

**Department of Veterans Affairs (VA)  
House Veterans' Affairs Committee  
VA Suicide Prevention and Vet Centers**

**September 27, 2018**

**Questions for the Record**

**Community Care**

**Question 1: Does VA utilize its community care networks to increase the reach and capacity of VA's suicide prevention efforts? If so, to what extent and through what methods? How could VA better engage suicidal veterans who do not use VA services?**

**VA Response:** Yes, VA does utilize community partners to reach at-risk Veterans. VA is implementing a broad-based public health approach that extends beyond the health care setting to prevent suicidal thoughts and behaviors in the overall Veteran population. As outlined in the National Strategy for Preventing Veteran Suicide, VA's Suicide Prevention Coordinators are implementing programs in the following strategic domains to increase the reach and capacity of VA suicide prevention efforts:

- **Healthy and Empowered Veterans, Families, and Communities**
  - Work with community partners (e.g., local military installations, faith organizations, American Foundation for Suicide Prevention chapters) and policy makers to promote resources for Veterans and to promote mental health awareness and treatment.
- **Clinical and Community Preventive Services**
  - Share resources, training opportunities (e.g., 15 Things Veterans Want You to Know and Signs, Ask, Validate, Encourage and Expedite (SAVE) Training), interventions, and lethal-means safety resources with providers outside of VA such as clergy, first responders, law enforcement officials, and community partners.
- **Treatment, Recovery, and Support Services**
  - Work with local emergency departments and hospitals to promote Veteran suicide prevention resources (e.g., Veterans Crisis Line, Make the Connection, Coaching Into Care) and continuity of care with all Veterans admitted to an inpatient mental health unit (e.g., appointment telephone reminders, "crisis cards," and emergency phone numbers).
- **Surveillance, Research, and Evaluation**
  - Share the VA National Suicide Data Report, State Data Sheets, Veteran Suicide Fact Sheets, and National Strategy for Preventing Veteran Suicide with community partners.

- Share the Behavioral Health Autopsy Report with community partners.
- Continue research with the Veterans Crisis Line to develop a more comprehensive understanding of suicide risk and clinical needs of Veterans Crisis Line callers.
- Collaborate with the Office of Research and Development (ORD) to establish a research agenda including alignment of activities with successful Air Force Suicide Program component, and continue participation in the Million Veteran Program (MVP).

Also, as we testified before the Senate Veterans Affairs' Committee (SVAC) on August 1, 2018, VA strongly supports the concept of Senator Bill Cassidy's proposed legislation to assist in VA's efforts to prevent Veteran suicides, and we would appreciate the opportunity to work with the Committee to explore some technical alternatives or modifying language that may improve this proposal. The purpose of this legislation is to establish a program to award grants to provide and coordinate the provision of suicide prevention services for eligible Veterans who are at risk of suicide and for their families. A Veteran would be eligible for services under this section if the Veteran is within the first 3 years of transitioning from the Armed Forces to civilian status. Grant applicants would be required to submit an application that describes the suicide prevention services; the identified need for these services; a detailed plan describing how the suicide prevention services would be delivered, including the community partners with whom the applicant proposes to work, the arrangements currently in place with such partners; and how long such arrangements have been in place. The suicide prevention services provided or coordinated would have to include the following: outreach to identify Veterans at risk of suicide with an emphasis on Veterans who are at highest risk of not receiving health care or services from VA; screening risk assessment and referral to care; education of suicide risk and prevention to families and communities; case management services; peer support services; assistance in obtaining benefits from VA and other Federal, State, and local government entities; temporary assistance in transportation in the form of a voucher, when appropriate and applicable, to be used in accessing services; personal financial planning; legal services to assist with issues that interfere with obtaining or retaining housing or supportive services; and other services necessary for improving the resiliency of Veterans at risk for suicide and their families.

We believe this expanded population of potential beneficiaries, would include some of the 14 Veterans who, on average, commit suicide every day and who do not access VA care. This legislation could provide a critical tool for coordinating with other entities in the community to reach this population of Veterans who do not rely on VA for care.

