the VA are most in need of household goods and transportation. We know that referrals are typically matched to an appropriate organization in under a day and successfully resolved the majority of the time. The VA has full access to this data. This level of transparency and monitoring is possible – it is also happening in places like North Carolina and Texas, to name a few.

Finally, I'd like to provide one of several opposing cases we heard at a recent roundtable we hosted with 11 of our partners who are recipients of the SSG Fox Suicide Prevention Grant Program.

- In one community, the local Suicide Prevention Coordinator was willing to sit shoulder to shoulder with the Fox grantee to develop a dedicated protocol to streamline enrollment for veterans whose risk level made them eligible for the program.
- In other communities, however, local Suicide Prevention Coordinators were hardly aware of the program and their ability to facilitate enrollment in VA care remained unchanged.

We need to make the first community the rule, not the exception. Effective practices require enterprise implementation. We have submitted a full brief on this roundtable and encourage the Committee and the VA to consider incorporating its findings into this important program.

If there is one message to leave you with it is this: There is more to feel hopeful about than there is to criticize.

We are all here because the stakes remain high, and the consequences of failure are quite literally existential – but we have collectively taken meaningful steps toward our shared goal. The evidence bears out. We simply need to monitor our progress and have the courage to adjust course along the way if necessary.

Thank you for the opportunity to share this with you today, and I look forward to your questions.

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record Submitted to
Dr. Matthew Miller, Ph.D., MPH
Executive Director, Suicide Prevention
Office of Mental Health and Suicide Prevention (OMHSP)
Veterans Health Administration (VHA)
Committee on Veterans' Affairs
United States Senate
"Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for our Nation's Veterans"

September 20, 2023

Questions for the Record from Senator Marsha Blackburn

Question 1: What percentage of VA employees currently utilize remote teleworking at least one day a week? How many mental health (MH) professionals operate in a remote capacity (even in a temporary or partial status) for the VA?

VA Response: VA's Human Resources system, HR SMART, provides information about eligibility to telework, not the actual amount of time that an employee performs in a telework status. As of August 31, 2023, 25.9% of all VHA employees are eligible for telework of at least 1 day a pay period, with 36.9% of Mental Health (MH) professionals (Licensed Mental Health Counselor, Marriage Family Therapist (MFT), Peer Support, PT, Psychiatry, Psychology, Nurse (MH), Social Worker (MH)) eligible for telework at least 1 day a pay period.

Question 2: Does the VA currently have any staffing shortages for LPMHCs or MFT? What is the total number of LPMHCs that are employed by the VA as of September 20th, 2023?

VA Response: As of October 3, 2023, VHA has 815 LPMHCs onboard and 269 full-time equivalent (FTE) vacancies. There are currently 209 MFTs onboard and 62 FTE vacancies.

Question 3: What are the minimum qualifications to be qualified, and employed as a Veterans Crisis Line (VCL) Responder?

VA Response: VCL requires that all responders meet basic Federal Government hiring requirements; educational and/or experience requirements; specialized experience and/or education and demonstrate specific knowledge, skills and abilities. Basic Federal Government hiring requirements include U.S. citizenship (as outlined in VA Handbook 5005, Part II, Appendix G64, Social Science Specialist (Crisis Responder) Qualification Standards) and English language proficiency (as required by 38 U.S.C. § 7403(f)).

The following provides further details regarding the minimum qualifications to be qualified and employed as a VCL responder:

1. **Educational and Experience Requirements:** (must meet one) successfully completed a bachelor's degree or higher from an accredited college or university, the degree must be in behavioral health or social science field appropriate to the work of the position (e.g. psychology, social work, sociology, family counseling, mental health counseling, nursing, ministry and criminal justice); or 2 years of specialized experience as a first responder (e.g., Police, Medic, Emergency Medical Technician, Emergency Dispatch, etc.) or in a social science related field that included behavioral health crisis response; and 2 years of higher education (i.e., above the high school level) from an accredited college or university in a behavioral health or social science related field appropriate to the work of the position (e.g., psychology, social work, sociology, family counseling, mental health counseling, nursing, ministry and criminal justice); or successful completion of a bachelor's degree from an accredited college or university in any field and 1 year of specialized experience that included behavioral health crisis response or mental health counseling.

2. **Specialized Experience or Education:** Specialized experience, in addition to the basic requirements, must have 1 year of creditable experience equivalent to the GS-9 grade level, which is directly related to the position to be filled. Specialized experience is defined as: performing crisis intervention work in a clinical behavioral health setting; conducting risk assessments with contacts experiencing an emotional crisis and as a result, may harm themselves or others; coordinating with team members to initiate emergency services or create facility transportation plans, as clinically appropriate; and engaging multiple entities, including law enforcement, medical and mental health providers and third parties; or education can be a Ph.D. or equivalent degree from an accredited college or university in a behavioral health related field appropriate to the work of the position (e.g., psychology, social work, sociology, or family counseling.

3. **Knowledge, Skills and Abilities:** These must be demonstrated by applicants include the ability to provide an evidenced based crisis intervention through a variety of modalities (e.g., telephone interviews, chat/text services, or social media forums); the ability to carry out crisis management steps while withholding judgment on controversial behaviors and not imposing one's values during the contact; and the ability to effectively prioritize complex problems quickly and respond appropriately in a crisis situation.

Question 4: What training does a VCL Responder required to conduct to be qualified for the position?

VA Response: VCL has a robust training program that is accredited by numerous external agencies and provides responders the highest level of preparation to provide

crisis intervention. Specifically, VCL has maintained accreditation with the American Association of Suicidology (AAS) with its most recent re-accreditation in January 2023, as well as the Commission on Accreditation of Rehabilitation Facilities (CARF). The accreditation process for both AAS and CARF involve in-depth reviews of quality and training at VCL, including review of documents, policies, records and Standard Operation Procedures (SOP) related to training to ensure an effective program is in place. The qualified VCL Responders training program includes the following:

1. **Responders complete a total of 160 hours of classroom training:** Prior to completion of a competency test, VCL Responders complete training in the following subjects: Military Culture, post-traumatic stress disorder (PTSD)/Moral Injury, Hazardous Materials, Readjustment, Military Sexual Trauma, Engagement, Motivational Interviewing, Risk Assessment, Violence Risk Assessment Lethal Means Safety, Substance Use and Overdose Risk, Interaction Categorization Guidance, Crisis Intervention, Police Perspective, Medora (electronic record system), Documentation, Medical Records and Mock Workstation.

2. **Final Competency Examination:** Responder trainees are expected to complete a final examination to demonstrate competency at the end of the classroom period. Trainees who do not demonstrate competency are subject to review and potential discharge, as evidenced by the memoranda they sign at the beginning of the training class.

3. **Precept Training:** After completing the training portion, new employees enter a precept phase of training. During this time, new VCL Responders are paired with an experienced individual to provide coaching, training and mentoring. On average, VCL Responders complete over 85 days of training and precepting before being released for independent work.

Question 5: How many total text messages have been sent to the VCL? And how many unique individuals have reached out to the VCL?

VA Response: From February 2011 to October 1, 2023, VCL received a total of 342,607 text messages. VCL received 70,361 texts during Fiscal Year (FY) 2023, which is a 53% increase compared to FY 2022. From February 2009 to October 1, 2023, 2,646,975 unique individuals have reached out to VCL by phone, chat and text.

Question 6: How many Suicide Prevention Coordinators (SPC) are employed by the VA? Is there a SPC located at every VA clinic location? Do all SPCs have an office space suitable to conduct meetings with individuals if requested?

VA Response: As of October 1, 2023, VHA employed 447 SPCs at local health care systems as part of suicide prevention teams. SPCs support suicide prevention programming across the VA enterprise.

Staffing for SPCs is directed by VHA Memorandum 2023-08-12, For Action: Guidance for Reporting and Monitoring of Suicide Prevention Program (SPP) Staffing (VIEWS 10685516), published on August 8, 2023. This memo establishes monthly SPC reporting requirements and dictates that each VA Medical Center (VAMC) and Community-Based Outpatient Clinic (CBOC) large enough to serve more than 10,000 unique Veterans per year must appoint and maintain at least one SPC with a full-time commitment to suicide prevention programming activities. As of October 1, 2023, in reviewing all sites of care required to assign an SPC, 24 VAMCs or very large CBOC were reported to not have 1 FTE Suicide Prevention Coordinator. Health care systems staff full suicide prevention teams who support the effort across the enterprise and include the following: SPCs, Suicide Prevention Case Managers and other support staff. Additionally, health care systems staff Community Engagement and Partnership Coordinators, Peer Support Specialists, Program Support Assistants and Education/Outreach Specialists.

Regarding SPC resources and office space, each Veterans Integrated Service Network is responsible to ensure adequate resources, including office space, to support all the responsibilities for local suicide prevention teams and suicide prevention programing (VHA Directive 1160.07 *Suicide Prevention Program*, dated May 24, 2021).

Question 7: What is the average wait time for a veteran to be seen at a VA clinic by a mental health professional? What is the average wait time for a rural veteran to be seen at a VA clinic by a mental health professional?

VA Response: In FY 2023, the average wait time for a new patient for MH services within the VA was 21.2 days. For established patients, the average wait time was 5.8 days. Similarly, for rural Veterans, the wait times were 21.6 days for new patients and 5.5 days for established patients.

Question 8: How many community care appointments for behavioral health have been scheduled for veterans in FY23? How many appointments have been scheduled to veterans living in highly rural areas in FY23?

VA Response: In FY 2023, there were approximately 1.62 million behavioral health appointments provided through community care. Of this total, approximately 34,500 appointments were for patients residing in highly rural areas. These totals are expected to increase slightly over the coming months as additional claims for FY 2023 services are submitted by community providers for processing.

Question 9: Did you receive an incentive pay award as part of the Critical Skill Incentive (CSI)?

VA Response: The Executive Director for Suicide Prevention received a CSI payment; however, this CSI award was cancelled along with that of other senior executives.

<u>Questions for the Record from Senator John Boozman</u>

<u>Question 1</u>: Dr. Miller, on March 23, 2023, Sec McDonough said he was proud of the seven privately funded VA clinical research studies related to MDMA-Assisted Therapy addressing veteran PTSD and suicide. There appears to be clear bipartisan support for the Secretary to continue and expand these efforts at the VA. How long will it take the VA to set up a program so that it's prepared to administer this therapy upon final Food and Drug Administration (FDA) approval, which is expected in 2024?

<u>VA Response</u>: VA is committed to ensuring access to safe and effective treatments that promote the health of the Nation's Veterans. In line with this goal, VA conducts studies under stringent protocols at various facilities nationwide to identify effective treatments for Veterans experiencing PTSD and suicide risk. VA researchers are currently engaged in studies that are examining if compounds such as 3,4-methylenedioxy-methamphetamine (MDMA) and psilocybin can treat Veterans with PTSD, treatment resistant depressive disorder, major depressive disorder and potentially other mental health conditions. VA monitors ongoing psychedelic research outside VA, and based on the scientific evidence, we will continue to evaluate expanding future studies.

VHA's Office of Research and Development (ORD) and OMHSP continually work together on proactive, planful approaches to determine potential benefits of treatments for Veterans. ORD and OMHSP co-hosted a State-of-the-Art (SOTA) Conference: Psychedelic Treatments for Mental Health Conditions in September 2023 with two aims: 1) to better understand the current state of scientific evidence and to identify a strategic framework to conduct future psychedelic treatment research for select mental health conditions and 2) for agents where U.S. Food and Drug Administration (FDA) approval may be anticipated, to determine the necessary steps for potential VA system-wide clinical implementation. Lessons learned from this conference will be applied to inform consideration of research strategy and policy and practice changes for mental health conditions. VA is actively working on the information generated from the SOTA Conference to consider additional research opportunities.

<u>Questions for the Record from Senator Bill Cassidy</u>

<u>Question 1</u>: What is the current employment status of the VCL responder referenced in the 9/14 VAOIG Report? Has this staffer been required to complete additional training? A reprimand? Since this person clearly made serious errors in the course of performing their core work, partially causing the suicide of a veteran in the VA's care, don't you think some kind of personnel response is in order for this employee?

<u>VA Response</u>: The VCL Responder, noted in VA Office of Inspector General (OIG) Report 22-00507-211, is a current VCL employee; however, this employee no longer performs VCL Crisis Responder duties. The employee was removed from regular silent monitoring duties for approximately 10 weeks while an investigation was completed. The employee received additional coaching and training from April 4, 2022, through April 12, 2022.

A VCL organization-wide change went into effect on March 23, 2022, which stipulated that title 5 (non-clinical) employees may no longer perform VCL Crisis Responder duties. VCL is making meaningful progress on all recommendations outlined in the VA OIG Report 22-00507-211, published on September 14, 2023. This includes actions regarding recommendation 1, which directs the VCL Director to conduct a full review of the VCL Crisis Responders management of the Veteran and third-party contacts, in consultation with Workforce Management Consultants (WMC) and Office of General Counsel (OGC). VCL will take actions as warranted.

<u>Question 2</u>: What is the current employment status of the VCL Director for Quality and Training referenced in the 9/14 VAOIG Report? Coaching an employee in how to "appropriately" respond to questions from the OIG is an egregious action for a senior federal employee. If this employee is still an employee of the VA, why? What personnel actions have been taken in regard to this employee?

<u>VA Response</u>: The VCL Director for Quality and Training referenced VA OIG Report 22-00507-211 remains a VCL employee as the Division Director for Quality and Risk Management. VCL is collaborating with the WMC and OGC to complete a review of case details as recommended by the VA OIG report, and VCL will take actions as warranted.

<u>Question 3</u>: What is the current employment status of the Executive Director of the VCL referenced in the 9/14 VA OIG Report? Is it true that this employee has been "promoted" to the position of Senior Advisor for Health to the VA Secretary at headquarters? If this person is a member of the Senior Executive Service, and thereby can be removed from federal service without cause, why is this employee still in federal service?

<u>VA Response</u>: The prior Executive Director of VCL, Dr. Lisa Kearney, was permanently appointed as a Chief Consultant to the Deputy Under Secretary for Health. This was a lateral move in November 2022 within the Senior Executive Service for Dr.

Kearney, who was asked to take the role after the departure of the prior Chief Consultant. While this role is housed within VHA, Dr. Kearney currently serves as the Senior Advisor on Health in the Office of the Secretary.

Question 4: According to information provided in the 9/14 VA OIG Report, the VCL advises its responders to terminate a text session if a customer is silent for 15 minutes. Why is this the case, when an individual veteran who is suffering could do something drastic in less than 15 minutes?

