VETERAN AND ACTIVE DUTY SUICIDES (PART I)

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OF THE

COMMITTEE ON OVERSIGHT AND REFORM

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VETERAN AND ACTIVE DUTY SUICIDES (PART I)

Wednesday, May 8, 2019

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON NATIONAL SECURITY
COMMITTEE ON OVERSIGHT AND REFORM
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:17 p.m., in room 2154, Rayburn House Office Building, Hon. Stephen F. Lynch (chairman of the subcommittee) presiding.

Present: Representatives Lynch, Welch, Rouda, Kelly, DeSaulnier, Plaskett, Speier, Hice, Amash, Gosar, Meadows, Cloud, Green, and Jordan.

Mr. LYNCH. The subcommittee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time.

The Subcommittee on National Security is convening to examine the issue of veteran and Active-Duty military suicides.

I now recognize myself for five minutes for an opening statement.

Today's hearing will mark our first step in our subcommittee investigation to examine the devastating suicide crisis affecting our Nation's veterans, and Active-Duty military members. Our oversight of this critical issue was founded in a genuine, bipartisan commitment to ensure that America's sons and daughters who have served, or are serving in the military, receive timely access to healthcare and support services that reflect the noble spirit of their sacrifice on behalf of the American people.

At the outset, I'd like to commend Ranking Member Hice of Georgia, my ranking member, and Representative Mark Green of Tennessee, for their leadership and their good work in this area.

With the return of over 2.7 million veterans from Operation Iraqi Freedom, Operation Enduring Freedom in Afghanistan, and other recent, oftentimes, multiple war zone deployments, America's solemn responsibility to care for our returning heroes is a more important mission than ever. Regrettably, the suicide crisis that has endured and markedly increased in our veteran community over the past decade stands as a stark reminder that we must redouble our efforts to address continued gaps in veterans' care.

Last week witnessed the seventh veteran suicide committed at a VA facility in 2019 when a veteran took his own life outside the Louis Stokes Cleveland VA Medical Center in Ohio. While the Department of Veteran Affairs has been able to successfully intervene in over 90 percent of the 260 veteran suicide attempts committed

on VA property since 2017, at least 25 veterans have taken their lives in this manner over the past 18 months.

Moreover, this national emergency extends far beyond these tragic cases at the VA. Ninety-nine-poin-six percent of veteran suicides are not committed at a VA facility. According to the most recent VA national suicide data report, an average of 6,000 veteran suicides occurred annually between 2008 and 2016. Over the course of a decade, the veteran suicide rate increased from 23.9 per 100,000 in 2005, to over 30 per 100,000 people in 2016.

The suicide rate for our youngest veterans, those between the ages of 18 and 34, his risen dramatically by nearly 80 percent over the same time period. Overall, agency statistics reveal that the suicide rate within the veteran community is 1–1/2 times as great as that for the nonveteran population, when those are adjusted for age and gender.

The scope of this crisis has also reached the active-duty servicemen and women who are currently enlisted and deployed in defense of our country. According to the nonpartisan RAND Corporation, the suicide rate among all active-duty members of the United States Armed Forces increased from 16.3 per 100,000 to over 20 per 100,000 between 2008 and 2016.

With nearly 140 reported suicides last year, active-duty suicides in the U.S. Army reached their highest levels in the last six years. Similarly, the number of confirmed and suspected active-duty suicides in the U.S. Marine Corps and U.S. Navy stand at their highest reported levels in a decade. Within U.S. special ops forces, the occurrence of 22 active-duty suicides in 2018 marked triple the number from the previous year.

Since Fiscal Year 2013, Congress has appropriated nearly $1 billion to the VA toward its 24-hour veterans crisis line, and other key suicide prevention outreach programs. An additional $120 million has been appropriated to the Department of Defense for its defense suicide prevention office, the lead agency component on suicide prevention, policy, training, and programs for active-duty personnel.

While we must continue to ensure that these agencies receive the necessary funding to tackle the prevalence of military suicides head on, sustained congressional oversight of existing deficiencies will prove equally essential to maximizing the effectiveness of suicide prevention programs. It will also augment the work of the suicide prevention task force established by the President, a VA executive order earlier this year.

Despite the best efforts of the dedicated professionals at the VA and the Department of Defense who work tirelessly to prevent military suicides, serious gaps remain that require our immediate attention. As reported by the independent Government Accountability Office last year, media outreach activities conducted by the VA Health Administration to raise awareness among veterans and their families about available crisis resources have declined significantly due to leadership turnover and office reorganization since 2017.

These same factors resulted in the agency's inability to utilize a majority of its allocated 6.2 million paid media budget for the Fiscal Year 2018 for suicide prevention outreach.

At the Department of Defense, a 2015 audit conducted by the agency's inspector general determined that leadership and organizational challenges resulted in the absence of a unified, and this is a quote, "unified and coordinated effort to address suicide prevention across the DOD," closed quote.