**Question 2: How, if at all, are VA's community-based suicide prevention strategies being incorporated into VA's ongoing community care efforts, including those pursuant to the MISSION Act?**

**VA Response:** The Veterans Health Administration (VHA) Office of Community Care (OCC) has been collaborating with the Rocky Mountain Mental Illness Research, Education, and Clinical Center (MIRECC) on suicide prevention efforts. OCC will provide resources from MIRECC, including the Suicide Risk Management Toolkit, to the Community Care Network (CCN) third party administrators (TPA) at the time of awarding of the Community Care Network Contract. In addition, OCC hosted a webinar for community providers on October 25, 2018, regarding VA's Suicide Prevention Strategy. Although suicide prevention training is not specifically called out in VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, these efforts all fall within the umbrella of the new community care program that VA is developing per MISSION Act requirements.

### Vet Centers

**Question 3:** To what can the 28 percent increase in successful suicide interventions at Vet Centers over the last two fiscal years be attributed? Given the success achieved and the increased workload Mr. Fisher reports, do you have any current plans to increase the number of Vet Centers?

**VA Response:** VA's Readjustment Counseling Service (RCS) believes this increase can be attributed to a heightened focus on the identification of "risk" and increased reporting of these situations. After a review of RCS counseling records, it appears that no one intervention or modality can be attributed to these successes but rather a range of interventions that includes but is not limited to increased care coordination and increases in Vet Center encounters with Veterans and Servicemembers. As per the Presidential Budget Request, RCS is seeking approval for five new Vet Centers over the next 2 fiscal years.

**Question 4:** The statement for the record from the National Alliance for Mental Illness notes that they see a trend of veterans and their families being unaware of Vet Centers. Is VA also seeing this, and, if so, what is VA plan to increase awareness of all of the services that Vet Centers have to offer?

**VA Response:** RCS is aware of the need for increased awareness of Vet Center services to augment the face-to-face outreach that is currently being done. RCS has recently hired a national communication officer whose responsibilities include implementing a national awareness strategy, increasing RCS' social media footprint, and working directly with Vet Centers to amplify strategic messaging and RCS priorities.

### Community Partnerships

**Question 5:** Dr. Franklin, I am glad to see that VA is taking steps to establish formal partnership agreements with outside entities to address suicide among veterans. How will you define the success of those agreements and what measures of success will you track?

**VA Response:** Partnerships are a critical component of our public health model, as not all Veterans are connected to VA, so we must find innovative strategies to serve Veterans who do not—and may never—seek care, benefits, or services within our system. We are creating a partnership strategy that directly supports our recently released National Strategy for Preventing Veteran Suicide. Included in the partnership strategy will be measures of success for our public and private partners, some of the current examples of those measures are total number of Servicemembers, Veterans, and their families within the reach of an organization and whether their Veterans are enrolled with VHA, total number of wellness resources provided through strategic communications to their network, and the total number of people trained in our suicide prevention gatekeeper training (civilians, Servicemembers, and Veterans). Ultimately, we want to move beyond these proximal measures and evaluate outcomes such as behavior change and actions, but these types of metrics are traditionally difficult to measure and will take time to evaluate and develop.

**Question 6:** VA written testimony references VA's partnership with Substance Abuse and Mental Health Services Administration (SAMHSA) and the implementation of the Mayors' Challenge. Seven cities have established coalitions and VA plans to expand the program to an additional 20 cities. Has VA observed any changes in the number of veteran suicides in these initial seven cities?

**VA Response:** VA launched the Mayor's Challenge—a partnership with the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to help local leaders in city governments work together to prevent suicide among Veterans. The Mayor's Challenge began with 7 cities and has now expanded to 24 sites nationally. National reporting of suicide data is typically 2 years behind, so information about changes in Veteran suicide rates is not yet available, but we continue to work with communities to define proximal measures as local plans are implemented.