VA Response: In cases where assessed risk for suicide or violent behavior has been mitigated, the VCL Crisis Responder will prompt the customer to re-engage if a customer stops engaging in the ongoing text conversation. If, after 15 minutes, a customer has not replied to the prompt, the VCL Crisis Responder will encourage the customer to reach back out, provide all VCL contact information and conclude the interaction. It is important to note that if there are still risks for suicide or violence that have not been mitigated, the VCL Crisis Responder will not end the interaction after 15 minutes of non-responsiveness. Instead, they will continue their efforts to engage and consult with a supervisor to explore the possibility of attempting outreach through a phone call. This process is outlined in VCL SOP for Digital Services Interaction Flow, dated July 27, 2023, which provides guidance on handling non-responsive text interactions.

<u>Questions for the Record from Senator Kevin Cramer</u>

<u>Question 1</u>: Dr. Miller, I was encouraged to hear your testimony at our September 20 hearing in which you reiterated the need to address veteran suicide as a top priority for the VA. Supporting the mental health needs of our service members is of critical importance. It is crucial veterans have access to proven therapies as they seek treatment for major depressive disorder and difficult-to-treat depression, including non-drug treatment options. Can veterans, under the guidance of their physicians at the VHA, access all FDA-approved therapies for treatment-resistant depression, including vagus nerve stimulation (VNS)? What is inhibiting therapies like VNS or other non-drug treatment options from being available and accessible to veterans who are struggling with depression proven difficult to treat?

<u>VA Response</u>: VA agrees that treatment resistant depression (TRD) is an impactful health condition among Veterans. It is crucial for Veterans to have access to evidence-based treatments for depression. VNS is one of several evidence-based treatments for patients with TRD. With guidance from their health care providers at VA facilities, Veterans utilizing VA services have access to FDA-approved treatments for TRD, both at VA facilities and through referrals to community care. VA data from FY 2022 indicate that 16 VA facilities treated 116 Veterans with VNS either at the facility or through a community care referral. Veteran access to non-pharmacological treatments for TRD such as VNS may be limited by the complexity of the intervention. The availability of trained providers with adequate expertise to place and manage such devices is often limited. Such interventions are complex, requiring coordination between multiple service lines such as psychiatry, surgery, anesthesia and neurology in order to ensure safety and efficacy. In addition, there are other pharmacological interventions for TRD such as ketamine or esketamine that Veterans may choose prior to invasive surgical procedures.

Questions for the Record from Senator Joe Manchin

Question 1: Mental Telehealth Appointments: As I've now learned, many VAMCs offer telehealth appointments as a way to provide mental health care to veterans but from what I'm hearing from veterans in my state is that they prefer in person appointments which is why the veteran who recently reached out to us, sought care in the community. Additionally, a majority of the veterans who reside in West Virginia tend to have limited access to internet due to the rural nature of our state and may even experience challenges using technology to attend a telehealth appointment because half of our veteran population is above the age of 65. I'd like to know how the VA working to ensure that veterans who are seeking mental health care are able to access in person treatment at a VA facility if they so choose?

VA Response: Telehealth is one of many modalities the offers to provide the soonest and best care to Veterans. Veterans always have the option to utilize a face-to-face appointment instead of telehealth for their care needs if they prefer.

Question 2: Suicide Rates Among Rural Veterans: West Virginia is the third most rural state in the nation, with over 51% of the state's population living in rural areas. Ensuring Veterans in rural America have access to the mental health treatment they need is a top priority of mine. Based on the 2022 National Veteran Suicide Prevention Report, rural and highly rural veterans are at a higher risk for suicide. Can you tell me what demographic differences in rural or highly rural veteran populations you believe would contribute to these high rates of suicide? How is the VA's suicide prevention office addressing these specific characteristics that drive rural veteran suicide?

VA Response: The 2022 National Veteran Suicide Prevention Report provides information on suicide rates by rurality, as defined by patient zip codes, among Veteran VHA Users only. Information on suicide rates by rurality among all Veterans is currently not available. The analysis finds elevated suicide rates among Veteran VHA users with rural (including highly rural) residence for all years in the period 2001-2020. The report notes that this disparity is partly attributed to demographic differences among Veteran VHA users by rurality status and cites, in a footnote, with work by Peltzman et. al (2022), which explores the role of race in explaining rural-urban suicide differences among VHA users. This study, which looked at all VHA users between 2003 and 2017, concluded that differences in the racial composition of rural and urban VHA users were the primary driver of the observed rural-urban suicide disparity, as rural users were significantly more likely to be White, and White VHA users were the group with the highest suicide rate. This conclusion was derived from analyses, which found that when race was added to models comparing rural and urban suicide rates, differences in rural and urban rates overall were not significant. Although this does not change the fact of an observed higher rate among rural VHA users from 2001-2020, it does suggest that this finding is primarily reflective of a persistently higher concentration of White Veteran VHA users in rural settings.

Given this important finding, a supplemental analysis was conducted for the 2022 National Veteran Suicide Prevention Report (results are presented in the aforementioned footnote) comparing rural and urban suicide rates, stratified by race and Hispanic ethnicity. This analysis found that between 2016 and 2020, suicide rates were lower for some groups of rural Veteran VHA users (14.6% lower for American Indian or Alaska Native Veterans, 16.5% lower for Black Veterans) and higher for others (2.7% higher for White Veterans, 3.8% higher for Native Hawaiian or Pacific Islander Veterans, 26.2% higher for Hispanic Veterans and 8.8% higher for Veterans with multiple race categories). Although these rates were not compared in statistical analysis for the report, they support findings from Peltzman (2022), which found that Hispanic VHA users had rates that were significantly higher in rural settings, while differences between rural and urban populations were not significant among White or Black VHA users. Work by Shiner et. al (2023) explored what factors might be driving this disparity and did not find stark demographic, clinical, or community differences in suicide risk between rural and urban Hispanic patients, but did note that mental health diagnoses and particularly substance use disorders were important drivers in both groups.

<u>Questions for the Record from Senator Kyrsten Sinema</u>

<u>Question 1</u>: As you know, the transition from active duty to civilian life or retired status can be an exceptionally challenging period, particularly for servicemembers grappling with substance use disorders. Reliable, ongoing support is vital during this sensitive time, both for the servicemembers themselves and for their families. Within the Department of the Navy, there has been a critically important program aimed at this vulnerable population: NavyMORE (My Ongoing Recovery Experience). This program has offered digitally accessible treatment for substance use disorders, benefiting not only active-duty servicemembers but also their families and veterans. Unfortunately, this program has recently had to suspend its operations due to a lapse in funding, leaving a glaring gap in the continuum of care. Could you provide information on any community-based programs to support Veteran recovery from mental health and substance use disorders, including data on their efficacy over time, similar to the Navy's utilization of and supporting data on outcomes for participants in the Navy My Ongoing Recovery Experience program?

<u>VA Response</u>: 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. Available mobile apps include those for use by Veterans (self-help) to support their ability to cope with personal issues (e.g., PTSD symptoms, PTSD and 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 goal is to empower Veterans and their families and potentially support VA's efforts to improve access to care. Please see: https://mobile.va.gov/appstore/mental-health.

Step Away is a mobile app for the self-management of drinking behaviors. It is one of the few mobile apps in which there are data from a randomized controlled trial demonstrating its effectiveness in improving drinking outcomes for adults. Stand Down is the Veteran version of the Step Away app. Stand Down is not a VA App and is not located on the VA App Store; however, it was developed with input from VA staff and is currently under study in VA. In an open trial, Veterans who screened positive for hazardous drinking during a primary care visit and were not receiving treatment for their drinking were asked to use the Stand Down app for 4 weeks and to concurrently receive weekly phone support from a Peer Specialist to facilitate engagement with the app. Acceptability of the intervention was high, and patients reported significant reductions in total standard drinks, drinks per drinking day and heavy drinking days over 4 weeks. Similar results were reported in an open trial study of Veterans using the Step Away app as a standalone intervention (without Peer Specialist facilitation). A large randomized controlled trial of the Stand Down app (with and without Peer Specialist facilitation) is currently underway at two VAMCs. If found to be effective in that trial, the Stand Down

app can address the VA's goal of offering harm reduction techniques and expanding outreach to Veterans with a substance use problem who are not currently engaged in treatment for these problems at a VA facility.

VetChange is a free online self-management program for active-duty military and Veterans who are concerned about their drinking following military deployment. VetChange was created in 2011 with support from the National Institute on Alcohol Abuse and Alcoholism. The results from a randomized controlled trial (https://psycnet.apa.org/doilanding?doi=10.1037/a0033697) of this early version produced evidence that the intervention helped many Veterans reduce their drinking and PTSD symptoms. The current version was developed by Boston University and VA Boston Healthcare System with support from the National Center for PTSD and the Bristol-Myers Squibb Foundation.

Question 2: Could you speak to the challenges and repercussions of phasing out specialized programs like NavyMORE, especially at a time when our nation is striving to improve mental health and suicide prevention measures for our veterans? How can we ensure that effective programs are not just created but also maintained for the long-term benefit of our servicemembers and veterans?

VA Response: VA did not use or implement the NavyMORE program.VA defers to the Department of Defense (DoD) on sustainment of DoD programs.

Questions for the Record from Senator Thom Tillis

Question 1: Regarding the VA OIG concerning access to care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, NC, the OIG learned that a patient had psychotherapy consults due to misconstrued information from prescribers believing that "permission" from the Behavioral Health Interdisciplinary Program (BHIP) team was required before placing a psychotherapy consult in a patient's health record. Was the VA able to conclude that the patient's death was indeed an accidental death or is it possible that the delayed care resulted in the patient committing suicide by motorcycle?

VA Response: VA concluded the Veteran's death was not a suicide based on the report of the Veteran's spouse and the State Highway Patrol. The Veteran's death certificate was requested and does not indicate suicide.

The OIG report describes their review of a Veteran's VA MH care from 2014-2021 and, specifically, focuses on the 28 days of care in 2021 the Veteran received at the Asheville VAMC for MH treatment. The Veteran did not experience a delay in care. From the first day of engagement with care at the Asheville VAMC on August 10, 2021, until his death 28 days later on September 6, 2021, the Veteran was provided 19 encounters from services across the continuum of care including Same Day MH Service, outpatient MH, Homeless program, Suicide Prevention, Inpatient Medicine with MH consulting, Post 9/11 Case Management and the VCL. He had seven encounters with outpatient MH staff that included medication management and supportive psychotherapy. A Behavioral Health Interdisciplinary Program (BHIP) consult was placed for this Veteran on day one of his outpatient care, and he was scheduled for 2 weeks later, which is not considered delayed per VA access guidelines. The Veteran did not appear for this BHIP consult appointment. In the 7 days following the missed appointment, four attempts were made to reach the Veteran to reschedule the BHIP consult appointment.

On day seven, after the missed appointment, the Veteran's provider was able to contact him and encouraged him to present to the Emergency Department for admission to inpatient psychiatry. The Veteran was admitted to a medical unit due to testing positive for Coronavirus Disease 2019. He was assessed by MH consult and medical staff and released the next day at the Veteran's request. The Veteran was assessed by the MH consult team prior to his release, and it was determined he did not meet the criteria for involuntary commitment. The Veteran received timely follow-up from his outpatient provider 1 day after his discharge from the inpatient medical unit. The Veteran's provider was providing medication management and supportive psychotherapy, including Motivational Interviewing, at each encounter. The Veteran was assessed for suicide risk in three settings (outpatient mental health, emergency department, inpatient medicine) by three different providers over the course of his treatment. While he endorsed vague suicidal ideation in these assessments, he credibly denied intent, plan or means to harm himself.

<u>Question 2</u>: I know VA was working with nonprofits on suicide prevention well before the Hannon Act and the Fox grants came to be. In one case, VHA's Office or Mental Health and Suicide Prevention teamed up with The Independence Fund based in my state to support their Operation Resiliency combat unit reunions and mental health retreats with peer-to-peer support as the core objective. Does VA collect any data on those earlier and now still ongoing nonprofit engagements that do not require Federal funding, or do you derive any "lessons learned" from those collaborations where VA staff come in direct contact with nonprofits aiding Veterans needing mental health support?

<u>VA Response</u>: Currently, neither the Office of Mental Health nor the Office of Suicide Prevention have any existing formalized partnerships with The Independence Fund. The Office of Mental Health and Suicide Prevention (OMHSP) and The Independence Fund had a Memorandum of Agreement (MOA) from January 11, 2021, through January 11, 2022. The primary objective of the MOA was to collaborate to expand the reach and awareness of suicide prevention, create awareness and/or educational opportunities and explore opportunities to identify Veterans not enrolled in VHA. While VA did not collect any data on that earlier engagement provided under the 2021 MOA, the Office of Suicide Prevention did assist The Independence Fund with the creation and initial implementation of a program evaluation plan and survey applied to Operation Resiliency. More broadly regarding partnerships and data collection, VA and VHA policy and guidance pertaining to the establishment, maintenance and evaluation of partnership effectiveness do require formalized and agreed-upon key performance indicators consistent with and valid indicators of defined goals and objectives specific to the partnership.

<u>Question 3</u>: I have heard that in some cases a Veteran may call the Crisis Line and first responders, including police, are sometimes dispatched to check on that Veteran. What is VA doing to connect with law enforcement agencies nationally on a state-by-state basis to help them understand the critical role they play in preventing or de-escalating violence by Veterans in crisis and appropriately diverting them for appropriate mental health care versus arrest and incarceration? I know some of this work is being done by The Independence Fund, a nonprofit in my state, to bridge that gap, but I would think VA has a role to play here as well.

<u>VA Response</u>: VA Suicide Prevention has developed a strong relationship with the Office of Operations, Security and Preparedness and the VA Law Enforcement Training Center who are leaders in Veteran de-escalation and violence prevention. Our teams work closely to build connections with and present for outside law enforcement agencies at conferences and trainings. The goal is to create understanding of Veteran-specific issues and the importance of prevention, de-escalation and diversion of Veterans from criminal justice and into healthcare. In FY 2023, our VA Suicide Prevention collaborated with the VA Police Service and Veterans Justice Programs to foster the growth of community police interventions designed to deflect Veterans into needed services and out of contact with the criminal justice system. To foster this growth, VAMCs were required to select three-person community partnership teams

consisting of one Veterans Justice Outreach Specialist, one VA Police Officer and one mental health provider to attend a one-time training. The aim of this training is to prepare these local VAMC teams to engage their communities around Veteran deflection efforts, creating pathways into care.