So for that reason, I remain concerned that four out of nine leadership positions in the office that oversees the defense—suicide prevention office are currently filled by officials that are serving in either a temporary capacity, or acting capacity. We must also begin to build upon legislation, including the Clay Hunt Suicide Prevention for American Veterans Act of 2015, that Congress enacted to address the increasing suicide rate among our veterans and active-duty personnel.

In the 116th Congress, I'm proud to cosponsor H.R. 2340, the Fight Veteran Suicide Act introduced by Representative Max Rose of New York. This bipartisan legislation would require the VA to submit timely reports to Congress regarding veteran suicide incidents on VA campuses in order to provide us with real-time data on the full scope of this crisis. I'm also very proud to cosponsor H.R. 2333, the Support for Suicide Prevention Coordinators Act, introduced by Representative Anthony Brindisi of New York. And this bipartisan bill would require the Government Accountability Office to assess the workload and vacancy rates of suicide prevention coordinators at the VA.

As acknowledged by the VA in its national strategy for preventing suicides among veterans, the agency by itself cannot adequately confront this issue. I strongly agree. Our ability to address the unique challenges facing the brave men and women who serve in the United States Armed Forces will be greatly dependent on maximum and sustained collaboration with the executive branch, our veteran service organizations, government watchdog entities, and other stakeholders. America's dedicated veterans and active-duty servicemen deserve no less.

Finally, I'd like to say the following to the men and women of our Nation's armed services and those who have retired from military service. We continue to stand with you. You have fought and sacrificed for your country. And now it is our job in Congress to fight for you.

So if you or someone you know is thinking about suicide, or if you're worried about a friend or a loved one, or would like emotional support, the suicide prevention lifeline network is available 24 hours a day, seven days a week. To speak with a trained crisis worker, please call 1–800–273–8255, 1–800–273–8255 or text 838255.

I now yield to my friend, the ranking member, the gentleman from Georgia, Mr. Hice, for an opening statement.

Mr. HICE. Thank you very much, Mr. Chairman. I think I speak for everyone on the Republican side in expressing our gratitude to you for holding this very important hearing. I've said it before, and I'll say it again. I believe we, in this subcommittee, have a great example to pursue real bipartisan solutions for the American people, and this hearing is one of those opportunities.

As you mentioned, Mr. Chairman, this is a real issue, a crisis that our military and veterans are—we are seeing more suicides on

the rise. Recently, three veterans killed themselves over five days at VA facilities in two different states. Two of our veterans took their own lives in the parking lots of Georgia VA medical centers.

My constituents back home are being significantly influenced and affected by this growing crisis, and I know all Americans around the country feel the same way. It's not just a Georgia problem. As we all know, this is a widespread issue touching so many in our communities. It impacts our friends and families as well. These men and women who volunteer to serve our country and keep us safe and free are suffering, and now is our time to stand up and address some of these real concerns. We have to do something. That's why we've asked the five of you to be here with us today. And we appreciate every one of you for being here, and the expertise that you bring to this committee.

It's time for us to try something new. I think it's time for us to try something different. And I look forward to hearing your comments on this.

Congress has provided billions of dollars to the Department of Defense as well as the VA, yet the number of suicides from veterans between 2008 and 2016 average 6,000 per year. That's a stunning number.

Suicide is a complex multifaceted issue, and we must tackle this public health crisis with new ideas. I am pleased to know that both the Departments of Defense and Veterans Affairs have made this a top priority. But it has to be more than just talking points, and more than just fancy new strategies.

Today, I want to hear how you're all working together to address this. And, Ms. Tanielian, you as well. And I say that as an inclusive aspect here. I look forward to hearing from you as well.

We've got to have a comprehensive approach. And it'll take all of us working together to address this crisis. I want to know what programs that DOD and the VA have initiated, and how you're going to tackle the issue and track the issues. I want to hear examples of something that didn't work, and how you're now adjusting appropriately. Where have there been missteps, and how can we address that?

The American people expect us not only to spend money wisely but, in this case, certainly to save lives. If there are programs that are working, then Congress needs to know about it. We need to see some change. We know that many men and women fear coming forward, for mental healthcare, because of fear of judgment, being passed over for a promotion or affecting their security clearances. This is unacceptable. Today, I want to hear how we are working to change the culture so that these men and women feel safe to seek help.

As we have learned in recent years, the best way to address this crisis is through a holistic approach. So today, I hope that we hear more about what that looks like. How are we alleviating stressors related to finances, healthcare, transitioning between active-duty and veteran status?

Ultimately, our objective here is a bipartisan one: to prevent suicides and take care of our veterans.

In the last few months, President Trump signed two executive orders to deal with the rising rates of veteran suicides. The execu-

tive orders are intended to increase coordination and prevention efforts among all stakeholders, Federal, state, local, and nonprofits. Our servicemen and women need to know that when they return home and transition to veteran status, they are connected, connected to family, to healthcare, to one another, and to all the services they need. So we've got a lot of questions today. And I hope that today, we're going to hear some good answers.