#### Government Partnerships

**Question 7:** Dr. Franklin, in the National Alliance on Mental Health's statement for the record, they advocate for VA to work in coordination with DOD to develop and carry out a longitudinal research study to identify psychiatric biomarkers for brain health conditions. Is VA considering any such research?

**VA Response:** In the August 2013 Executive Order, the National Research Action Plan (NRAP) directs the Department of Defense (DoD) and VA to work collaboratively on research on biomarkers, mechanisms and treatments for Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Suicide Prevention. Part of the NRAP is the comprehensive longitudinal mental health study, including the Study to Assess Risk and Resilience in Servicemembers – Longitudinal Study (STARRS-LS) STARRS-LS study. The STARRS-LS is a research project funded by DoD to create practical, actionable information on risk reduction and resilience-building for suicide, suicide-related behavior, and other mental/behavioral health issues in the military. It continues and expands the vital work begun by the Army STARRS project. ORD is also currently conducting the

MVP, a longitudinal study of Veterans. Both longitudinal studies identify biomarkers related to suicide risk and protective factors.

**Question 8: Dr. Franklin, can you tell us more about the Air Force's successful suicide prevention strategy and how you are applying it to your work at VA?**

**VA Response:** In August 2018, the Suicide Prevention Program (SPP) office completed a crosswalk of our initiatives/ activities against the 11 key components of the Air Force's successful suicide prevention program. We have numerous implemented projects and activities in alignment with each of the 11 components, including trainings of clinical and non-clinical staff, increasing community and Veteran outreach efforts, evidence-based therapies targeting PTSD, depression and suicide prevention, best practices in safety planning, data and surveillance to guide priorities and identify gaps. One of the most powerful key components for success in the Air Force model is leadership involvement. We appreciate the ongoing support of the SPP efforts by our VA Secretary and executive leadership as well as the support of this committee both here in Washington and back home in your districts.

While there may be some similarities, it is vital to acknowledge the significant differences between Air Force Suicide prevention efforts and those of VA. VA is focused on Veterans both in and out of VHA care. This public health approach requires more extensive partnerships with local and state level partners to address issues closest to home for Veterans in crisis and before they reach a crisis point. The Air Force has more control of the immediate and systematic conditions and solutions for its scope of responsibility.

#### VA Programs & Training

**Question 9: Please tell us more about the REACH VET program. How does it identify veterans who may be at risk of suicide and how have you verified that it is making an impact with regard to early outreach?**

**VA Response:** Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) uses clinical and administrative data in Veterans' VA medical records to identify and proactively engage in care those who may be at risk for hospitalization, illness, suicide, and other adverse outcomes. REACH VET works to help inform VA providers of the most vulnerable Veterans under their care. Through REACH VET, VA providers:

- Review identified Veterans' diagnoses, mental health conditions, and risk factors,
- Contact identified Veterans to collaboratively discuss their health care,
- Ensure Veterans can access care, including transportation to appointments, and
- Consider appropriate enhancement strategies, such as safety planning or increased

monitoring during stressful life events.

Our initial implementation assessment findings indicate Veterans identified by REACH VET have:

- More health care appointments,
- More mental health appointments,
- Decreases in the percent of missed appointments,
- Greater completion of suicide prevention safety plans, and
- Less all-cause mortality

**Question 10:** The statement for the record from the National Alliance for Mental Illness indicates that several mental health diagnoses - including PTSD - are not taken into account in the REACH-VET predictive model, which is supposed to identify veterans at-risk of suicide before they reach a crisis point. Is that true? If so, why would those diagnoses not be relevant to REACH-VET?

**VA Response:** Modeling of risk is a scientific field that uses established methods to identify candidate predictors and validate against available data. REACH VET uses approximately 60 factors that were validated to predict risk of suicide and other adverse outcomes. The current model includes some mental health diagnosis, including depression, bipolar disorder, and substance use disorder because they contributed most to risk. We are currently working to update the risk model that informs REACH VET and evaluating a large set of potential risk factors as candidate predictors so additional diagnosis will be considered, but the intent is to build a better model that more accurately predicts suicide and not simply to add risk factors.