Additionally, in FY 2023 VA Suicide Prevention presented at the National Tactical Officers Association Conference and VA Police Chiefs conference to train community and VA police agencies on specific Veteran drivers of risk, as well as prevention, intervention and educational resources specially designed for police. VA Suicide Prevention also works with Substance Abuse and Mental Health Services Administration though their Crisis Intercept Mapping (https://www.samhsa.gov/smvf-ta-center/crisis-intercept-mapping) program and our Community-Based Interventions for Suicide Prevention program to support communities seeking to increase coordinated crisis care services.

Questions for the Record from Senator Tommy Tuberville

Question 1: What type of predictive analytics does the VA use to determine whether an individual is at a higher risk of self-harm or suicide?

VA Response: VA employs a suicide risk prediction algorithm in a program called Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) to alert facilities of Veterans at the top 0.1% increased statistical risk for those Veterans in VHA care at those facilities. This algorithm is based on data from the past 2 years of the VA health record to help streamline clinical reviews and provide an additional clinical data point for conceptualization and treatment enhancement by the treatment team. Although identified Veterans are at high statistical risk for adverse outcomes, including suicide, this does not necessarily indicate current acute clinical risk for suicide. REACH VET is intended to supplement, rather than replace, current clinical strategies. REACH-VET has been associated with increased attendance at outpatient appointments, a greater proportion of individuals with new safety plans and reductions in mental health admissions and emergency department visits and reduction in suicide attempts. Please see McCarthy et al. 2021, Evaluation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration. JAMA Network Open. 4(10):e2129900. doi:10.1001/jamanetworkopen.2021.29900 below.

Question 2: Has the model flagged veterans who have died by suicide? Have there been any veterans who have died by suicide but were not flagged as high risk of self-harm using the REACH Vet model?

VA Response: Yes, the REACH VET algorithm identifies high-risk Veterans and of those who are identified, some have died from suicide. This is documented in a published evaluation of the effectiveness of the REACH VET algorithm. Please see McCarthy et al. 2021, Evaluation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration. JAMA Network Open. 4(10):e2129900. doi:10.1001/jamanetworkopen.2021.29900.

Sen. Tuberville Statement: Dr. Miller, last week, the Office of Inspector General published a troubling report regarding a veteran who died by suicide after texting with a Veterans Crisis Line responder for 75 minutes. Of the many issues the report identified, the VCL appears to not have text retention capability, resulting in a family member having to screen shot the text chain back to the VCL to review whether situation was handled appropriately by the responder.

Question 3: There are numerous issues recognized in the report, but at a minimum, has the VCL instituted text message retention since this investigation concluded?

VA Response: As the VA OIG Report 22-00507-211 notes, VCL examined available options for the retention of interaction transcripts in the VCL Medora information system after current and prior text service vendors could not supply this feature. A method of retaining text transcripts was identified through copying and pasting the interaction transcript from the text service to Medora. This method was reviewed and approved by the Privacy/Freedom of Information Act Officer. This method has been in place since May 2022. In addition, VCL enhanced procedures for Silent Monitors to verify the text interaction is pasted into Medora during their review process through a modification of the Policy for Crisis Responder Interaction Standards and Silent Monitoring SOP, dated July 10, 2023. Additionally, the SOP (dated July 28, 2023) for Social Science Specialist (Crisis Responder) Documentation Guidelines now requires VCL Crisis Responders to paste transcripts for chat and text interactions into Medora.

Senator Tuberville Statement: Months after the veteran died by suicide, their family continued to receive information from the VA regarding appointments they had been scheduled for, because their health record had not been updated to reflect their death.

Question 4: Will the VA be reviewing all case files of veterans who have contacted the VCL regarding suicide or self-harm ideations to determine if their health records have been updated accordingly?

VA Response: VA has established guidance to ensure coordination between VCL and facility electronic health record documentation. Specifically, VHA Memorandum 2023-03-21 Enhancing Management and Oversight of Veterans Crisis Line (VCL) Requests (VIEWS 9623904), dated March 15, 2023, established that facility managers must complete regular, ongoing performance reviews of facility SPCs' management of VCL Requests pursuant to VHA Directive 1503(2), Operations of Veterans Crisis Line Center, May 26, 2020, sections 5.n. and 5.o and the minimum requirements described in this memorandum.

The memorandum required facilities to conduct performance reviews within 120 days of publication of the memorandum and to develop an ongoing quality assurance process that established the following requirements:

1. A time-based cadence for VCL Request periods of review;
2. The number or percentage of records to be reviewed within the period;
3. A clinical case review of VCL Request management electronic health record documentation for all required clinical documentation; and
4. Confirmation of SPC compliance with completing VCL outreach attempts that are interspersed over a consecutive 3-day period when outreach efforts to the customer have been unsuccessful.

Department of Veterans Affairs
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Supplemental Online Content

McCarthy JF, Cooper SA, Dent KR, et al. Evaluation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment suicide risk modeling clinical program in the Veterans Health Administration. *JAMA Netw Open*. 2021;4(10):e2129900. doi:10.1001/jamanetworkopen.2021.29900

eAppendix. Parallel-Trend Assumption Tests for REACH VET Evaluation Outcomes Prior to and After Identification

eTable 1. Mean Continuous Outcomes per Cohort and Time Period

eTable 2. Proportion Outcomes per Cohort and Time Period

This supplemental material has been provided by the authors to give readers additional information about their work.

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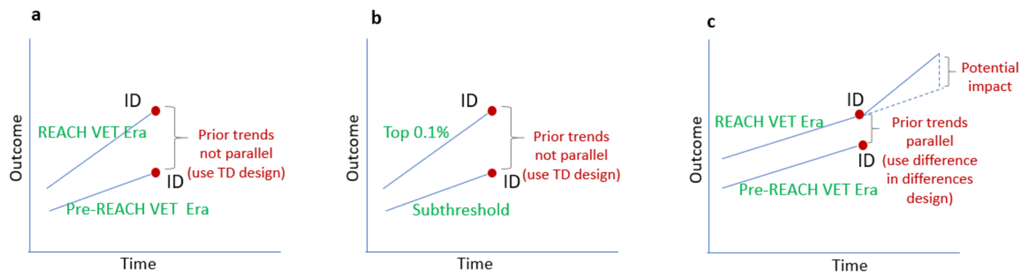
eAppendix. Parallel-Trend Assumption Tests for REACH VET Evaluation Outcomes Prior to and After Identification

Background

Difference in differences analyses assume that in the absence of an intervention the differences between treatment and control groups would remain constant over time.[1] In cases where parallel trends are not observed in a pre-intervention period, it is appropriate to employ a triple differences (TD) study design, in order to adjust for non-parallel trends. In this study, the parallel trend assumption was assessed for each measure, for two possible differences-in-differences approaches: 1) differences across REACH VET and pre-REACH VET time periods among patients identified in the top 0.1% risk tier, and 2) differences across risk tiers (top 0.1% versus subthreshold) among those in the REACH VET era. Panel a and b in the illustrative figure below show violations of the parallel trend assumption, thus requiring a TD approach, and panel c demonstrates parallel trends, which would be consistent with use of the difference-in-differences approach.

Appendix Figure: Parallel Trends Assumption and Implications for Design: Illustrative Examples



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Methods

To assess for parallel trends, outcomes were collected across four 6-month periods prior to each patient's cohort entry (prior 0-6 months, prior 6-12 months, prior 12-18 months, prior 18-24 months). The parallel trend assumption across REACH VET eras among individuals in the top 0.1% risk tier was assessed using an interaction term between time period and REACH VET era (Model 1). The parallel trend assumption across REACH VET risk tiers among those in the REACH VET era was assessed using an interaction between time period and REACH VET risk tier (Model 2). The estimate and 95% confidence intervals for the difference in the associations with time across groups are presented in Appendix Table 1, below. A 95% confidence interval excluding zero indicates a statically significant difference in the pre-identification trends across groups during the 24 months prior to identification into the REACH VET cohort. In these cases, the parallel trend assumption is violated.

Model 1: Parallel Trend Assumption Test for Differences in Differences across REACH VET Eras among the Top 0.1% Risk Tier

$$\text{Outcome}=\beta_0+\beta_1*\text{REACH_VET_Era}+\beta_2*\text{Time}+\beta_3*\text{REACH_VET_Era}*\text{Time}+\varepsilon_i$$

Population was limited to those in the top 0.1% risk tier.

Time was a continuous indicator for the four 6-month periods prior to the patient's REACH VET identification date.

Model 2: Parallel Trend Assumption Test for Differences in Differences across REACH VET Risk Tiers in the REACH VET Era

$$\text{Outcome}=\beta_0+\beta_1*\text{Top0.1\%Tier}+\beta_2*\text{Time}+\beta_3*\text{Top0.1\%Tier}*\text{Time}+\varepsilon_i$$

Population was limited to those in the REACH VET era.

Time was a continuous indicator for the 4, 6-month periods prior to the patients REACH VET identification date.

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While the triple differences estimation adjusts for non-parallel trends across groups, there may be residual differences in trends across comparison groups.[1] To assess any differences in trends within the pre-identification period, we used an interaction between time period, REACH VET risk tier, and REACH VET era (Model 3). Estimates with a 95% confidence interval that did not include zero indicated that adjustment for period and risk-tier was insufficient to eliminate all pre-REACH VET identification trends. There may be unobservable factors contributing to trends in these outcomes even in the absence of the REACH VET program and consequently results for outcomes that violate the triple differences parallel trend assumption should be interpreted with caution.

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Model 3: Parallel Trend Assumption for Triple Differences

$$Outcome=\beta_0+\beta_1*Time+\beta_2*REACH_VET_Era+\beta_3*Top0.1\% +\beta_4*Time*REACH_VET_Era+\beta_5*Time*Top0.1\%$$

$$+\beta_6*REACH_VET_Era*Top0.1\%+\beta_7*Time*REACH_VET_Era*Top0.1\%+\varepsilon_i$$

Time was a continuous indicator for the four 6-month periods prior to the patients REACH VET identification date.

Results

eAppendix Table. Parallel Trend Assumption Tests[a]

	Differences in Differences across REACH VET Eras within Top 0.1% Risk Tier	Differences in Differences across Threshold Groups within the REACH VET Era	Triple Differences
Outcome	Estimate (95% Confidence Interval)	Estimate (95% Confidence Interval)	Estimate (95% Confidence Interval)
Average Scheduled Outpatient Appointments	-0.023 (-0.082, 0.037)	**0.136 (0.075, 0.197)**	0.005 (-0.075, 0.086)
Average Completed Outpatient Appointments	-0.031 (-0.080, 0.018)	0.015 (-0.034, 0.065)	-0.028 (-0.095, 0.037)
Proportion of Scheduled Outpatient Appointments Missed	-0.002 (-0.004, 0.001)	**0.013 (0.011, 0.016)**	0.003 (-0.001, 0.006)
Average Outpatient Mental Health Visits	**0.610 (0.528, 0.691)**	**1.478 (1.381, 1.575)**	**0.531 (0.409, 0.652)**
Average Inpatient Mental Health Admissions	**0.016 (0.014, 0.019)**	**0.040 (0.039, 0.042)**	**0.019 (0.017, 0.022)**
Average Emergency Department Visit Days	**0.020 (0.016, 0.025)**	**0.064 (0.059, 0.069)**	**0.016 (0.010, 0.022)**
Proportion with Any Documented Suicide Attempt	**0.002 (0.002, 0.003)**	**0.005 (0.004, 0.005)**	**0.002 (0.001, 0.003)**
Proportion with Any Safety Plan Documentation	**0.017 (0.016, 0.018)**	**0.015 (0.014, 0.016)**	**0.007 (0.006, 0.009)**

[a] bold indicates significance and violation of parallel trends assumption.

The parallel trend assumption was violated for all differences-in-differences analyses except for average number of scheduled outpatient appointments, average number of completed outpatient appointments, and proportion of scheduled outpatient appointments missed across REACH VET eras, among the top 0.1% risk

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tier, and for number of completed outpatient appointments across risk tiers, in the REACH VET era. In these instances, a differences-in-differences approach may have been sufficient, yet since all other outcomes indicated that a TD analysis was warranted, that more conservative approach was employed for all outcomes.

The TD parallel trend assumption was violated for all outcomes except the number of scheduled and completed outpatient appointments and the proportion of scheduled outpatient appointments that were missed. The violation of the TD parallel trend assumption does not prevent one from drawing conclusions, yet requires a more nuanced interpretation of the results.[1,2,3,4] Trends for inpatient mental health admissions, emergency department visit days, prevalence of any documented suicide attempt, and prevalence of any safety plan documentation prior to identification into REACH VET were in the opposite direction of the observed associations of the REACH VET program. This suggests that the true magnitude of the REACH VET association may be larger than what was documented, given the presence of non-parallel trends. Meanwhile, the pre-identification trend for outpatient mental health visits was in the same direction as the REACH VET association. However, since the TD assessment of the REACH VET association with outpatient mental health visits was non-significant, the pre-identification trend does not change our conclusions. Overall, pre-identification trends were close to zero and frequently were in the opposite direction from the observed REACH VET TD associations. The latter case suggests that there may be greater REACH VET associations than were ascertained in the TD analysis, because the TD design insufficiently controlled for pre-existing trends in the outcome. We note that significant TD parallel trend assumption tests may reflect the high statistical power of these tests rather than substantive differences in trends.