So, again, I want to thank you, Mr. Chairman, for holding this hearing. I want to thank our witnesses, again, for your expertise and for being a part of this hearing today. And I look forward to hearing from you each of you.

And with that, I yield back.

Mr. MEADOWS. Mr. Chairman.

Mr. LYNCH. The gentleman from——

Mr. MEADOWS. Thank you, Mr. Chairman.

And I want to echo what the ranking member just said. Your leadership and, candidly, your willingness to engage on this very important topic, without politics, without anything other than the well-being of our men and women who have served our country is to be applauded. And I want to go on the record today of thanking you personally for that leadership, and double-down on my commitment to make sure that we work with all the witnesses here, but with you and Chairman Cummings, to address this issue.

And I thank you.

Mr. LYNCH. I thank the gentleman.

We do have a distinguished panel that has been—members who have been working on this issue for quite a long time, and we really do appreciate your expertise and you're willing to come forward and help the committee with its work.

Today, we'll hear from Captain Mike Colston, Director of Mental Health programs at the United States Department of Defense. Within the Department of Defense, Captain Colston and his team work to improve the health and livelihood of the U.S. servicemembers by overseeing, managing, and evaluating the Department's treatment of psychological health, substance abuse disorders, traumatic brain injury, and suicidal tendencies.

Joining Dr. Colston is Dr. Karin Orvis, Director of the Defense Suicide Prevention Office, United States Department of Defense. In this role, Dr. Orvis is responsible for policy, oversight, and advocacy of the Defense Department's suicide prevention programs. She has held multiple positions within the Department where she oversaw and implemented a multitude of programs to support our active-duty servicemembers and their families.

For the Department of Veterans Affairs, we will hear from Dr. Richard Stone, executive in charge from the Veterans Health Administration, United States Department of Veterans Affairs. Dr. Stone is responsible for overseeing the Veterans Health Administration, which is tasked with delivering care to more than 9 million enrolled veterans across more than 1,200 healthcare facilities in the United States. Dr. Stone is a retired U.S. Army major general where he served as the Army's Deputy Surgeon General and Deputy Commanding General of support for U.S. Army MedCom.

Dr. Stone is joined by Dr. Keita Franklin, National Director of Suicide Prevention, Office of Mental Health and Suicide Prevention

for the United States Department of Veterans Affairs. As National Director, Dr. Franklin is the principal adviser for the VA on Suicide Prevention. Dr. Franklin is a licensed social worker and previously served as the Director of Defense Suicide Prevention Office in the Department of Defense.

And we are also proud to—and happy to be joined today by Terri Tanielian, senior behavioral scientist at RAND Corporation. While at RAND, Ms. Tanielian has conducted extensive research on behalf of both the Department of Veterans Affairs and the Department of Defense. And her subject matter expertise on veterans healthcare and suicide treatment has been integral to the efforts of both the VA and DOD, in partnership in addressing our national suicide crisis and the mental health of our military members and veterans.

So, now, if the witnesses would please stand, I'll begin by swearing you in. Please raise your right hand.

Do you swear or affirm that the testimony you are about to give to this is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record show that the witnesses have all answered in the affirmative.

Thank you, and please be seated.

So these microphones are fairly sensitive, but please speak directly into them. Without objection, your written statements will be made part of the record.

With that, Dr. Colston, you are now recognized to give an oral presentation of your testimony for five minutes.

STATEMENT OF CAPTAIN MIKE COLSTON, DIRECTOR, MENTAL HEALTH PROGRAMS, U.S. DEPARTMENT OF DEFENSE

Captain Colston. Chairman Lynch, Ranking Member Hice, and members of the subcommittee, thank you for the opportunity to discuss DOD's biggest public health problem: Suicide. I'm honored to be here with both of our Department Suicide Prevention Directors, our RAND colleague, and General Stone.

Before I discuss trends in science, I want to say, as a physician and a military leader, that every life lost is a tragedy. Behind every suicide is a precious human being and shattered lives. As a psychiatrist, I've been truly shaken by suicides in my proximity. So let me discuss what I've seen in the last 30-odd years.

Our military suicide rate was once low. When I was a surface warfare officer in the 1990's, our suicide rate was lower than the population rate despite high stress, family separations, and grueling deployments. Mental health professionals call this phenomenon "the warrior effect."

Like the rest of America, DOD has seen an increase in suicide even as clinical and community resources have vastly increased. I've watched it happen.

From the time I was an intern in 1999 through 2016, DOD's active-duty suicide rate doubled. The national rate went up about a quarter over the period increasing in almost every state. So what are we doing?