**Question 11:** Dr. Franklin's written testimony mentions an initiative to bolster mental health services for women. Will VA please discuss the unique challenges to combating suicide among women veterans and how the initiatives mentioned aim to address such challenges?

**VA Response:** To address women Veterans' mental health treatment needs and preferences, VA provides a full continuum of mental health services for women Veterans, including general outpatient, specialty care, residential, and inpatient treatment options. Outpatient services include mental health assessment, evaluation, pharmacotherapy, and individual, group and family psychotherapy.

Specialty care programs are available to target problems such as PTSD, substance use, depression, and military sexual trauma (MST), each of which has been associated with heightened suicide risk. For example, evidence-based therapies for conditions such as PTSD, including prolonged exposure and cognitive processing therapy, have been shown

to decrease suicidal ideation and are available at every VA medical center. In addition, MST-specific care and services are also available at every VA medical facility and are provided free of charge. Eligibility for MST-specific counseling and care and services does not require Veterans to have an adjudicated service-connected condition resulting from MST or evidence of the sexual trauma event in their military records. Eligibility for MST-specific treatment is strictly a clinical determination, as described in law. Veterans do not need to be enrolled in VA's health care system to receive MST-specific counseling, care, and services.

Every VA health care system also has a Women's Mental Health Champion who contributes to the development of local outreach, advocacy, policy and clinical programming to advance local mental health services for women Veterans. These Champions frequently collaborate with other local points of contact with complementary (or related) areas of focus, such as Suicide Prevention Coordinators; Women Veterans Program Managers; MST Coordinators; Intimate Partner Violence Coordinators; Lesbian, Gay, Bisexual, Transgender Veteran Care Coordinators; and Maternity Care Coordinators.

VA has enacted universal screening programs for common mental health conditions and related experiences — including those associated with increased risk for suicide — such as depression, PTSD, alcohol use, and MST. These screening programs provide a timely opportunity to identify individuals in need of mental health care and refer them to appropriate mental health services. Screening rates are very high, exceed private sector rates, and do not significantly differ by gender.

VA has developed a portfolio of innovative clinical training initiatives to ensure that mental health providers have the knowledge and skills to meet the treatment needs of the growing population of women Veterans. Training initiatives include online resources, didactic teleconferences about issues specific to women's mental health — including a special series for mental health prescribers — expert clinical consultation, and interactive Web-based trainings. The curricula include content that is specifically designed to address suicide risk in women Veterans. For example, recurring women's mental health monthly teleconference series featured suicide-related topics twice in FY 2018: clinical management of high-risk women Veterans, and pharmacotherapy for complex PTSD and borderline personality disorder. Examples of other trainings initiatives include:

- Multidisciplinary Eating Disorders Treatment Team Training: Rates of suicide attempts and death by suicide are elevated among individuals with eating disorders. VA's Office of Mental Health and Suicide Prevention (OMSHP), in partnership with Women's Health Services, developed a state-of-the-art, multidisciplinary treatment training consistent with Joint Commission standards on the outpatient treatment of eating disorders. Clinicians learn how to provide specialized outpatient care, as part of a multidisciplinary team, that includes evidence-based psychotherapy for eating disorders, psychiatric medication management, primary care, dietitian services, and case management.
- Skills Training in Affective and Interpersonal Regulation (STAIR): Research suggests that emotion dysregulation is associated with suicidal ideation. STAIR is an 8-10

session trauma treatment that uniquely focuses on strengthening emotion regulation and social functioning/relationship skills, which are areas of functioning often disrupted in women who have experienced severe interpersonal traumas, such as sexual assault. In partnership with the developer of STAIR, OMHSP created a live, Web-based didactic and interactive case consultation training in STAIR and a similar expert-led training in Parenting STAIR, which is designed for Veterans whose emotional reactions negatively impact their parenting and parent-child relationships. In partnership with the Office of Rural Health, a telemedicine application of STAIR has been developed to increase access to trauma treatment for Veterans who are unable or unwilling to seek treatment at a VA healthcare facility.