[1]Olden A, Moen J. The Triple Difference Estimator. NHH Dept. of Business and Management Science Discussion Paper No. 2020/1. 2020. Retrieve from https://ssrn.com/abstract=3582447

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eTable 1. Mean Continuous Outcomes per Cohort and Time Period

	Pre-REACH Vet Top 0.1%				Pre-REACH Vet 0.3%-0.1%				REACH Vet Top 0.1%				REACH Vet 0.3%-0.1%			
	Prior 6-Months		Subsequent 6-Months		Prior 6-Months		Subsequent 6-Months		Prior 6-Months		Subsequent 6-Months		Prior 6-Months		Subsequent 6-Months	
Outcome	Average	Std Dev	Average	Std Dev	Average	Std Dev	Average	Std Dev	Average	Std Dev	Average	Std Dev	Average	Std Dev	Average	Std Dev
Scheduled Outpatient Appointments	10.70	13.1	16.85	21.6	10.69	12.9	13.82	17.7	11.82	14.8	17.12	22.3	11.62	14.5	13.58	18.0
Completed Outpatient Appointments	6.93	9.9	11.31	17.6	7.33	10.0	9.69	14.4	7.56	11.3	11.50	17.8	8.00	11.2	9.54	14.2
Outpatient Mental Health Visits	30.23	32.2	37.66	52.6	23.51	31.9	23.66	41.6	36.01	37.8	40.74	56.8	26.15	36.1	23.06	43.1
Inpatient Mental Health Admissions	1.22	0.8	0.49	1.0	0.78	0.8	0.21	0.6	1.27	0.9	0.50	1.0	0.74	0.8	0.19	0.6
Emergency Department Visit Days	2.08	2.3	1.30	2.4	1.70	2.0	0.90	1.8	2.21	2.6	1.32	2.6	1.72	2.1	0.87	1.8

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eTable 2. Proportion Outcomes per Cohort and Time Period

	Pre-REACH Vet Top 0.1%		Pre-REACH Vet 0.3%-0.1%		REACH Vet Top 0.1%		REACH Vet 0.3%-0.1%	
	Prior 6-Months	Subsequent 6-Months	Prior 6-Months	Subsequent 6-Months	Prior 6-Months	Subsequent 6-Months	Prior 6-Months	Subsequent 6-Months
Outcome	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)
Scheduled Outpatient Appointments Missed[a]	135,803 (35.0)	194,896 (32.7)	154,785 (31.2)	188,312 (29.7)	170,886 (35.9)	224,649 (32.8)	170,924 (30.8)	193,795 (29.7)
Any Documented Suicide Attempt	3,778 (10.3)	1,040 (2.8)	2,049 (4.3)	468 (1.0)	5,251 (12.9)	1,188 (2.9)	2,214 (4.5)	405 (0.8)
Any Safety Plan Documentation	19,508 (53.3)	7,992 (21.8)	15,774 (33.5)	4,982 (10.6)	28,021 (68.7)	11,778 (28.9)	20,430 (41.9)	6,196 (12.7)
New Safety Plan[b]	---	1,982 (12.8)	---	1,439 (5.2)	---	1,812 (16.8)	---	1,332 (5.6)
All-Cause Mortality[c]	---	712 (1.9)	---	1,349 (2.9)	---	884 (2.2)	---	1,546 (3.2)

[a]Total appointments missed. Cohorts were limited to those with at least one appointment in the prior and subsequent six months (Total N = 158,346).

[b]Cohorts were limited to those with no safety plan in the prior two years (Total N = 77,625)

[c]Mortality ascertained from the Vital Status File. Cohorts were limited to those for which vital status could be ascertained (Total N = 173,305)

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Veteran drug overdose mortality, 2010–2019

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ABSTRACT

Background: Prior work documents that Veteran drug overdose mortality increased from 2010 to 2016. The present study assessed trends from 2010 to 2019, by drug type and recent receipt of Veterans Health Administration (VHA) services, and compared rates for Veteran and non-Veteran US adults.

Methods: This retrospective cross-sectional study used data from Veterans Affairs (VA) medical records, the VA/Department of Defense Mortality Data Repository, and CDC WONDER. Trends were compared using Joinpoint regression.

Results: From 2010–2019, age-adjusted overdose mortality rates increased 53.2% among Veterans and 79.0% among non-Veterans. Age-adjusted rates of overdose mortality among Veterans rose from 19.8/100,000 in 2010 to 32.6/100,000 in 2017, before falling to 30.3/100,000 in 2019. Despite the decrease from 2017 to 2019 in overall overdose mortality, rates of overdose deaths involving synthetic opioids other than methadone and involving psychostimulants continued to increase through 2019. In 2019, overdose mortality was lower for male Veterans than male non-Veterans (standardized rate ratio (SRR) = 0.81, 95% confidence interval (CI): 0.77–0.84). Among male Veterans, rates were higher in all years for those with recent VHA use than those without (2019: SRR=1.69, 95% CI: 1.56–1.83). From 2010–2019, overdose mortality rates increased faster among female Veterans without VHA use than those with VHA use.

Conclusions: From 2015 onward, Veteran men experienced lower age-adjusted overdose rates than non-Veteran men. In all years, overdose rates were higher among male Veterans with recent VHA use than those without recent use. While overall rates of Veteran overdose deaths declined from 2017 to 2019, rates involving psychostimulants and synthetic opioids continued to rise.

1. Introduction

From 1999–2019, the United States (US) rate of drug overdose mortality increased by 254.1%. (Hedegaard et al., 2020) The percentage of US overdose deaths that involved opioids rose from 47.8% in 1999 to 70.6% in 2019. Stimulant involvement in overdose deaths rose from 25.9% in 1999 to 45.4% in 2019, with rapid increases in overdose deaths involving cocaine and psychostimulants with abuse potential, such as methamphetamine.

Overdose mortality trends vary by demographic and geographic factors and by the specific drugs involved. The few studies that have examined overdose mortality among US Veterans have primarily focused on patients receiving care in the Department of Veterans Affairs health system, the Veterans Health Administration (VHA). (Ilgen et al., 2016; Lin et al., 2019; Warfield, 2019) For example, research indicates that the fiscal year 2005 rate of opioid overdose mortality in VHA patients was nearly twice that of the general US population. (Bohnert et al., 2011) However, Veterans with recent VHA care comprised only 32.5% of all Veterans in 2018, and VHA findings may not generalize to the overall Veteran population. (U.S. Department of Veterans Affairs Office of Mental Health and Suicide Prevention, 2020a). Indeed, Veterans in VHA care have a higher prevalence of chronic pain, medical, and mental health conditions than other Veterans. (Meffert et al., 2019) Opioid overdose prevention efforts in VHA include reducing opioid prescribing, increasing naloxone distribution, and substance use screening, treatment, and education. (Gellad et al., 2017; U.S. Department of Veterans

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Table 1
Veteran Overdose Mortality Rates,[a] 2010–2019, Overall and by Drug Type[b].

	All drug overdose			Opioid overdose			Stimulant overdose		
	2010 Rate	2019 Rate	Change from 2010 to 2019	2010 Rate	2019 Rate	Change from 2010 to 2019	2010 Rate	2019 Rate	Change from 2010 to 2019
All Veterans	19.8	30.3	53.2%*	11.1	21.5	93.4%*	3.0	12.9	333.4%*
Sex									
Female	17.9	18.0	0.4%	8.9	11.3	26.3%*	1.9	5.2	168.0%*
Male	20.3	32.8	61.2%*	11.7	23.6	102.5%*	3.1	14.3	361.1%*
Age group (years at death)									
18–24	16.8	16.0	-4.7%	12.1	12.2	1.0%	–[c]	5.7	–
25–34	22.3	38.7	73.4%*	13.8	31.4	127.9%*	2.7	13.7	402.4%*
35–44	21.3	41.8	96.2%*	11.7	29.9	156.6%*	3.2	17.9	454.0%*
45–54	32.2	31.1	-3.4%	17.0	21.0	23.3%*	5.9	14.6	148.8%*
55–64	20.9	41.0	96.7%*	10.2	25.3	147.8%*	4.3	20.5	374.4%*
65+	3.5	9.3	167.2%*	1.1	5.0	337.8%*	0.2	3.9	1490.2%*
Geographic region[d]									
Midwest	20.0	33.6	67.8%*	10.7	24.3	125.6%*	2.9	12.5	334.8%*
Northeast	22.4	52.8	136.1%*	11.9	43.9	267.9%*	3.6	20.8	483.5%*
South	17.7	24.9	40.6%*	10.1	17.7	74.9%*	2.5	10.8	336.3%*
West	22.5	27.3	21.5%*	13.0	15.4	17.7%	3.8	13.5	255.2%*
Race[e]									
American Indian, Alaskan Native	23.3	22.7	-2.6%	11.7	10.4	-10.5%	–	11.0	–
Asian, Hawaiian, or Pacific Islander	15.6	17.4	11.4%	7.8	9.6	22.7%	4.6	8.1	77.2%
Black	16.5	34.5	109.4%*	6.6	22.1	236.3%*	7.8	20.6	164.7%*
Multiple Races	17.2	69.5	304.1%*	7.9	48.0	510.1%*	–	34.6	–
White	15.6	21.5	37.4%*	8.3	14.2	70.2%*	1.9	8.7	358.2%*
Ethnicity[f]									
Hispanic	17.4	20.5	18.1%	10.0	13.1	31.2%*	3.6	9.4	165.3%*
Not Hispanic	15.4	24.0	55.4%*	7.9	15.7	99.6%*	2.5	10.8	322.3%*
Recent Use of VHA Services[g]									
Yes	37.0	41.7	12.8%*	21.0	29.7	41.2%*	5.3	18.0	242.3%*
No	15.6	25.7	65.1%*	8.7	18.3	108.9%*	2.4	10.7	356.0%*

* Statistically significant difference (for rates based on <100 deaths, no overlap of gamma confidence intervals; for rates based on >100 deaths, z-tests with $p < .05$).
[a] Crude rates are presented for age, race, and ethnicity groups. Historic Veteran population estimates were not available stratified by both age and race or ethnicity. Therefore, crude rates are presented for race and ethnicity groups. All other rates presented are age-adjusted.
[b] An overdose death identified as involving both an opioid and a stimulant contributed to rates for each group.
[c] Rates based on fewer than 10 deaths have been suppressed in accordance with privacy standards
[d] US Census Regions, determined by state of death
[e] Race was missing for 2.8% of decedents. Race groups presented reflect individuals identified as exclusively belonging to that category.
[f] Ethnicity was missing for 3.3% of decedents
[g] Recent use defined as a VHA encounter during year of death or year prior

Affairs Opioid Overdose Education & Naloxone Distribution (OEND) Program - Pharmacy Benefits Management Services, 2021) Recent VHA efforts to treat stimulant use disorders include contingency management approaches and evidence-based medication therapies. (DePhilippis et al., 2018; Gordon et al., 2020).

A recent analysis of the entire Veteran population for 2010–2016 suggests that trends in opioid-involved Veteran overdose deaths align with those for the overall US adult population. (Peltzman et al., 2020).

The present analysis builds on this work by examining Veteran overdose mortality in the period of 2010–2019, considering additional drug types, demographic factors, and recent use of VHA services. Finally, the present analysis provides statistical comparisons of rates for Veterans and non-Veteran US adults.

2. Methods

This analysis examined 536,478 drug overdose deaths within the 50 US states and Washington, D.C., from 2010 to 2019. (Hedegaard et al., 2020) Of these, 42,627 were deaths of Veterans. Veterans were defined as "persons who served on federal active duty and were not currently serving at the time of their death", using methodology consistent with the National Veteran Suicide Prevention Annual Report. (U.S. Department of Veterans Affairs Office of Mental Health and Suicide Prevention, 2021a). Veteran deaths were identified using National Death Index search results included in the Department of Veterans Affairs/Department of Defense Mortality Data Repository. (U.S. Department of Veterans Affairs Office of Mental Health and Suicide Prevention, 2021b). Veteran overdose rates were calculated using linearly interpolated estimates of the Veteran Population Projection Model 2018 (VetPop2018) population, calculated to provide a point estimate as of July 1 of each year. (National Center for Veterans Analysis and Statistics, 2021; VA Office of Mental Health and Suicide Prevention, 2021a) Counts of overdose deaths among the general US adult population (ages 18 and older) and corresponding population estimates were obtained from Centers for Disease Control (CDC) Wide-ranging ONline Data for Epidemiologic Research (WONDER). (Centers for Disease Control and Prevention, 2021) Non-Veteran numbers were estimated by subtracting known Veteran counts from general US adult population numbers. Age-adjusted rates were calculated based on the 2000 Projected US population and displayed per 100,000 population. (Klein and Schoenborn, 2001) Standardized rate ratios (SRR) were calculated to compare age-adjusted rates among the Veteran and non-Veteran US adult population, stratified by sex. Use of VHA services was obtained from the Veterans Affairs Corporate Data Warehouse database of patient health records, and recent Veteran VHA users were defined for each calendar year as Veterans who had a VHA encounter in either that calendar year or the prior year. (U.S. Department of Veterans Affairs Office of Mental Health and Suicide Prevention, 2020b). Veteran VHA user populations were determined by tallying the number of recent Veteran VHA users as of July 1 of each year. Numbers of Veterans without recent

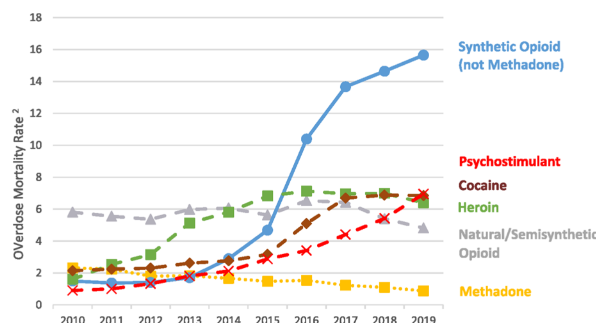

Fig. 1. Age-Adjusted Veteran Overdose Mortality Rate, by Drug Type [1], 2010–2019. [1] *Rates presented are not mutually exclusive; an overdose death involving multiple drugs would contribute to each relevant trend line.* [2] *Age-adjusted mortality rate per 100,000 population.*

VHA use were estimated by subtracting known counts of Veterans with recent VHA use from overall Veteran population numbers. Race and ethnicity were identified for Veterans using VHA administrative data and the United States Veterans Eligibility Trends and Statistics (USVETS) database. Calculations according to geography utilized US Census Regions, determined by state of death. (U.S. Census, 2021).

Overdose deaths were identified according to International Classification of Disease (ICD-10) underlying cause-of-death codes X40–44 (unintentional), X60–64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent). Identified overdose deaths were examined according to the specific drug involved using multiple cause-of-death codes as follows: heroin (T40.1); natural, semisynthetic, or other opioids (T40.2); methadone (T40.3); synthetic opioids other than methadone (T40.4); cocaine (T40.5); and psychostimulants/methamphetamines (T43.6). Overdose deaths were also examined according to two drug type categories: all opioids (one or more of: T40.0–T40.4, T40.6) and all stimulants (T40.5, T43.6). Overdose deaths having indications of involvement of multiple drug types contributed to the counts and rates for each indicated type. Counts and rates for all listed drug types for the years 2010–2019 are presented in the appendix. Overdose deaths solely involving drugs not listed above (e.g., benzodiazepines) are included within the category "all overdose" but are not presented in drug-specific analyses. This is consistent with CDC Data Brief reporting on drug overdose deaths. (Hedegaard et al., 2020).