First, we're being transparent. Our trend is worse than the secular trend, and it's unacceptable. We need to fix it. We have more

than tripled the size of our mental health system since 2001. We have embedded mental healthcare into primary care and line units. Every evidence-based treatment for suicide is available in DOD, including CBT, dialectical behavior therapy, problem-solving therapy, and medication such as lithium and clozapine.

We're leveraging access and opportunity in our health system to identify and treat suicidal servicemembers, regardless of their portal of entry. Our VA DOD clinical practice guidelines for suicide risk shaped with me over the past year by cochampions Dr. Lisa Brenner, from VA's Rocky Mountain MIRECC, and Dr. Amy Bell, chair of the public health review board at Army Public Health Center, has just been refereed and is being prepared for press.

We found evidence for screening, crisis response planning, and post-intervention contacts as a means to reduce suicide risk in the ranks. These practices are happening now, but we must standardize and optimize them.

Based on our appraisal of the literature, we need to further develop research in many domains of suicide prevention. Suicide science is nascent, especially in comparison to PTSD, depression, and substance use disorders.

The population level interventions we can leverage right now are critically necessary. Veterans who get healthcare in VA die by suicide less than other veterans. So we're doing all we can to smooth transition in the VA care.

When I led the clinical integration of our naval hospital Great Lakes mental services with VA services at its North Chicago location, I saw firsthand how collaboration enhanced the well-being of transitioning servicemembers.

VA and DOD now share over 130 clinical spaces. And DOD stemming the opiate crisis of its ranks with drug testing, pain treatment, and pharmacy controls. Our overdose death rates from suicides and accidental overdoses is now 1/4 of the national rate.

Finally, we'll stay focused on the human beings in front of us. The hopelessness of suicide can stem from a loss of purpose and belonging. All of us, soldiers, sailors, airmen, Marines, can bring meaning and joy to one another's lives as we focus on our important mission to protect democracy worldwide.

Thank you, and I look forward to answering your questions.

Mr. LYNCH. Thank you.

Dr. Orvis, you now recognized for five minutes.

STATEMENT OF DR. KARIN ORVIS, DIRECTOR, DEFENSE SUICIDE PREVENTION OFFICE, U.S. DEPARTMENT OF DEFENSE

Ms. ORVIS. Thank you.

Chairman Lynch, Ranking Member Hice, and distinguished members of the subcommittee, I thank you for the opportunity to discuss the critical work of preventing suicides within our military.

The servicemember is the heart of the Department of Defense. And preventing suicide amongst our servicemembers is a top DOD priority. It drives us each day to do better. Every loss of life is heartbreaking. Each has a deeply personal story. We cannot rest until we've created every opportunity to prevent this tragedy among our Nation's bravest.

The DOD embraces a public health approach, incorporating both community-based prevention efforts and medical care to address suicidal thoughts and behaviors. We focused intently over the past several years on building an infrastructure to prevent suicide. We have an executive level suicide prevention governance body that guides departmental suicide prevention efforts. We've collectively developed vital departmental guidance, first with the 2015 defense strategy for suicide prevention modeled after the national strategy. Shortly after, we published a training competency framework to enable more standardized training and education, and published our first DOD policy instruction to further shape suicide prevention programming across the entire Department.

We've also established a robust program evaluation framework which includes key outcomes, such as suicide deaths, attempts, unit cohesion, and help-seeking behaviors.

Over the past several years, we have ensured reliability and standardization of data collection reporting across the military services, including the reserve component. The DOD and the Department of Veterans Affairs have partnered to create an inner agency suicide data repository, which improves our ability to understand patterns of suicide before and after military separation.

In terms of public reporting, beginning this year, we'll release the official annual counts and rates of suicide deaths among our servicemembers and our family members in an annual suicide report. This inaugural report will be released this summer, and will include 2018 data for our servicemembers, as well as examine trends and suicide over time.

The Department has implemented a number of initiatives and resources to educate and foster awareness, foster leader and servicemember connections, encourage peer engagement, and other efforts. Servicemembers in crisis are encouraged to call, text, or chat, using the veterans and military crisis line as well as Military One Source for confidential counseling and peer support.

Further, suicide prevention is an evolving science that's quickly advancing. The Department is conducting several evidence-informed pilots related to problem-solving, help-seeking, and means safety. We cannot act alone to prevent suicide. Our collaborative work across the public and private sectors is integral to reaching our goals. For example, the Department has a robust inner agency partnership with the VA and the Department of Homeland Security focusing on the high-risk population of transitioning servicemembers and recent veterans.

Having previously served as the director of the transition to veterans program office in DOD, I am keenly aware of how critical the transition period is in preventing suicide, as well as across the military life cycle.

In closing, the Department has made strides in establishing an infrastructure to prevent military suicide. This includes aligning our strategy to a public health perspective, establishing policy guidance and enterprisewide governance, advancing data surveillance, research and program evaluation, as well as fostering collaborative partnerships. This subcommittee is an extension of such important partnerships. I welcome your insights and your input. I know we

have much more work to do, and I take this charge incredibly seriously.