- **VA/DoD Women's Mental Health Mini-Residency:** This intensive, 3-day clinical training, held in August 2018, covered a broad range of topics related to the treatment of women Veterans and Servicemembers, including evidence-based psychotherapies and psychiatric medications. Specific training topics included treating women who have experienced gender-linked traumas, such as intimate partner violence and sexual abuse, working with women whose mental health problems are influenced by hormonal changes and the reproductive cycle, and understanding suicide risks in female patients. This mini-residency has been a key way for VA to develop a national network of VA Women's Mental Health Champions who, as described earlier, work locally to disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care.

**Question 12: Dr. Brown states in his testimony that the quality of safety plans in VA medical records was low. As a result, VA developed a medical record template along with instructions and a manual, and supposedly additional training is planned. Who will conduct this training, how interactive will it be, how will this training be tracked, what is the role of the program office in ensuring accountability for this training?**

**VA Response:** In May 2018, Suicide Safety Planning Training was offered on three dates following the release of the nationally standardized Suicide Prevention Safety Plan note template and manual. Adobe Connect was utilized as the training platform to permit use of interactive surveys, live question and answer, access to clinical resources, and audio recordings of role-play scenarios. Training was facilitated by suicide prevention subject matter experts including Suicide Prevention Coordinators, clinicians from the Rocky Mountain Veteran Integrated Service Network (VISN) 19 MIRECC for Suicide Prevention, and the Patient Education Resource Center. The live webinar presentations were attended by 894 mental health clinicians. The training was recorded and is also available in VA's Talent Management System (TMS), item # 36232. Training records are available for review in TMS, and we continue to communicate this to the field.

For FY 2019, we plan to improve safety planning training by developing an Evidence Based Practice evaluation of Safety Plan interventions. Findings will support improvement of the quality of safety plans.

**Question 13: VA testimony repeatedly notes that suicide prevention is VA's top priority. How is that priority status reflected in budgeting, staffing, programming,**

**and research and what more can Congress do to better support VA's suicide prevention efforts?**

**VA Response:** Suicide Prevention is VA's top clinical priority. Upon its inception in the fall of 2016, SPP consisted of two permanent full-time equivalent (FTE) employees and seven detailees from the field. It has since undergone two re-alignments within VHA and established an expanded organizational chart, increasing the Program's allocated FTE from two to 26. To date, 11 FTE have been permanently hired, there are five tentative offers out to candidates who are expected to start in the next 4-6 weeks, and we anticipate the remaining 10 staff will be onboarded by the end of or shortly thereafter the end of 2018. In addition to the permanent hires, over the past 2 years, the Program has received staffing support from field subject matter experts, project managers from the Office of Strategic Integration Veterans Engineering Resource Center and government contracts. During this time, the Program has shifted from a medical model of suicide prevention to a public health model, which we spoke about extensively at the hearing. This moves VA from focusing mostly on crisis intervention for at risk Veterans in VA's care to reaching all at-risk Veterans, a substantive increase in scope for the Program.

In FY 2018, SPP funded 23 research projects and activities allocating \$4.2 million dollars. Four of these projects had universal reach to all Veterans, 12 have targeted selected high-risk groups, and 7 projects were aimed at Veterans indicated to be at high suicide risk. With the increased staff mentioned above, we now have additional resources dedicated to SPP Research and Program Evaluation to better track research needs, gaps, and findings, and to improve our research to implementation of best practices in a timely and effective manner.

VA is also working to continuously improve our services by providing evidence-based mental health care across a full continuum of interventional services, to anticipate and respond to Veterans' needs and to support returning Servicemembers as they reintegrate into their communities. The Veterans and Military Crisis Line connects Servicemembers, Veterans, and their families and friends with caring responders through a phone call, an online chat, or text messaging. Every day, more than 400 Suicide Prevention Coordinators (SPCs) and their teams, located at every VA medical center (VAMC), connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs, such as REACH VET, VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care—such as follow-ups for missed appointments, safety planning, and care plans. VA also partners with hundreds of organizations and corporations at the national and local levels, including the DoD, Veterans Service Organizations, professional sports teams, and major employers, to raise awareness of VA's suicide prevention resources and to educate people about how they can support Service members and Veterans in their communities.