For calculations involving rates based on fewer than 100 deaths in any stratum, statistical significance was assessed by comparing gamma confidence intervals for overlap; for rates based on 100 or more deaths, z-tests were used with $p < .05$ determining significance. (Fay and Feuer, 1997) Statistical significance was assessed for SRRs using gamma confidence intervals. Joinpoint 4.8 was used to compare trends across groups, assessing differences in average annual percent change for the best fit Joinpoint regression models selected at alpha = 0.05. (Joinpoint Regression Program, 2020) Pairwise comparisons were used in Joinpoint to test for differences in trends, indicating whether rates of change in overdose mortality were significantly different across groups over the period 2010–2019. (Kim et al., 2004).

This study was conducted as part of VHA operations and program evaluation. Per VA guidance, it was not classified as research and did not require institutional review board review. This work was reviewed and approved by the VA Office of Mental Health and Suicide Prevention.

3. Results

From 2010–2019, there were 42,627 overdose deaths among US Veterans, including 18,573 Veterans with recent VHA care and 24,054 Veterans without recent VHA care. The average Veteran population during this period was 21,367,900 (standard deviation: 1,021,234).

As shown in Table 1, from 2010 to 2019, the age-adjusted rate of drug overdose mortality among Veterans increased by 53.2% overall, by 93.4% for overdoses involving opioids, and by 333.4% for overdoses involving stimulants. The percentage of Veteran overdose deaths that involved opioids increased from 51.5% (n = 1891) in 2010 to 65.7% (n=3,197) in 2019; for stimulants it increased from 16.7% (n = 612) in 2010–44.6% (n = 2172) in 2019.

Male Veterans experienced a 61.2% increase in overall overdose mortality from 2010 to 2019, with age-adjusted rates of opioid-involved deaths doubling from 11.7 to 23.6 per 100,000, and rates of stimulant-involved deaths more than quadrupling from 3.1 to 14.3 per 100,000. Female Veterans did not experience a statistically significant change in overall overdose mortality from 2010 to 2019, despite statistically significant rate increases of 26.3% for opioid-involved deaths and 168.0% for stimulant-involved deaths.

Veterans aged 65+ experienced the largest relative increase in overdose mortality from 2010 to 2019. Veterans aged 25–34, 35–44, and 55–64 experienced comparable increases in overdose mortality, roughly doubling during this time, while Veterans aged 45–54 did not experience a statistically significant change. Among US Census regions, the largest absolute and relative increases in rates of overdose mortality occurred in the Northeast. Among race groups compared, Veterans identified as being of multiple races had the highest crude rate of overdose mortality in 2019, with 69.5 deaths per 100,000. Veterans identified as non-Hispanic experienced a 55.4% increase in overall overdose mortality from 2010 to 2019. In 2019, age-adjusted overdose mortality rates were 41.7 per 100,000 among Veterans with recent use of VHA services, and 25.7 per 100,000 among Veterans without recent VHA use.

Veteran overdose mortality varied substantially by specific drug involved. From 2010–2019, age-adjusted rates of overdose deaths involving synthetic opioids rose from 1.5 to 15.7 per 100,000 and rates involving heroin rose from 1.6 to 6.4 per 100,000. Rates involving methadone fell by more than half, from 2.3 to 0.9 per 100,000. Rates involving natural/semisynthetic opioids decreased from 5.8 to 4.8 per 100,000. Rates involving stimulants grew notably, increasing by 219.3% for cocaine to 6.9 per 100,000 and by 669.2% for psychostimulants to 7.0 per 100,000 as of 2019. Figs. 1–3.

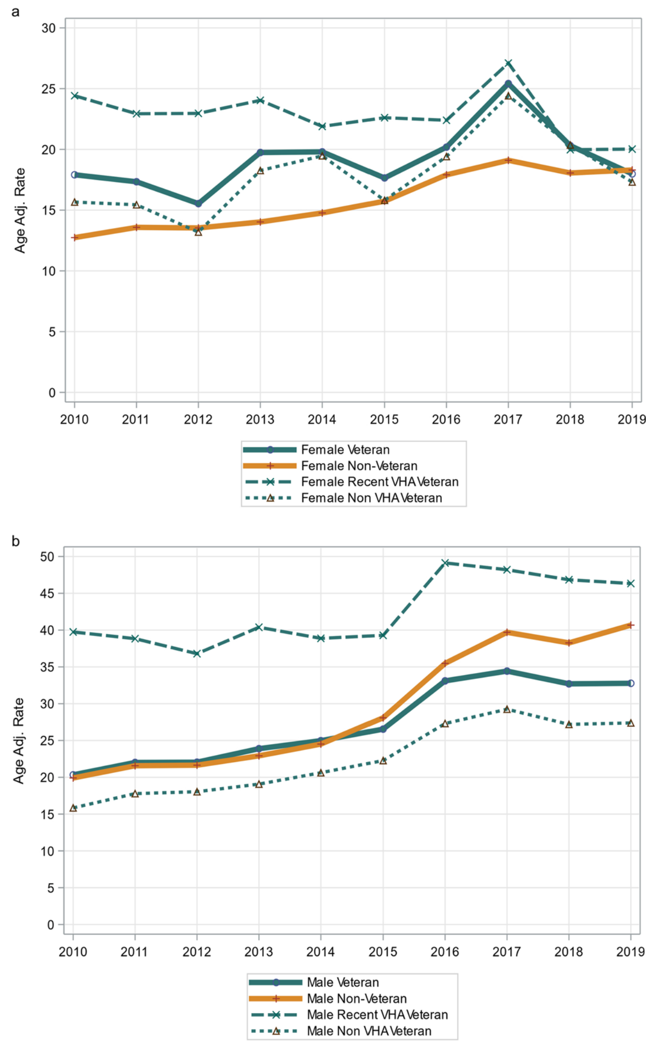

Fig. 2. **a** Among Women: Age-Adjusted Rates of Drug Overdose Deaths, by Veteran Status and VHA Use, 2010–2019. **2 b:** Among Men: Age-Adjusted Rates of Drug Overdose Deaths, by Veteran Status and VHA Use, 2010–2019.

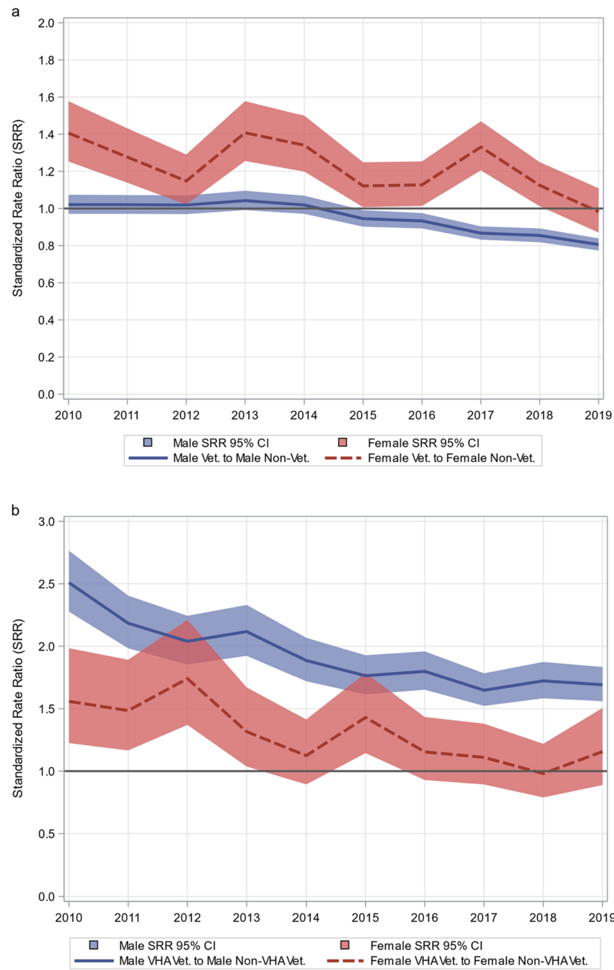

Fig. 3. **a** Age-Adjusted Rate Ratio of Overdose Mortality, Veteran vs. Non-Veteran US Adults, by Sex. **3 b**: Age-Adjusted Rate Ratio of Overdose Mortality, VHA-Using Veteran vs. Non-VHA-Using Veteran, by Sex.

The 2019 age-adjusted rate of overdose mortality was 19% lower for male Veterans than for male non-Veteran US adults (SRR 0.81, 95% CI [0.77, 0.84]). The 2019 age-adjusted rate of overdose mortality was 69% higher among male Veterans with recent VHA use than those without recent VHA use (SRR 1.69, 95% CI [1.56, 1.83]). In 2019, rates among women were not significantly different according to Veteran status or recent VHA use.

From 2010–2019, age-adjusted overdose mortality increased among both male Veterans and male non-Veteran US adults. However, the average annual percent change (AAPC) was significantly lower for male

Table 2
Veteran Overdose Deaths, Crude and Adjusted Rates by Drug.

Year of death	Drug	Deaths	Veteran population estimate	Crude rate per 100,000	Age adjusted rate per 100,000
2010	All Overdose	3669	22,752,000	16.1	19.8
2011	All Overdose	3737	22,521,000	16.6	21.0
2012	All Overdose	3624	22,193,000	16.3	20.8
2013	All Overdose	3866	22,000,000	17.6	23.2
2014	All Overdose	4010	21,666,000	18.5	24.0
2015	All Overdose	4130	21,241,000	19.4	25.0
2016	All Overdose	4820	20,863,000	23.1	30.8
2017	All Overdose	5119	20,480,000	25.0	32.6
2018	All Overdose	4787	20,166,000	23.7	30.4
2019	All Overdose	4865	19,797,000	24.6	30.3
2010	All Opioids	1891	22,752,000	8.3	11.1
2011	All Opioids	1894	22,521,000	8.4	11.6
2012	All Opioids	1854	22,193,000	8.4	11.4
2013	All Opioids	2084	22,000,000	9.5	13.6
2014	All Opioids	2314	21,666,000	10.7	15.0
2015	All Opioids	2441	21,241,000	11.5	16.0
2016	All Opioids	3010	20,863,000	14.4	20.7
2017	All Opioids	3236	20,480,000	15.8	22.4
2018	All Opioids	3080	20,166,000	15.3	21.3
2019	All Opioids	3197	19,797,000	16.1	21.5
2010	All Stimulants	612	22,752,000	2.7	3.0
2011	All Stimulants	605	22,521,000	2.7	3.2
2012	All Stimulants	660	22,193,000	3.0	3.5
2013	All Stimulants	771	22,000,000	3.5	4.3
2014	All Stimulants	861	21,666,000	4.0	4.7
2015	All Stimulants	1031	21,241,000	4.9	5.8
2016	All Stimulants	1395	20,863,000	6.7	8.2
2017	All Stimulants	1719	20,480,000	8.4	10.4
2018	All Stimulants	1955	20,166,000	9.7	11.7
2019	All Stimulants	2172	19,797,000	11.0	12.9
2010	Cocaine	444	22,752,000	2.0	2.1
2011	Cocaine	430	22,521,000	1.9	2.2
2012	Cocaine	439	22,193,000	2.0	2.3
2013	Cocaine	493	22,000,000	2.2	2.6
2014	Cocaine	504	21,666,000	2.3	2.8
2015	Cocaine	571	21,241,000	2.7	3.2
2016	Cocaine	879	20,863,000	4.2	5.1
2017	Cocaine	1087	20,480,000	5.3	6.7
2018	Cocaine	1145	20,166,000	5.7	6.9
2019	Cocaine	1187	19,797,000	6.0	6.9
2010	Heroin	232	22,752,000	1.0	1.6
2011	Heroin	362	22,521,000	1.6	2.5
2012	Heroin	429	22,193,000	1.9	3.2
2013	Heroin	655	22,000,000	3.0	5.1
2014	Heroin	770	21,666,000	3.6	5.8
2015	Heroin	896	21,241,000	4.2	6.8
2016	Heroin	1006	20,863,000	4.8	7.1
2017	Heroin	980	20,480,000	4.8	7.0
2018	Heroin	987	20,166,000	4.9	7.0
2019	Heroin	977	19,797,000	4.9	6.4
2010	Methadone	389	22,752,000	1.7	2.3
2011	Methadone	355	22,521,000	1.6	2.2
2012	Methadone	284	22,193,000	1.3	1.8
2013	Methadone	285	22,000,000	1.3	1.8
2014	Methadone	268	21,666,000	1.2	1.7
2015	Methadone	234	21,241,000	1.1	1.5
2016	Methadone	236	20,863,000	1.1	1.5
2017	Methadone	202	20,480,000	1.0	1.2
2018	Methadone	192	20,166,000	1.0	1.1
2019	Methadone	142	19,797,000	0.7	0.9
2010	Natural and Semi-Synthetic Opioids	1023	22,752,000	4.5	5.8
2011	Natural and Semi-Synthetic Opioids	972	22,521,000	4.3	5.6
2012	Natural and Semi-Synthetic Opioids	948	22,193,000	4.3	5.4
2013	Natural and Semi-Synthetic Opioids	997	22,000,000	4.5	6.0
2014	Natural and Semi-Synthetic Opioids	1078	21,666,000	5.0	6.1
2015	Natural and Semi-Synthetic Opioids	1005	21,241,000	4.7	5.6
2016	Natural and Semi-Synthetic Opioids	1104	20,863,000	5.3	6.5
2017	Natural and Semi-Synthetic Opioids	1076	20,480,000	5.3	6.4
2018	Natural and Semi-Synthetic Opioids	932	20,166,000	4.6	5.4
2019	Natural and Semi-Synthetic Opioids	819	19,797,000	4.1	4.8
2010	Psychostimulants	182	22,752,000	0.8	0.9
2011	Psychostimulants	185	22,521,000	0.8	1.0
2012	Psychostimulants	236	22,193,000	1.1	1.3
2013	Psychostimulants	299	22,000,000	1.4	1.8
2014	Psychostimulants	385	21,666,000	1.8	2.1
2015	Psychostimulants	488	21,241,000	2.3	2.9
2016	Psychostimulants	565	20,863,000	2.7	3.4
2017	Psychostimulants	718	20,480,000	3.5	4.4
2018	Psychostimulants	897	20,166,000	4.4	5.4
2019	Psychostimulants	1106	19,797,000	5.6	7.0
2010	Synthetic Opioid Other than Methadone	280	22,752,000	1.2	1.5
2011	Synthetic Opioid Other than Methadone	247	22,521,000	1.1	1.4
2012	Synthetic Opioid Other than Methadone	239	22,193,000	1.1	1.4
2013	Synthetic Opioid Other than Methadone	288	22,000,000	1.3	1.7
2014	Synthetic Opioid Other than Methadone	417	21,666,000	1.9	2.9
2015	Synthetic Opioid Other than Methadone	662	21,241,000	3.1	4.7
2016	Synthetic Opioid Other than Methadone	1343	20,863,000	6.4	10.4
2017	Synthetic Opioid Other than Methadone	1828	20,480,000	8.9	13.7
2018	Synthetic Opioid Other than Methadone	1971	20,166,000	9.8	14.6
2019	Synthetic Opioid Other than Methadone	2214	19,797,000	11.2	15.7

Veterans (AAPC=6.4) than male non-Veterans (AAPC=9.6) during this period. Among male Veterans, the rate of increase did not significantly differ according to recent VHA use. From 2010–2019, age-adjusted overdose mortality did not significantly increase among female Veterans but did significantly increase among female non-Veterans. The rate of increase was not significantly different between these two groups. Among female Veterans, the rate of change was significantly lower among those with recent VHA use (AAPC = −1.2) [1] than those without recent VHA use (AAPC = 3.9).