I look forward to your questions.

Mr. LYNCH. Thank you, Doctor.

Dr. Stone, you are now recognized for five minutes.

STATEMENT OF DR. RICHARD A. STONE, ACCOMPANIED BY DR. KEITA FRANKLIN, EXECUTIVE DIRECTOR OF THE VA SUICIDE PREVENTION PROGRAM

Dr. STONE. Good afternoon, Chairman Lynch, Ranking Member Hice, and members of the subcommittee. I appreciate the opportunity to be here to discuss the critical work VA and DOD are undertaking to prevent suicide among our Nation's veterans. I'm accompanied today by Dr. Keita Franklin, Executive Director of the VA Suicide Prevention Program.

Suicide is a serious public health tragedy that affects communities across this Nation. And recently, this tragedy has occurred on the grounds of our VA healthcare facilities when, in the month of April alone, four veterans ended their lives. Although less than one-half of one percent of suicides occur at both VA and civilian healthcare facilities, these events highlight the important discussion that we will have here today.

While we understand that the media needs to cover these events, we must remember that the way media portrays suicide can have life-changing consequences. Let me repeat what the chairman said in his opening statement. Ninety-nine-poin-six percent of veterans' suicides do not occur on VA healthcare campuses. It occurs in our homes, in our automobiles, and almost always, in a perceived sense of intense personal isolation. More than 50 research studies worldwide have shown that the way the tragedy of suicide is reported, can also influence future behavior in our communities, either positively or negatively.

We know that a story that uses careful, thoughtful language can encourage someone to seek help. We also know that programs like the Netflix Series 13 Reasons Why, depicting teenage suicide, although well-intended, purportedly led to a 29 percent increase of teenage suicides across this Nation in the month after its release in 2017.

The 2018 national strategy for preventing veteran suicide is a multiyear effort that provides a framework for identifying priorities, organizing our efforts, and focusing community resources to prevent suicide among veterans. This four-pronged strategy is intended to move us from a crisis intervention focus to one that enhances the relational skills and resilience of our heroes.

We know, and it has been stated previously, that 20 active-duty servicemembers and veterans die by suicide every day. This number has been identified in your statements, has remained relatively stable over the last several years. Of those 20, only six have used VA healthcare in the two years prior to their death, while the majority, 14, have not.

In addition, we know from national data that more than half of Americans who died by suicide in 2016 had no mental health diagnosis at the time of their death. This is also true for our veterans. We also know that a massive expansion of mental health providers,

and world-class mental health access, has done little to reduce the total number of suicides among veterans.

Maintaining the integrity of VA's mental healthcare system is vitally important. But clearly, it is not enough. The VA alone, without the help of all of you, cannot end veteran suicide. The VA has expanded its suicide prevention efforts into a public health approach while maintaining and expanding our crisis intervention services.

We ask all of you to help, and we certainly appreciate the public service announcements that some of your colleagues have already recorded. VA is expanding our understanding of what defines healthcare by developing a whole-health approach that engages, empowers, and equips veterans for lifelong health, improved resilience, and improved well-being. The VA is uniquely positioned to make this a reality for our veterans and for our Nation. This effort is about enhancing individual resilience.

On March 5, 2019, the President signed Executive Order 13861, entitled "National Roadmap to Empower Veterans and End Suicide" in order to improve the quality of life for our Nation's veterans, and develop a national public health roadmap to lower the veteran suicide rate. This executive order will further VA's efforts to collaborate with partners and communities nationwide, and to use the best available information to support all veterans.

We must partner with, empower, and energize all communities to engage veterans who do not use VA services. We are committed to advancing our outreach prevention, empowerment, and treatment efforts and will continue to improve access to care. Our objective, however, is to give our Nation's veterans the top quality care they have earned wherever and whenever they choose to receive it.

Mr. Chairman, this concludes my statement. My colleagues and I are prepared to respond to your questions.

Mr. LYNCH. Thank you, Dr. Stone.

Dr. Franklin, I assume that Dr. Stone has delivered joint testimony; is that correct?

Okay. So you're off the hook.

Ms. Tanielian, you're recognized for five minutes.

STATEMENT OF TERRI TANIELIAN, SENIOR BEHAVIORAL SCIENTIST, RAND CORPORATION

Ms. TANIELIAN. Chairman Lynch, Ranking Member Hice, and members of the subcommittee, thank you for the opportunity to testify today. We all know the statistic: 20 veterans die by suicide each day. Since the statistic became a rallying cry, we have lost more than 45,000 veterans to suicide. This is not just a number.

While they served our Nation, they were the very same individuals we sought to protect with better body armor and improved technology to improve injury survivability. They are the same veterans for whom we design complex benefit and healthcare systems as a sign of our gratitude.

To ensure we remember the number of veterans lost to suicide each day, there have been awareness campaigns, pushup challenges, and a sale of trigger rings designed to call on the public to do something.