**Question 14: How many mental health vacancies does VA currently have and what additional tools does VA need to ensure that it is able to quickly hire the mental health staff that it needs to treat veterans in need?**

**VA Response:** VHA currently has 2,688 FTE vacant mental health provider positions,

which corresponds to an 11.2 percent vacancy rate, consistent with the overall vacancy rate in VHA and reflects the normal churn of turnover as well as anticipated growth in mental health positions.

VHA is currently engaged in a strategic Mental Health Hiring Initiative (MHHI) to add 1,000 mental health providers to the workforce, and has so far achieved a net increase of 568 psychiatrists, psychologists, social workers, peer specialists, and other counselors. The initiative has been extended to ensure VHA healthcare systems achieve optimal staffing levels to meet the growing demand for mental health care. Other efforts include offering the Education Debt Reduction Program (EDRP) to qualified providers, national job announcements, an aggressive marketing campaign, and virtual trainee hiring fairs.

**Question 15: Dr. Franklin's testimony mentions that 400 Suicide Prevention Coordinators train Vet Center staff. What kind of training do these 400 Suicide Prevention Coordinators receive?**

**VA Response:** SPCs are subject matter experts in the field of suicide prevention and come from diverse clinical backgrounds in the field of mental health care including clinical social work, psychology, and nursing. The SPC onboarding process includes extensive training on the SPC Orientation Manual. Training is also available in VA TMS to Suicide Prevention Coordinators and Mental Health Clinicians to enhance their knowledge of suicide prevention interventions (e.g. Suicide Risk Management Training for Clinicians, Lethal Means Safety Training, Suicide Risk Screening and Assessment Training, Suicide Safety Planning Training, and Suicide Prevention for Women Veterans).

**Question 16: Dr. Franklin, tell us more about the Whole Health groups initiative. How is this different from the PACT model of care? How is it integrated into that model? Who is responsible for establishing, monitoring, and measuring the success of this initiative that is supposedly located at all VA medical centers?**

**VA Response:** Mental health and well-being involve not only disease management and risk reduction, but also supporting a life worth living. The VA's Whole Health approach empowers and equips Veterans to take charge of their health and well-being to live their fullest life. A critical part of supporting transitioning Servicemembers and all Veterans to be mission ready for their lives and optimizing their health in service of what matters to them are Whole Health groups led by peers. In these groups, Veterans explore together their new mission, and begin to create an overarching personal health plan that serves as an integrator for Veterans and their health care teams to develop shared health and well-being goals.

The VHA Office of Patient Centered Care & Cultural Transformation (OPCC&CT) provides support to VAMCs in the design and implementation of the Whole Health approach, which includes Whole Health education and training for peers, clinicians and staff; field implementation consultations; resource material; and tools. In partnership with VISNs, OPCC&CT is engaged in the evaluation of a 3-year effort to implement the Whole Health system in 18 flagship sites. All VAMCs have the opportunity to train peer facilitators to deliver Introduction to Whole Health, an orientation that provides Veterans with both

information and experiences on the Whole Health approach. This was implemented in support of Executive Order 13822, "Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life" and results in options for eligible Veterans to participate in additional local Whole Health programs or be referred to local Mental Health services. The offerings and Veteran participation in the Introduction to Whole Health are tracked locally and nationally through the Executive Order implementation efforts.

**Question 17:** Dr. Franklin, how does the VA's Telemedicine Outreach for PTSD (TOP) program, which targets veterans living in rural locations, fit in with your "Anywhere to Anywhere Telehealth" initiative?