Overdose rates among male Veterans decreased relative to male non-Veterans after 2014. The comparison between female Veterans and female non-Veterans fluctuated throughout the study period, but suggests an overall decline with rates higher among female Veterans from 2010

[1] Note: the 2010–2019 AAPC among female Veterans with recent VHA use was not statistically significantly different from 0. All other AAPC values presented were statistically significantly different from 0.

Table 3
Veteran Drug Overdose Mortality Counts 2010–2019, Overall and by Drug Category [a].

	Overall drug overdose		Opioid overdose		Stimulant overdose	
	2010 Deaths	2019 Deaths	2010 Deaths	2019 Deaths	2010 Deaths	2019 Deaths
All Veterans	3669	4865	1891	3197	612	2172
Sex						
Female	356	372	172	229	35	102
Male	3313	4493	1719	2968	577	2070
Age group (years at death)[b]						
18–24	57	42	41	32	< 10	15
25–34	393	619	243	503	48	219
35–44	574	897	314	642	87	384
45–54	1268	912	670	615	231	428
55–64	1064	1530	521	944	220	763
65+	312	853	102	457	22	358
Geographic region[c]						
Midwest	775	1074	376	750	122	420
Northeast	526	989	258	787	87	385
South	1405	1770	734	1168	224	802
West	963	1032	523	492	179	565
Race						
American Indian, Alaskan Native	38	37	19	17	< 10	18
Asian, Hawaiian, or Pacific Islander	48	69	24	38	14	32
Black	414	853	165	546	195	508
Multiple Races	59	317	27	219	< 10	158
White	3011	3460	1604	2282	367	1406
Unknown	99	129	52	95	20	50
Ethnicity						
Hispanic	210	311	121	199	43	143
Not Hispanic	3331	4395	1703	2886	551	1975
Recent Use of VHA Services[d]						
Yes	1575	2158	807	1410	269	1004
No	2094	2707	1084	1787	343	1168

[a] An overdose death identified as involving both an opioid and a stimulant contributed to counts for each group.
[b] Age was missing for one decedent.
[c] US Census Regions, determined by state of death
[d] Recent use defined as a VHA encounter during year of death or year prior

to 2018 then not significantly different in 2019.

4. Discussion

This report presents new information on overdose mortality among US Veterans. The analyses examine the most recent available Veteran mortality data, through 2019. Age-adjusted rates of Veteran drug overdose deaths increased 64.6% from 2010 to 2017, decreased 6.7% from 2017 to 2018, and were not significantly different between 2018 and 2019. This work offers the first comparison of drug overdose mortality among Veterans and non-Veteran US adults. Findings by sex suggest that overdose rates among Veterans diminished relative to non-Veterans during the study period: Adjusting for age, after 2014 Veteran men had lower overdose mortality rates than non-Veteran men, and in 2019 previously elevated rates among Veteran women fell to become not significantly different from those of non-Veteran women. Similar findings were observed for overdose deaths specifically involving opioids and for those involving stimulants.

The study also evaluates differences in overdose mortality within Veteran population subgroups, comparing those with recent use of VHA health care to those without recent use. Among male Veterans, those with recent VHA use had higher rates of overdose mortality than other male Veterans. This may reflect a more complex clinical profile among Veterans with recent VHA care and it highlights the importance of overdose prevention efforts in the context of health care encounters. Among female Veterans, those with recent VHA use experienced higher rates of overdose mortality compared to other female Veterans in 2010–2018, however not in 2019. While female Veterans with recent VHA use did not experience significant average annual increases in overdose mortality from 2010 to 2019, significant increases were documented for female Veterans without recent VHA use.

Findings are consistent with prior reports showing higher opioid overdose mortality among VHA patients compared to the general US population (Bohnert et al., 2011), and they emphasize the importance of overdose prevention efforts for Veteran men who use VHA care, among whom risk concentration is highest. However, prevention efforts should also consider Veterans not in VHA care, who have the greatest number of overdose deaths (2707 in 2019 among Veterans not in VHA care, versus 2158 among Veterans in VHA care). Targeted approaches may be warranted to address the unique needs of Veteran subgroups.

Veteran overdose deaths involving opioids increased from 1891 in 2010 to 3,197 in 2019. Although Veteran overdose deaths involving heroin, methadone, and natural and semi-synthetic opioids have decreased or remained steady since 2016, Veteran overdose deaths involving synthetic opioids have continued to rise substantially. VHA has worked to address Veteran opioid overdose through a multifaceted approach including reducing opioid prescriptions, improving naloxone distribution, and increasing use of evidence-based medications for opioid use disorder. (Gordon et al., 2020; Lin et al., 2017; Rubin, 2019) Stimulants, while still involved in a minority of Veteran overdose deaths (44.6% in 2019), also present cause for concern: age-adjusted rates of Veteran overdose deaths involving stimulants more than quadrupled from 2010 to 2019 (from 3.0 to 12.9 per 100,000). In 2019, one quarter of Veteran overdose deaths involving opioids also involved a stimulant, and further work is needed to understand and address this growing trend.

This analysis had several limitations. Overdose deaths may be mistakenly attributed to other causes such as cardiac arrest, potentially resulting in undercounting of cases. (Tseng et al., 2018) Rates involving non-Veterans were estimated by removing counts of known Veterans from the general population, and are therefore influenced by the availability of Veteran status data. Improvements in toxicology testing during the study period may account for some of the observed increase in cases reported. Availability of overdose mortality reporting varies by state and may impact regional trends presented. (Centers for Disease Control and Prevention, National Center for Health Statistics, 2020). Race and ethnicity were classified for Veteran decedents using medical record and administrative data, and although self-reported data were prioritized where available, may not reflect personal identity or experience.

5. Conclusions

This study provides an improved understanding of trends in overdose deaths among Veterans and offers information that can be used to target prevention efforts to reach those most at risk. In particular, our findings highlight the need to address overdose risk by Veteran subgroup given that results differ by recent VHA use history and by sex. The high rates among recent VHA users underscores the need for ongoing prevention efforts by VA. Despite decreases in overdose rates among Veterans relative to rates among the broader US population, current CDC projections and challenges posed by the COVID-19 pandemic suggest that this topic needs to be an ongoing area of attention for VA. Provisional data from CDC's National Center for Health Statistics indicate a

projected 30.8% increase in overdose deaths from 2019 to 2020 among the general US population. (Ahmad et al., 2021) Future analyses will assess whether Veteran trends follow a similar pattern.

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Credit authorship contribution statement

All listed authors made a substantial contribution. C.R., T.P., S.M., and B.S. provided input on the structure of the analysis and presentation of results. S.M. and T.P. provided guidance on appropriate statistical methodology. J.M. provided editorial review and supervision. M.B. conducted the statistical analysis and drafted the manuscript with input from all authors. L.A. provided subject matter expertise and input on VHA initiatives related to substance use. All authors have approved this manuscript.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have influenced or appeared to influence the work reported in this paper.

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Appendix

See Tables 2–3.

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Statements for the Record

Statement for the Record

Senate Committee on Veterans' Affairs Hearing:
Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for our Nation's Veterans.

Prepared by:
D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University

September 20, 2023

Background

Successfully addressing and preventing veteran suicide requires a comprehensive and holistic approach at the individual, community, and policy levels. This collective approach must include addressing the variety of upstream, non-medical drivers of mental health that contribute to a veteran's overall health outcomes and risk of suicide. Examples of non-medical drivers of health include socioeconomic status, financial strain, housing stability, food security, and access to reliable transportation. The complex nature and interactions of these contributing factors present *multiple opportunities to intervene* when a veteran is at risk of suicide. At each of these steps, community-based organizations and government agencies have the chance to prevent further deterioration of the veteran's health by providing resources to meet the veteran's material and non-material needs. Due to their long-standing presence and trusted partnerships, non-profit community-based organizations (CBOs) are particularly well poised to intervene and assist veterans who are at risk of suicide.

Established in 2020 with the passing of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) plays a vital role in addressing the pressing issue of veteran suicide in the United States. By providing funding to CBOs to address underlying causes of veteran suicide in addition to facilitating referrals for clinical care, the SSG Fox SPGP recognizes the complex nature of factors leading to veteran suicide and takes *meaningful action to partner with and support communities in the prevention effort*.

In September, the D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University hosted several events in recognition of National Suicide Prevention Month at the National Veterans Resource Center. In addition to local attendees, we invited our community partners that are recipients of the SSG Fox SPGP to join in person. During the gathering, we convened a roundtable where SSG Fox SPGP grantees had the opportunity to share valuable insights on both the program's successes and the challenges it faces. The feedback provided in

this document represents the collective viewpoints of eleven grantees from across the country who actively engaged in this discussion.

Eligibility

One topic the roundtable participants discussed related to eligibility was restrictions based around level of risk. Participants noted that these restrictions prevent them from potentially capturing high-risk individuals who don't meet the administrative eligibility, such as the 24-month requirement. the potential expansion of the SSG Fox SPGP to support additional populations.

Participants also recognized instances where individuals scored within an eligible range for some assessment metrics but fell short in others, leading to disqualification from SSG Fox SPGP intervention. For example, grantees noted that individuals who score high on psychosocial assessments but not on the Columbia Suicide Severity Rating Scale (C-SSRS) still present a potential risk and should be eligible. In a few more dire cases, despite exploring other avenues to assist these individuals, communities reported they had witnessed tragic outcomes, including suicide. Our discussion emphasized that understanding the *motivations behind* individuals declining assessments could lead to a more comprehensive approach.

Grantees also highlighted constraints to eligibility regarding covered services. They raised significant concerns about barriers to entry into the SSG Fox SPGP, both in terms of outreach and getting to the point of screening. Many individuals struggle with transportation, as it isn't covered until a client becomes officially enrolled in the program. Others are more responsive to initial outreach efforts that are more social in nature, rather than focused specifically on mental health. Providing veterans with material resources such as food and transportation assistance simultaneously reduces risk factors and builds trust with individuals in their communities.

Additionally, specific barriers were recognized as potentially addressable by non-SSG Fox SPGP funding, such as the Supportive Services for Veteran Families (SSVF) for housing. Still, these programs may have their own entry challenges, and keeping track of different federal funding sources for similar activities can be burdensome.

One other topic that arose was the idea of expanding populations eligible for the program. These populations might include Reservists, National Guard members, and even family members. For example, if a veteran enrolled in SSG Fox SPGP dies by suicide, their spouse may subsequently experience suicidal ideations. However, the program is currently unable to provide the needed support.

Screening

In addition to the eligibility side of screening, a range of crucial issues regarding screening tools and process emerged. While supportive of the selected assessments in general, as noted above, grantees want to eliminated situations where a veteran would be automatically disqualified despite the potential risk still present. This dilemma prompted discussions on how to make the screening process more comfortable and conducive to open conversations, as well as addressing

its labor-intensive and formal nature. Suggestions included actively seeking feedback from grantees to enhance comfort, promoting organic and conversational interactions, involving non-clinicians in the screening process, and exploring ways to distill necessary information from more natural conversations.

One of our presenters in another session (Joe Geraci, PhD, Director of the Transitioning Servicemember/Veteran and Suicide Prevention Center at the VISN 2 MIRECC) shared a 17-question screener used by his team, which *includes the C-SSRS questions*. Many participants seemed to believe this screener would be a valuable asset, relative to the host of other screeners currently part of SSG Fox SPGP.

Participants acknowledged that screenings are subjective and contingent on a client's truthfulness, adding to the complexity of the process. There's also a culture clash between current military culture and openly discussing mental health. To overcome this hurdle, grantees stressed the importance of finding effective ways to communicate in the language of the service member and to reshape their perspective on mental health. In light of these challenges, participants and our team underscored the trusted standing that CBOs hold within their communities, and how they play a critical role in engaging with veterans and creating the space they need to obtain support and assistance.

And lastly, while the Fox grantees' programs and interventions differ from one another, the screening tools and eligibility criteria are uniform. Many of the participants expressed interest in collaboration and efforts to share resources more effectively, particularly when a practice was working well in one community but not another.

VA Referrals & Process

The process of referring eligible individuals to the VA has revealed both successful practices and areas necessitating improvement. One success reported was direct collaboration between the VA and the grantee, where they were able to work directly with the Suicide Prevention Coordinator (SPC) to create procedures for enrollment. These actions not only streamlined the referral process, but also enhanced understanding of the VA's capacity to accommodate these referrals.

However, there have been notable challenges in the referral process. Though well-intentioned, the Office of Mental Health and Suicide Prevention has sometimes fallen short in ensuring local VA Medical Centers (VAMCs) follow programmatic guidance and intent. Successful collaboration with SPCs as described above was the exception, and levels of support seem to vary highly from VAMC to VAMC. Even where partnerships were strong, they were not stable in the event of turnover.

Furthermore, VAMCs may not have the readiness to accommodate referrals through this channel. Suicide Prevention teams, often stretched thin, have cited capacity constraints. Another critical issue is the absence of a specific code in the intake to identify SSG Fox SPGP participants, leading to delays in care due to administrative hurdles. There is also a need for improved tracking of clients' treatment history across different systems to streamline the referral process and ensure seamless coordination between the VA and CBOs.

Grantees also noted that the referral process would benefit from being more bidirectional, particularly at the point where patients may be discharged from VA care. Communities faced discrepancies in whether their local VA was willing to take the appropriate steps to authorize releases of information. They noted that the services they are able to provide can often make an enormous difference to veterans' experiences managing their mental health and day-to-day lives.

Overwhelmingly, our partners remained positive about the potential of the SSG Fox SPGP. They believe that by continuing to build upon the partnerships with CBOs through the program, the VA can continue to provide comprehensive care for veterans that aims to address root causes of health and wellness that allow veterans to thrive.