But what are we asking them to do? As a Nation, we need to do more than just acknowledge that we have a veteran suicide problem. We need to implement and sustain meaningful strategies and comprehensive suicide prevention approaches. Today, I'm honored to join colleagues from the DOD and the VA, two agencies on the front lines addressing military and veteran suicide.

However, these agencies should not bear this burden alone. As my comments highlight, there are other Federal agencies that should be engaged and equally invested. It is widely acknowledged that a public health approach is needed to address the challenge of suicide. As I outlined in my written testimony, strategies must be pursued simultaneously to promote self-care, identify those at risk, enhance crisis intervention, provide high-quality mental healthcare, and reduce access to lethal means.

Today, I want to highlight my recommendations for improving the collective Federal efforts to reduce suicide among veterans. These actions should be implemented across the government to strengthen existing approaches already underway.

First, we must implement and enforce zero tolerance policies to eliminate the culture of harassment and assault that pervade the military and veteran community. Military sexual trauma is a known risk factor for dying by suicide among veterans. To reduce this risk, we must decrease exposure to sexual harassment and assault while individuals are still in uniform and when they visit the VA. Zero tolerance policies in these agencies could help to change the culture.

Second, efforts are needed to address work-related stress. Work-related stress can lead to poor sleep and increased use of alcohol and drugs, two known risk factors for suicide. Veterans are an important component of the Federal work force, especially in DOD, the Department of Transportation, the VA, and the Department of Homeland Security. Efforts to support veterans within this Federal work force are needed to promote the use of self-care skills, referrals to support mental health and substance abuse problems, thereby reducing their risk for suicide.

Third, we must improve the U.S. mental healthcare system. Although the VA is a demonstrated leader in providing appropriate crisis followup and delivering high quality mental healthcare, data on the quality of care in the private sector either is nonexistent or, when made available for comparison, worse than at the VA.

There are proven treatments for most mental health conditions, and treatment works for reducing suicide if the provider delivers the appropriate course of treatment. Unfortunately, this is not a guarantee in the U.S. healthcare system.

For the veterans who rely on VA healthcare, and the military members and retirees that use TRICARE, we must expand their work force that serves them, prioritize training and evidence-based techniques, and we must demand the same high standards of care from any private sources of care for these same individuals. Because the majority of veterans do not rely on the VA for their healthcare, efforts to reduce suicide will require that the U.S. does more to improve the overall mental healthcare system. Concentrated efforts are needed to recruit, train, and support a bigger mental healthcare work force. Also, ensuring that mental health

parity is fully implemented and enforced will help address the work force challenge, expand access to care for those at risk, and lead to lower suicide rates.

Last, we must reduce access to firearms and promote firearm safety among veterans. Firearms are the method of suicide for nearly 70 percent of veteran suicide deaths. Policies that directly address the risk that firearms pose to veterans need to be created, enacted, and tested. It also must be acceptable for healthcare providers, leaders, friends, and family to ask about firearm access, discuss safe storage, and discuss appropriate removal of firearms from individuals who are at highest risk of suicide. Healthcare providers in both the VA and DOD should be expected to have these conversations. Discussions about firearms are an effort to save lives.

The number of veterans who died by suicide in the past year surpasses the number of lives lost during the operations in Afghanistan and Iraq to date. In the past 20 years, the number of veteran suicide totals, that is twice the number of the veterans lost during the Vietnam War. But this crisis is more than just a number to me. I lost my own veteran father to suicide. Suicide is a veteran problem. It is a national security problem. It is a national public health crisis. We can and must do more, and that is why I'm here today.

Thank you again for inviting me, and I look forward to your questions.

Mr. LYNCH. Thank you very much. We thank all the witness.

I now yield myself five minutes for questioning.

My first broad question is really for the whole panel, and you can take your own opportunity to address it, or pass on it. But my own experience, I had about, I think, over 40 trips to Afghanistan and Iraq. And on one occasion, we got a chance to visit Camp Leatherneck, which is in Helmand Province in Afghanistan. And it's sort of a usual thing that I do, just a little—I met with a bunch of Marines at the DFAC there, the dining facility. And I asked them—there were about 20 or 30 of them there. And I said, How many of you are here on your first tour? And only about three hands went up. And I asked, How many here on your second tour? And maybe a few more hands went up.

To make this shorter, I got all the way up to seven tours of duty before I ran out of Marines. So there was one Marine there on his seventh tour of duty. So Marines are doing about a year hitch. The other services, you know, vary.

But my question is, is what we are seeing the result of these repeat tours of duty? Do we have data on that, you know, in terms of—you know, because some of this doesn't—well, I know that many of these incidents happen in the year or year and a half after people return.

But when you have that type of stress—and, remember, our sons and daughters in uniform in Iraq and Afghanistan are on the front line. There's no rear in those theaters, so they're exposed to high stress and danger on a regular basis.