**VA Response:** The Anywhere-to-Anywhere Telehealth initiative helps to facilitate VA programs across state lines, and the TOP program is currently using the initiative in its Quality Enhancement Research Initiative and Office of Rural Health funded implementation projects at six VA sites delivering services to Veterans in their homes and in rural hard-to-reach areas. The TOP program uses the Clinical Video to Home service delivery and utilizes nurse care managers to promote Veterans' engagement in Cognitive Processing Therapy and Prolonged Exposure trauma-focused therapies for PTSD. The TOP implementation project began in 2016 with funding through FY 2019. Efforts are in progress to make these nurse care manager positions permanent using facility funding.

#### Research

**Question 18:** VFW's statement for the record mentions some intriguing work that linguistic psychologists from the Massachusetts Institute of Technology (MIT) are doing to identify those at-risk of suicide. Is VA aware of that work? If so, what application does VA think it might have for your work to identify veterans at-risk of suicide?

**VA Response:** VA is aware of promising research, such as the MIT mentioned work, that leverages linguistic analyses to identify individuals potentially at risk for suicidal behaviors. VA is engaged in multiple projects to leverage novel indicators of suicide risk that may enhance predictive analytics. These include nearer term improvements to modeling in support of the REACH VET program and other predictive risk efforts.

**Question 19:** During a conference with the National Association of Veterans' Research and Education Foundations (NAVREF) last month, Dr. Ramoni mentioned that VA had recently established a working group on suicide prevention research. Please tell us more about that working group, to include who its members are, how often they are meeting, and what their charter is.

**VA Response:** The SPP Office actively participates in bi-weekly meetings with research colleagues at ORD. This workgroup is specific to suicide prevention research and implementation projects. Our goals are to improve across office collaborations, complement our efforts not duplicate them, streamline our processes to implement research findings into actionable effective programming to help Veterans. These bi-weekly meetings are attended by SPP Research & Program Evaluation staff, Director of the

OMHSP New England Program Evaluation Center and ORD suicide prevention research leads from Clinical Services Research and Development, Health Services Research and Development, and the Million Veteran Program (MVP). We've codified our cooperative and collaborative relationship and data sharing capabilities in a Memorandum of Understanding.

### Other

**Question 20:** VA's most recent National Suicide Data Report includes findings on veteran suicide based on National Death Index mortality data for all the 50 states and DC. Could you please elaborate on how VA is working to acquire information on veteran suicide in the territories? How is it engaging with local stakeholders to acquire this information? Do you have any insight on veteran suicide in the territories that you can share?

**VA Response:** Currently, National Death Index (NDI) contains about 95 million records from 1979 through 2016 from 50 states, the District of Columbia (DC), Puerto Rico (PR), and U.S. Virgin Islands. As of 2017, Guam, American Samoa, and the Northern Marianas are also included (see [https://www.cdc.gov/nchs/data/factsheets/factsheet\\_ndi.htm](https://www.cdc.gov/nchs/data/factsheets/factsheet_ndi.htm)). Using NDI data, VA currently reports on yearly Veteran suicide deaths that occur nationally (from across all geographic locations available in NDI), for each state, DC, and PR. The primary reason that Veteran suicide deaths are not reported for the additional territories is that suicide is an infrequent event, with rates calculated per 100,000, and the Veteran population in many territories is relatively small. Additionally, per agreement with the Centers for Disease Control (CDC) and DoD, any Veteran suicide deaths below a count of 10 for a given geographic location would not be able to be reported separately to protect individual and family privacy.

**a. How is it engaging with local stakeholders to acquire this information?**

**VA Response:** Currently VA is partnering with DoD and CDC to capture state- and territory-level reporting of Veteran suicide deaths. VA is partnering with local stakeholders to develop and implement Veteran suicide prevention programming as part of initiatives like the Mayor's Challenge.

**b. Do you have any insight on Veteran suicide in the territories that you might be able to share?**

**VA Response:** Using additional information from CDC, below is death certificate data from Guam, American Samoa, Northern Marianas, and Virgin Islands (Veterans and Non-Veterans combined). Prior to 2017, these data are not available from NDI, and so VA has not been able to report on Veteran suicide mortality in these areas. These territories will be included in NDI as of 2017, which will enable the potential data capture of any Veteran suicide deaths that will occur in future reporting.