Data Collection & Sharing

While grantees acknowledged ongoing improvements from the VA and MITRE, data collection remains a challenge. One prominent issue revolves around the lack of clarity on how the MITRE dashboard will display important and relevant information. Grantees agreed it feels as if they're sending data off without a clear sense of how it will be shared or utilized. Participants also emphasized the necessity for more immediate feedback and quicker turnaround on screening scoring. Others suggested more flexibility in the required data forms, depending on any changes that may come to screening process requirements.

We also noted other missed opportunities to capture meaningful data. For example, while this program is in its early stages and therefore still improving, it would be beneficial to track individuals who score high on psychosocial assessments but zero on the C-SSRS screening, those who screen positive but face administrative-caused ineligibilities, and those who refuse assessments. There is also a desire for more comprehensive data on those screened but not deemed eligible, including insights into their circumstances. Participants have expressed a perception of limited interest from the SSG Fox SPGP data team regarding information on individuals who do not strictly meet the eligibility criteria. Additionally, they expressed concern over the omission in collecting information about why individuals withdraw from the program. There was a strong willingness to collect and share this type of information with the VA, if more data was available in return.

As a final point on data collection and reporting, grantees conveyed the complexity with managing multiple federal grants that have specific coverage and measurement requirements. There was wide agreement that there is an opportunity to increase efficiency and consider the ways in which data can be standardized and aligned throughout the process of administering different programs.

In response to data challenges, programs have undertaken their own tracking and documentation of program data to understand the broader context better, integrate into their other operations more effectively, and address the pain points described above. We know that robust and accessible data is necessary to effectively address the underlying causes of poor mental health and veteran suicide. Both the IVMF and our partners strongly hope that data from SSG Fox SPGP is collected thoughtfully, incorporated into meaningful analysis, and transparently shared.

Conclusion

We thank the Committee for the opportunity to share these insights and for its continued focus on the target and shared goal of preventing veteran suicide. The SSG Fox SPGP provides the needed support to CBOs to address upstream factors of mental health that contribute to a veteran's risk of suicide. We look forward to seeing how veteran health continues to improve with the incorporation of this feedback to strengthen the SSG Fox SPGP and ensure its long-term viability and sustainability.

Chairman, Ranking Member, and Members of the Committee,

My name is Heath Steel. I serve as the Executive Vice President & Chief Business Officer for Volunteers of America Northern Rockies, and I am here today to testify on behalf of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

I want to thank senior United States Senator Jon Tester for inviting us to be here today. Senator Tester has been a longtime ally to Veterans in Montana, and his support is critical to the services we provide.

Volunteers of America Northern Rockies is the largest private provider of Veteran services in Montana, Wyoming, and Western South Dakota. We serve more than 3,300 Veterans annually with homeless prevention, rapid rehousing, employment, and moral injury services. We are honored to be of service to the men and women who sacrificed so much for our great Nation.

The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program is having tremendous impact on communities in our region. I want to start by applauding the United States Veterans Affairs Department for welcoming the out of the box thinking that produced this grant. I don't need to lecture you on the devastating reality that is the current Veteran Suicide rate of 31.7 per 100,000. It breaks our heart … and having served Veterans for more than a decade, 31.7 isn't just a number to Volunteers of America - it is clients, staff, and friends.

Moral injury is the internal pain we feel when life's experiences violate our own understanding of right and wrong. This wounding of the soul may leave us feeling emotionally broken, distrustful of others, or of ourselves. Such a burden on our soul limits our capacity to live fully and to live in peace.

Volunteers of America is incredibly proud of our staff and the work they do through our Mending Moral Injury program. In this non-clinical peer-led program, Veterans begin the healing process by sharing their stories, processing grief and trauma, and walking through forgiveness. Then, our staff are able to reconnect them with purpose, hope, faith and the community.

Volunteers of America was awarded a Staff Sergeant Fox Grant in 2022, and while the application process was straightforward, the implementation process was burdensome and delayed the start of our program, as well as many other awardees, by three months.

In the nine months since we began operation, we've served 59 veterans, including 16 of their family members through the Mending Moral Injury Program. We currently have five paid staff and 35 volunteer facilitators. These individuals have organized seven groups in six communities and continue to expand the footprint of this program daily.

By using Veteran volunteer facilitators, we are able to empower those who have found healing from their own morally injurious experiences to provide healing for others, resulting in tremendous impact on the rural communities we serve.

Immediately after participating in our 8 to 12 week Mending Moral Injury Program, the Patient Health Questionnaire (PHQ9) surveys show that Veterans are less depressed and have less suicidal ideation. We are currently collecting and analyzing six-month follow-up data. These results are inspiring and can be realized firsthand through this Veteran testimony...

I want to share one quick story from Mac LaVerne McDonald. Mac wanted to be sure each and every one of you heard that "not all veterans have physical wounds that you can see and easily get healing from" - She came to the VOA Mending Moral Injury Program with deep military sexual trauma. She proudly shared "The experience I had within the group was supportive and encouraging, and I would not be alive today if it was not for Volunteers of America and their Mending Moral Injury Program supported by the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant. Thank you for providing this supportive program, it saved my life."

Again, I want to thank Senator Tester for this opportunity to share the impact of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant. This program is saving the lives of America's Veterans like Mac and transforming their ability to engage with their families and their communities. I urge you to protect these funds in advocacy for our Nation's heroes.

God bless you all, and God bless our Nation.

MARK GORDON
GOVERNOR OF WYOMING
CHAIR

MICHELLE LUJAN GRISHAM
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JACK WALDORF
EXECUTIVE DIRECTOR

September 25, 2023

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate
412 Russell Senate Office Building
Washington, DC 20510

The Honorable Jerry Moran
Ranking Member
Committee on Veterans' Affairs
United States Senate
412 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Tester and Ranking Member Moran:

In light of the Committee's September 20, 2023 hearing, Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for our Nation's Veterans, attached please find Western Governors' Association (WGA) Policy Resolutions 2023-08, Veterans, and 2022-07, Physical and Behavioral Health Care in Western States.

In the veterans resolution, Western Governors urge the Department of Veterans Affairs to improve mental health care for veterans by: prioritizing the integration of peer support and behavioral health services for traumatic brain injury into mental health care models; providing training and support for peer specialists; focusing on workforce development and retention; supporting suicide prevention programs; ensuring equitable access to essential health care services in rural areas; and conducting ongoing evaluations for the effective implementation of these practices. The health care resolution outlines Western Governors' behavioral health policies and highlights the need to improve the quality and quantity of behavioral health services available to all western residents.

I request that you include these documents in the permanent record of the hearing, as they articulate Western Governors' policy positions and recommendations related to this urgent issue.

Thank you for your attention to this matter and your consideration of this request. Please contact me if you have any questions or require further information.

Sincerely,

Jack Waldorf
Executive Director

Attachments

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Policy Resolution 2023-08
Veterans

A. **BACKGROUND**

American military personnel often return home to a hero's welcome after completing their service, but they face a series of complex challenges. Veterans, whether they volunteered or were drafted, commonly confront a range of issues such as food insecurity, homelessness, unemployment, physical and psychological wounds, and bureaucratic barriers when seeking support services. Western Governors recognize the need to support veterans and address the challenges they face. With one-third of the known veteran population residing in western states, Governors recommend federal regulatory and statutory changes to foster an environment that facilitates access to support services for veterans and encourages further investment in initiatives tailored to assist them.

B. **GOVERNORS' POLICY STATEMENT**

1. Western Governors urge the Department of Veterans Affairs (VA) to prioritize the integration of peer support services and behavioral health services for Traumatic Brain Injury (TBI) into mental health care models. Additionally, Western Governors urge the VA to address staffing models to support the increasing health concerns for memory care (Dementia, Alzheimer's) and other neurological disorders. VA should also provide continuous training and support for peer specialists and focus on developing and retaining the behavioral health care workforce. Western Governors have highlighted substantive health care workforce recommendations in our health care policy resolution. Ongoing evaluations should be conducted to ensure effective implementation of these practices, which should be disseminated across all VA health care settings to ensure broad access to peer support services for all veterans.

2. Western Governors acknowledge the importance of the VA Governor's Challenge and urge VA to continue its provision of support for programs aimed at effectively addressing the issue of veterans' suicide.

3. Recognizing the need to improve health program services for women veterans, Western Governors urge VA to take urgent action to address gaps in the VA health care system. Improving the promotion of, access to, and the quality of health care for women veterans is essential and requires timely and effective measures to be implemented across VA. Western Governors recommend that VA initiate research programs to study health issues specific to women veterans.

4. Western Governors recognize the significance of expanding access to health care services for veterans, especially those residing in remote areas. VA should take action to increase the accessibility of:

   a. VA Community Care for veterans residing in areas that do not have access to VA health care facilities. It is imperative that VA consult with Governors to ensure

that veterans living in rural areas are not disadvantaged in accessing health care;

b. Vet Centers for veterans living in rural areas, to ensure that they have access to necessary health services and support;

c. Health care professionals in rural areas, to provide flexibility for veterans and allow them to access the health care provider of their choosing; and

d. Telemedicine services, which are a vital tool that can help bridge the gap in accessing health care services.

5. Western Governors recommend that VA seek consultation and input from tribal leaders and communities to inform the development and administration of its programs and services for American Indian, Alaska Native, and Native Hawaiian veterans.

6. To ensure that veterans have timely access to high-quality health care, Western Governors recommend that Congress prioritize providing VA with the necessary resources, authority, and ability to recruit, hire, train, and retain health care professionals. This includes physicians, nurses, mental and behavioral health providers, long-term care professionals, and administrative staff. In addition, Western Governors believe VA should streamline the hiring process, offer competitive salaries and benefits, and provide ongoing training and professional development opportunities for health care professionals.

7. Western Governors believe VA should collaborate with states and territories to improve and expand the Highly Rural Transportation Grants program. This includes identifying counties that require assistance, simplifying the application and implementation process, and consulting early with Governors for valuable input on their state's needs. Additionally, VA should reevaluate and expand the current eligibility criteria to ensure that more veterans can benefit from the program.

8. Western Governors urge VA to conduct a comprehensive evaluation of the Veteran Transportation Services (VTS) exam and implement necessary revisions to reduce its complexity, facilitating the process for individuals to obtain a license to transport veterans to VA health care facilities and authorized non-VA health care appointments.

9. Western Governors call on VA to improve community care for veterans by enforcing timely referrals and appointments, particularly for programs like VA Community Care. VA should also streamline reimbursement processes to third-party health care providers in line with industry standards and ensure prompt access to services and increased provider participation.

10. To ensure that our nation's veterans receive the benefits and services they are entitled to in a timely and efficient manner, Western Governors urge VA to continue to improve and streamline the claims process, especially with the new Sergeant First Class (SFC) Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act (Pub. L. 117-168) claims.

11. Western Governors recommend that VA implement a policy allowing veterans to select their own care providers, including those who are not affiliated with VA health care

facilities. By doing so, veterans would have greater flexibility and choice when seeking health care services.

12. Western Governors recognize the necessity of conducting a comprehensive review of VA regulations regarding payments for State Veterans Homes and urge VA to consult with states to identify the unique needs of each state. Additionally, Western Governors recommend expanding coverage to include all specialty care services, and prioritize funding for specialized cognitive care.

13. Western Governors recommend that VA authorize and prioritize the expansion of VA programs to provide comprehensive financial support for third-party assisted living and nursing facilities, which offer varying levels of care for long-term care services to our nation's veterans.

14. Western Governors urge Congress to pass legislation that requires VA and the Department of Defense (DOD) to modernize their electronic health record-keeping systems and mandate VA to upgrade its overall technology infrastructure. These upgrades are necessary to streamline access to critical health information, enhance coordination between the two departments, and improve the claims process for veterans, which is a priority for the Governors.

15. Western Governors recommend that the federal government provide funding for state and congressionally chartered Veterans Service Organizations (VSOs) to offset the costs of training and to enhance the workforce capacity of VSOs. This would help to improve the level of support and care provided to veterans and their families by such VSOs, ensuring that they have access to the resources and services they need to thrive.

16. Western Governors emphasize the need for VA to provide Veteran Services Officers with access to vital information, enabling them to better assist veterans in navigating VA's programs and services. This will ensure that veterans receive the support and resources necessary to thrive.

17. Western Governors recommend that VA expand its dental services to all veterans enrolled in the VA health care system, regardless of their service-connected dental issues or other narrow criteria.

18. Western Governors urge Congress to authorize and appropriate funds for VA to provide grants to state, territorial, and tribal governments. The purpose of these grants is to increase outreach and assistance to veterans and their families by raising awareness of benefits and aiding them in applying for VA benefits. Priority should be given to areas with high rates of veteran suicide and a shortage of Veteran Services Officers.

19. Western Governors support the idea that service members should be given the opportunity to receive credit or professional credentials for the training they undergo in the military, which can then be transferred to the private sector or educational institutions. This initiative will help veterans transition into civilian careers by providing them with the necessary credentials and recognition for the skills developed through their military service.

20. Western Governors urge Congress to provide diligent oversight over VA and DOD to ensure that transitioning service members receive comprehensive information on VA benefits at least twelve months prior to their transition to civilian life. This includes ensuring that service members are aware of the full range of programs and support services available to them.

21. Western Governors recommend that VA conduct a comprehensive study on their efforts to reduce homelessness and identify those programs that have provided the highest return on investment.

C. GOVERNORS' MANAGEMENT DIRECTIVE

1. The Governors direct WGA staff to work with congressional committees of jurisdiction, the Executive Branch, and other entities, where appropriate, to achieve the objectives of this resolution.

2. Furthermore, the Governors direct WGA staff to consult with the Staff Advisory Council regarding its efforts to realize the objectives of this resolution and to keep the Governors apprised of its progress in this regard.

This resolution will expire in June 2026. Western Governors enact new policy resolutions and amend existing resolutions on a semiannual basis. Please consult http://www.westgov.org/resolutions for the most current copy of a resolution and a list of all current WGA policy resolutions.

Policy Resolution 2022-07

Physical and Behavioral Health Care in Western States

A. BACKGROUND

1. Ensuring access to high-quality, affordable health care is critical to enhancing the quality of life in western states for our growing populations and is the foundation of building and maintaining healthy and vibrant communities and economies.

2. The COVID-19 pandemic illustrated the importance of our health care and public health systems and the urgency with which we must improve health inequities and disparities. Despite warnings of an impending global pandemic, federal, state, local and Tribal governments encountered significant issues containing and responding to the virus, resulting in economic turmoil, supply chain shortages, and a devastating loss of life. In addition, inequities and disparities fueled the spread of COVID-19, affecting many racial and ethnic minority groups who are more likely to live and work in suboptimal conditions.