And I'm just concerned, you know, that we're underestimating the long-term impact that repeat tours of duty over and over again might have on their psyche, on their psychological health. And I'm not sure if any of you—I welcome any feedback that you have on that.

Dr. Orvis, yes.

Ms. ORVIS. I appreciate the question.

We know, as you acknowledge in your opening statement, that suicide is very complex. It's a complicated set of risk factors and protector factors that vary for the individual. And what the data actually shows us in terms of deployment and OPTEMPO is it's complicated. What we know from our most recent data is more than—approximately 44 percent of our servicemembers that die by suicide have had no deployments. It's many more complicated factors. So it depends on what military occupational specialty they may have been in, what level of combat they may have seen, how frequent back-to-back the deployments were.

We don't have any evidence, to date, that OPTEMPO is related to increased risk for suicide. And I would be happy to turn it over to Captain Colston to elaborate.

Mr. LYNCH. Sure.

Captain Colston. And there's been plenty of federally funded research in this area. Reger and colleagues out at JBLM didn't find an association, while Kessler at Harvard did. It's a question that goes on. And certainly, when you get down to the individual level, by all means, you know, I have seen individuals who have succumbed to suicide because they were overwhelmed with what was going on in their lives. And certainly, back-to-back deployments is a very hard thing to weather, the family separation, the fact that your affiliative needs can't always be met, the fact that you're not watching your kids grow up, those types of things.

Mr. LYNCH. Let me ask Dr. Stone. The steady drumbeat of suicides that we are seeing in and around some of the VA facilities, and I know you've had a very high success rate on intervention. Are there steps that we're taking right now, sort of as we confront this, that have been newly introduced at the VA to sort of—you know, as a countermeasure to what we're seeing more recently?

Dr. STONE. Mr. Chairman, we want the VA facilities to be welcoming places. We don't want to create a gate where we search cars.

Mr. LYNCH. Yes.

Dr. STONE. We have instituted enhanced random screening. We've limited door access. We've asked for ID cards. And we've gone through a number of processes. I was just down in West Palm Beach where we've had two events where we've gone through some of that.

But that is not the solution. I was also out in Seattle where we looked at a new model for a mental health facility that limited movement through the facility with door access in order to enhance safety.

I wish this was as simple as putting more policemen into our parking lots, and doing more tours across various areas. It's not that simple.

Mr. LYNCH. Right.

Dr. STONE. Not only that, a number of the suicides that have occurred have occurred with notes that said, I've committed suicide here, or I've taken this act here, because I knew I'd be taken care of, and I knew my family would be taken care of. Not all. Some is a negative statement toward us.

But it is not simply a matter of finding a way to do more police tours, or simply securing the grounds.

Mr. LYNCH. No. I completely understand. And this is a complex, complex issue. There are no easy answers. But, you know, I think your experience in the field can give us some evidence of what might work best.

The chair yields back and recognizes the gentleman from Tennessee, Mr. Green, who has been an outstanding advocate on behalf of both active military and veterans in need of services.

Mr. GREEN. Thank you, Mr. Chairman. I really appreciated your words in your opening statement. They're very powerful. Thank you for that, and for your commitment to this process. And I want to thank the ranking member as well for his sensitivity to this issue, his commitment to serving those who sacrifice so much for us. And I'd like to thank the witnesses for not only their service to this great Nation, but their service to the warriors who serve this great Nation.

You know, the definition of insanity, though, you guys have all heard it, doing the same thing and excepting a different result. And it was interesting that the spokesman from the Veterans Administration, the witness today, Dr. Stone, said we've spent massive amounts of money and seen little change.

In his farewell speech to West Point, General Douglas MacArthur said, quote, "The soldier, above all others"—"other people prays for peace, for he must suffer and bear the deepest wounds and scars of war," end quote.

Having served in the Army in combat as a special operations physician, I've seen firsthand soldiers suffer from the scars of war, both visible and invisible. In the past year, the rates of active-duty military suicides have clearly increased, and it is our duty to ensure warriors and veterans are mentally, emotionally, and, I'd like to introduce today, spiritually prepared for war.

When it comes to suicide, the data clearly suggests that nonreligious individuals appear to be more at risk for suicide. In just one example, a peer reviewed study published in the American Journal of Psychiatry concluded, quote, "Religiously unaffiliated subjects had significantly more lifetime suicide attempts, and more first degree relatives who committed suicide than subjects who endorsed a religious affiliation. Furthermore, subjects with no religious affiliation perceived fewer reasons for living, particularly fewer moral objections to suicide," end quote.

Mr. Chairman, I'd like to admit that study into the record, and my staff will get it to you.

Mr. LYNCH. Without objection.