U.S. Territories	2015	2016
Guam	33	47
American Samoa	<10	<10
Northern Marianna Islands	10	<10
Virgin Islands	<10	<10

Source: National Vital Statistics Reports

**Question 21: How is VA accounting for variations in suicide rates in the aftermath of natural disasters?**

**VA Response:** Natural disasters are disruptive to individual lives, and VA regularly provides support in those times of need. Using National Death Index data, VA can monitor changes in suicide rates at the state and national population level. However, at a population level it is difficult to attribute any potential change in suicide rates to a specific natural disaster. Research of the impact of natural disasters on suicide rates suggests a complex relationship with the scope of a disaster, existing local demographics and culture, an increased sense of community following a disaster and other population characteristics as potential contributing factors to an increase or decrease in suicide rate.

**Question 22: Could VA please elaborate on the vision for the Crisis Line and how is the VA ensuring it works properly, especially in the territories where it might be more challenging due to distance and limited medical networks? What is the proper procedure for directing assistance through the Crisis Line to local support – such as a 911 line?**

**VA Response:** The mission of the Veterans Crisis Line (VCL) is to provide 24/7, world-class suicide prevention and crisis intervention services to Veterans, Servicemembers, and their family members. The VCL will always provide supportive, timely, high quality crisis intervention and connect Servicemembers or Veterans to the services of their choice to ensure that they never struggle alone. The VCL can be reached via phone at 1-800-273-8255 (option 1), via text at 838255, and via online chat at [www.veteranscrisisline.net](http://www.veteranscrisisline.net).

The VCL monitors performance via the Executive Leadership Council (ELC), consisting of boards focusing on Quality, Employee Experience, Customer Experience, Business Operations, and Partnerships, with Key Performance Indicators (KPIs) identified and tracked for each. Utilizing the Quadruple Aim, VCL monitors access (demand, call typing, rollover, abandonment, average speed to answer, and service level), quality (silent monitoring results, responder dashboards, and effectiveness), cost (vacancy percentage, agent utilization, leave, and overtime trends), and experience (all employee survey results,

wellness, caller feedback, and average handle time). Quadruple Aim data is reported monthly through the ELC.

For Veterans who reside in territories where it might be more challenging to access care due to distance and limited medical networks, the VCL is available 24/7, 365 days a year. To ensure care coordination for Veterans who are not in immediate crisis, but could benefit linkage to local services, the VCL collaborates with a network of over 400 Suicide Prevention Coordinators (SPC), located at VA facilities across the nation. Upon completion of a call to VCL, an electronic consult may be submitted to the facility nearest to the Veteran. The Veteran's local SPC will respond to this consult within 24 business hours; over the past year, approximately 95 percent of SPC Consults were addressed within 24 business hours and closed within 3 business days.

If a Veteran is in immediate danger, the VCL Responder will work with a Social Services Assistant (SSA) to contact the Veteran's nearest emergency dispatch center in order to coordinate local emergency services. A consult to the nearest SPC will also be submitted to ensure local follow-up after the immediate crisis has resolved.

**Question 23: What protocols, if any, are in place to ensure that providers are cautioned against the contraindication of opioids and benzodiazepines unless absolutely necessary?**

**VA Response:** VHA developed a process to review opioids prescribing practices for VA and community care providers. VHA established mandatory Opioid Safety Initiative (OSI) education and training to all applicable health care providers, including community care providers. OCC ensures all participating community providers have received and reviewed the evidence-based guidelines outlined in the OSI. OCC implemented a process for all community care consults to include relevant Veteran medical history and their current medication list as known to VHA. VA's Employee Education System tracks community provider completion of VHA OSI education and training. OCC will ensure OSI training is included in the CCN provider training plans.

Additionally, the Academic Detailing Service in VHA offers a larger number of educational materials for provider and patient education, including several tools specifically addressing benzodiazepine prescribing that educate about the increased risk with opioid and benzodiazepine co-prescribing. These documents are available to VHA providers, and may be accessed externally through VA's Pharmacy Benefits Management Web site at: <https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp>.