3. Western states face unique challenges in health care that have been compounded by the pandemic, including growing rates of behavioral health conditions, which encompass mental health and substance use disorders; provider shortages in underserved and rural areas; and limited access to broadband, which has limited the availability of telehealth services. Low population densities and the vast distances between population centers also make it difficult for providers to establish economically sustainable health care practices in rural areas.

4. In addition, distance and density inhibit construction of the technology infrastructure that would provide or improve broadband connectivity in underserved and rural areas. Expanding broadband access provides numerous quality-of-life benefits for rural Americans, including economic development, social connectivity, education, public safety, and access to telehealth and telemedicine.

5. Telehealth utilization has skyrocketed due to the loosening of federal and private insurance restrictions to meet emergency needs during the pandemic. Telehealth is an essential tool to advance health care access, especially in rural areas and among underserved populations, but its use has been limited over the years by federal regulations and licensing barriers.

6. The health care sector faces severe workforce shortages in western states despite efforts of Western Governors, such as the foundation of Western Governors University and other medical training programs in western states, to ensure adequate numbers of qualified medical personnel. This issue has been further exacerbated by COVID-19 and is particularly acute in the West's underserved and rural areas. Ensuring access to health care services requires an adequate number and distribution of physicians, nurses, mental and behavioral health counselors, and other trained health care professionals. Population growth, aging residents, and challenges involving Tribal health care and services for veterans require a renewed focus on developing our nation's health care workforce.

7. Social and economic factors distinct from medical care are powerful predictors of health outcomes and disease burden throughout a person's life. The U.S. Department of Health and Human Services (HHS) defines these social determinants of health (SDOH) as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. It has also identified five key areas of SDOH: economic stability; education; social and community context; health and health care; and neighborhood and built environment.

8. In many cases, SDOH disproportionately affect communities of color and other minority populations in the West and drive disease, worsen health disparities, and present barriers to accessing health care. As such, the integration of health and human services is important to promote a whole person orientation to care that is focused on prevention and is delivered in a culturally and linguistically appropriate manner. Understanding the effect of SDOH on health and health care can inform the development of effective policy to increase access and improve health outcomes for these populations.

9. Western states have a unique body of experience, knowledge, and perspective with respect to health care. The Western Governors' Association (WGA) is ideally situated to collect and disseminate information, including best practices, case studies and policy options, that states can use to improve the foundation for health care services and advocate for shared policy priorities on behalf of their citizens.

Behavioral Health Integration

10. Behavioral health needs are often associated with negative stigma and harmful misperceptions, which can have many detrimental effects, including: a lack of understanding by family members, friends, coworkers, and others; reduced professional, educational, and personal opportunities; various forms of discrimination; and bullying, physical violence, or harassment. Stigma can result in a reluctance to seek help or treatment and contribute to self-doubt and shame associated with behavioral health conditions, including mental health and substance use disorders.

11. Two-thirds of all diagnosable mental illness onset before adulthood, yet the vast majority of adolescents do not receive any treatment. Access to prevention and early intervention services and support for children and youth helps treat behavioral health conditions before they become debilitating and lead to negative outcomes in adulthood.

12. Western states experience higher than average suicide rates. Suicide is the second leading cause of death among youth, and the ten states with the highest suicide rates in the nation are all located in the West.

13. Integrating behavioral and physical health care services and supports can have many positive effects on health outcomes and health care spending. Behavioral health integration presents a more holistic approach to patient care and offers increased access for consumers. Integration can also be an effective tool to de-stigmatize treatment for behavioral health.

14. Substance use disorders (SUDs), including alcohol and drug misuse, are a major public health and safety crisis affecting nearly 21 million Americans. They are particularly prevalent in western states, where individuals are more likely to experience SUDs or have a family member who has. SUDs cross all social and economic lines and tragically take the

lives of tens of thousands of Americans every year. Much attention has been focused on opioid use, and recent federal investment has prioritized opioid prevention and treatment. In western states, however, methamphetamine overdose deaths outpace those resulting from opioid use. It is important to recognize that SUDs encompass all drug classes and polysubstance misuse, and to balance federal SUD investments accordingly. While state and federal progress has been made to address SUDs, additional efforts are necessary to help bridge prevention, treatment, and recovery gaps in western states.

15. Jails and prisons have become de facto behavioral health treatment facilities, which are unequipped to provide needed care. This reality results in inefficient use of public resources and poor outcomes for patients. Youth experiencing a first episode of psychosis are too often sent to juvenile halls, and adults with mental illness and SUD become incarcerated without proper treatment for their underlying chronic behavioral health conditions.

16. Many people experiencing homelessness also struggle with a behavioral health condition, which contributes to the risk of being unhoused. Both supportive housing and adequate, coordinated health and social services must be available to prevent and reduce homelessness for people with mental health and SUDs.

17. The quality and completeness of patient records is an important element of care coordination and patient safety. Ensuring the protection and privacy of these records is a critical aspect of maintaining patient confidence in the health care system and ensuring that patients are forthcoming about their behavioral health needs.

18. Currently, federal privacy rules prohibit SUD treatment providers from fully participating in health information exchanges. This may leave health care providers without a full understanding of a patient's medical history and use of medications, which can reduce the quality of care and lead to negative patient outcomes, including potentially deadly medication interactions.

19. Electronic health records (EHR), state Prescription Drug Monitoring Programs (PDMP), and Health Information Exchange (HIE) are important tools in improving care coordination and addressing the opioid crisis, allowing prescribers and pharmacies to help prevent opioid misuse. At present, there are instances of limited interoperability between EHRs and PDMPs that reduce the potential positive effect of these tools on patient safety. Robust systems for HIE can help to address these shortfalls.

20. Current federal statute limits the ability of state Medicaid programs to cover inpatient and residential treatment and recovery services at facilities with more than 16 beds, also known as the Institutions for Mental Diseases (IMD) exclusion. This antiquated limitation prevents many adults with behavioral health needs from receiving adequate treatment in a licensed health care facility. Waivers for this exclusion offered by the U.S. Department of Health and Human Services (HHS) have provided states with important flexibility and improved access to treatment for patients with SUD, but barriers still remain.

21. Medication-assisted treatment (MAT), including opioid treatment programs, combines behavioral treatment and recovery services with medications to treat SUDs. While MAT has been proven to improve health outcomes and reduce mortality among opioid addiction patients, stigma and myths surrounding the use of MAT limit its potential use in SUD treatment and recovery.

22. The passage of the SUPPORT for Patients and Communities Act in 2018 was a significant step forward for MAT, including by promoting greater flexibility in its use and expanding access to and coverage for MAT. However, significant limits remain on MAT use and providers' ability to take full advantage of these treatment methods.

23. Support from individuals with lived experience, peer support groups, and community-based organizations, including faith-based and cultural organizations, are important components of effective treatment and recovery for SUD and other behavioral health conditions.

B. GOVERNORS' POLICY STATEMENT

1. Federal efforts to address health care workforce and access needs should reflect early, meaningful, and substantive input from Governors, who are best positioned to assess the needs of their states and help develop solutions to meet these needs. State-federal collaboration and coordination are integral to addressing these health care challenges. Wherever possible, and where appropriate, the federal government should respect state authority and maximize flexibility granted to states and Governors.

2. The federal government should work with states to facilitate the deployment of broadband to underserved and rural areas, recognizing that adequate broadband access has a direct correlation to rural populations' ability to access telehealth and telemedicine.

3. Western Governors urge the federal government to make permanent regulatory changes based on waivers and authorizations granted during the COVID-19 public health crisis to provide flexibility and increase access to telehealth and telementoring. We propose actions to create an environment conducive to the expansion of telehealth beyond the pandemic, including but not limited to permanently changing provisions of 42 CFR and Section 1834(m) of the Social Security Act (SSA) such as:

   a. Eliminating the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allowing visits to be conducted, as appropriate, via telehealth options (42 CFR 483.30);

   b. Waiving interactive telecommunications systems requirements and permitting audio-only visits for certain services (Section 1834(m)(1) of the SSA);

   c. Removing requirements specifying the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site, which expands the type of practitioner that can provide services through telehealth and allows all practitioners eligible to bill Medicare for services to deliver those services via telehealth (Section 1834(m)(4)(E) of the SSA);

   d. Making Federally Qualified Health Centers and Rural Health Clinics qualified distant site providers of telehealth services (1834(m) of the SSA);

   e. Granting clinicians the ability to provide remote patient monitoring services to new and established patients for both acute and chronic disease management and for patients with only one disease condition (1834(m) of the SSA);

f. Eliminating originating site requirements to allow patients to take visits from their homes (42 CFR 409.46(e)); and

g. Expanding geographies to include all counties, not just those located outside metropolitan statistical areas or in health professional shortage areas (1834(m) of the SSA).

Any changes to federal telehealth policy should ensure that patient needs are at the center of those changes. Any changes should also ensure that patient choice to receive in-person services is preserved and only clinically appropriate services are provided via telehealth.

4. Despite efforts by Western Governors to address the shortage of qualified health care workers, significant challenges remain. Governors urge the federal government to examine and implement programs to ensure states have an adequate health care workforce – including in primary care, behavioral and oral health as well as other in-demand specialties – that is prepared to serve diverse populations in urban, suburban, and rural communities. Additionally, the federal government should consider funding new types of personnel, such as community health workers or promotores, in order to further extend the health care team and ensure that patients are connected to resources. Understanding that there remain significant disparities in access and treatment for many populations, Governors also support efforts to increase diversity and representation in the health care workforce to improve health outcomes for all.

5. Western Governors recognize the role that social determinants of health (SDOH) have on the health outcomes and well-being of our citizens, and the effect that social determinants – including economic stability, education, social and community context, and neighborhood and built environment – have on an individual's health status. Western Governors support efforts to identify risks facing high utilizers of health care services, including food insecurity, domestic violence risk, unmet transportation needs, lack of housing and housing instability, utility, and other essential supports and services, and to develop innovative models designed to improve coordination of medical and non-medical services and use of evidence-based interventions. These models can provide valuable information on how meeting non-health needs and addressing other social determinants can improve overall health status and decrease health spending.

6. Western Governors encourage Congress to adopt legislation that would empower states and local governments to address persistent economic and social conditions – like limited access to health care providers, stable housing, reliable transportation, healthy foods, and high-quality education – that often hinder health outcomes. Such legislation would assist states in developing plans to target social determinants that negatively affect health outcomes for western populations.

7. Western Governors acknowledge the importance of improving our nation's public health preparedness and response systems. The federal government must examine the lessons learned from COVID-19 in collaboration with states and ensure that we have the capability and necessary public health infrastructure investment to effectively confront future public health challenges. We recommend that the federal government clarify pandemic response roles and build operational capacity within the appropriate health-related agencies. The federal government should also consider how to expand our international health surveillance and public health threat detection mechanisms.

Behavioral Health Policy

8. Western Governors believe patients should have the same access to behavioral health care as they have for physical health care, including prevention and early intervention services and supports for chronic conditions like mental illness.

9. Western Governors support efforts to improve the quality and quantity of behavioral health services and supports available to our residents, as these services and supports are essential to reducing suicide rates and treating a range of behavioral health conditions, including mental illness and SUDs.

10. Western Governors recognize and support efforts at the federal, state, and local levels to promote the integration of physical and behavioral health services. The Governors encourage Congress to adopt legislation and the Administration to implement policies that support states' integration efforts and that encourage health care providers to better integrate behavioral and physical health into their practice of care.

11. Western Governors also support innovation within the behavioral health workforce to create new classifications and address gaps in the continuum of care professionals.

12. Western Governors believe the federal government should work toward treating addiction as a chronic illness and work with Western Governors to develop strategies for addressing SUD that work in concert with state efforts and recognize regional variations in SUD patterns.

13. Western Governors believe that the federal government should take steps to increase opportunities for early intervention and law enforcement diversion to prevent entry into the justice system for individuals with behavioral health conditions. That includes providing law enforcement and emergency service providers with the resources and training they need to divert when appropriate and expanding the availability of community reentry programs that provide appropriate treatment for underlying behavioral health conditions that contribute to involvement in the justice system.

14. Western Governors support efforts to increase the availability of transitional and permanent supportive housing with coordinated health and social services to more fully support and sustain recovery for people with behavioral health conditions.

15. Western Governors encourage Congress to pass legislation that aligns federal privacy requirements for SUDs (42 CFR Part 2) with the requirements for all other types of medical conditions under the Health Insurance Portability and Accountability Act (HIPAA) to improve care coordination and reduce stigma for patients with SUD.

16. The exchange of health information is fragmented and often does not occur, limiting the ability of a provider or team of providers to understand the complete needs of a patient and provide whole-of-person care. Western Governors believe the federal government should take steps to support and help sustain states' administration of PDMPs and ensure that EHRs and PDMPs are fully interoperable between states and the federal government, accessible to relevant health care providers, including opioid treatment providers, and include adequate protections for patients from stigmatization and discrimination.

17. Western Governors support legislation to address the so-called Institutions for Mental Diseases (IMD) exclusion to improve access to SUD treatment and recovery services at residential and inpatient facilities with more than 16 beds, as well as to the full continuum of community-based behavioral health care. This policy solution must also improve access to both inpatient and ongoing, recovery-focused treatment in community settings. Until a legislative solution is enacted, the federal government should continue working with states to provide IMD waivers that offer important flexibility and improve access to treatment for patients with SUD. Implementation of these waivers must also occur in connection with expansions of the full community-based continuum of behavioral health care so that consumers receive services in the lowest level of clinically appropriate care in the community whenever possible.

18. Western Governors support legislative action to increase access to MAT for patients with SUD. This includes eliminating the unnecessary and burdensome registration requirements for physicians, physician assistants, and nurse practitioners to obtain a waiver from the Drug Enforcement Administration to treat opioid use disorder with buprenorphine, which would provide health care professionals with additional flexibility to use MAT to treat opioid-related SUD.

19. Western Governors urge the federal government to develop an evidence-based, culturally competent national education and awareness campaign to reduce the stigma associated with mental health and SUDs and encourage individuals to seek help for these health conditions.

C. GOVERNORS' MANAGEMENT DIRECTIVE

1. The Governors direct WGA staff to work with congressional committees of jurisdiction, the Executive Branch, and other entities, where appropriate, to achieve the objectives of this resolution.

2. Furthermore, the Governors direct WGA staff to consult with the Staff Advisory Council regarding its efforts to realize the objectives of this resolution and to keep the Governors apprised of its progress in this regard.

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