Mr. GREEN. One Nurses' Health Study surveyed nearly 90,000 women over a decade. The study found that those women with regular religious attendance have a fivefold lower risk of suicide compared to women who didn't attend mosque, church, or synagogue services. This also seems to correlate to veteran suicide. A VA study by Dr. Kapocz observed that veterans who attempted suicide self-rated spiritual health in a worse condition, or worse category, than veterans without suicide ideation. Another study in March of this year concluded that, quote, "Negative spiritual coping," end quote, was often associated with an increase in mental health diag-

nosis and symptom severity while, quote, "positive spiritual coping had a healing effect."

Studies that ask whether soldiers are religious or not show that at least in the Army, essentially, reflect our society with about two-thirds saying they believe in some religion. In fact, the data the Army sent us for this hearing today supports my overall point about religion and suicide. Fifty-seven percent of the suicides in 2018 in the Army had no religious affiliation. If two-thirds of the Army is religious, meaning only one-third is not, yet nearly two-thirds of the suicides are by soldiers who are not religious, the point is clear. Religion helps men and women cope with the pains of war.

Mr. Chairman, as an Army physician, I spent 7 years taking care of combat soldiers, and I found those struggling with suicide ideation had guilt from two sources. They either had killed someone, and were struggling with the guilt of taking a human life, or they had killed—or they had a friend killed, and they were struggling with the guilt of surviving when their friend did not. This is the basis for what many psychiatrists are calling moral injury. Mr. Chairman, all three monotheistic religions, the face of those two-thirds of our military men and women, teach just how to cope with those two guilt situations.

Now, not every soldier is religious. But those who are should be able to have access to those resources. Yet there seems to be an assault on religion in the military. Chaplains report that they cannot approach soldiers about the issue. Chaplains are being disciplined because they refuse to operate outside their specific beliefs despite the fact that the NDAA specifically says commanders cannot force chaplains to do something in violation to his or her beliefs.

Just this week, the United States Air Force Times had an article relating a lawsuit against a Veterans Administration facility that was displaying a bible in a POW display. Commanders are not allowed to pray at certain ceremoneys, and religion itself is being ridiculed.

The associations that represent chaplains have all voiced to us their concerns that their members cannot address the spiritual needs of warriors despite the data which clearly shows it can save lives. Without the proper spiritual counseling, at least to those who consider themselves spiritual, we're sending warriors into battle unprepared for the emotional challenges.

Mr. Chairman, I know each of these presenters today could probably tell us how their equipment readiness is. They could talk about marksmanship and weapons training. They could talk about maneuver and how well measured those are. However, I would submit that they probably cannot tell us or measure the spiritual readiness of those soldiers who self-identify as spiritual or religious, because to do so would upset the politically correct anti-religion crowd who would protest at even the thought of it despite the fact that the data is clear, it can save lives.

It is time to put the political correctness on this issue aside. We must focus on the spiritual fitness of our force to help them survive the emotional horror of war. I ask each service represented here today to consider for those soldiers who self-identify as religious, how would you quantify if they're truly ready to kill in combat. Or

how ready are they to lose a best friend and survive themselves. How would you measure the spiritual resilience of a soldier or the spiritual readiness of a unit.

Until we figure this out, we can continue to have our warriors struggle, and it will be our fault for not addressing this important need. A very effective faith-based system advanced under the clinical guidance of the not-for-profit reboot for recovery has achieved amazing results in saving lives among warriors with suicidal ideation. Other programs have attempted to take their methods minus the mention of God and failed. How much is one life worth?

We should never push faith-based systems on nonreligious soldiers. I am advocating for faith-based solutions for those soldiers who would consider themselves spiritual and religious. For those who are religious, we need commanders to also understand the spiritual readiness of that warrior.

Thank you, Mr. Chairman, for allowing me to share those thoughts from my experience. And I have no questions.

Mr. LYNCH. The gentleman yields back.

The gentlewoman from Illinois, Ms. Kelly, is recognized for five minutes.

Ms. KELLY. Thank you all for being here today. And thank you, Chairman Lynch, for holding this important hearing.

Despite efforts made by Congress and the executive branch, as we've been talking about today, we are still losing too many veterans to suicide, and nearly 70 percent of them involve the use of firearms. Combating our Nation's gun violence public health crisis has been had a major focus of my time here in Congress. And the pervasiveness of firearm suicide, especially among our Nation's veterans, is often an overlooked element of that crisis. We can and must do more to protect those brave men and women that protected us overseas.

Essential to combating firearm death among our veterans and addressing all forms of mental healthcare is expanding technologies and methodologies used by healthcare providers in treating veterans. According to the National Center for PTSD, approximately 11 to 20 percent of veterans who served in Operation Iraqi Freedom and Enduring Freedom have PTSD in a given year.

Cognitive behavior therapy has been found to be one of the most effective treatments for PTSD. CBT also includes exposure therapy, which exposes patients in a safe environment to situations, thoughts, and memories that are viewed as frightening or anxiety provoking, so they can begin to overcome their fears on their own.

Dr. Franklin, is this correct?

Ms. FRANKLIN. Yes, ma'am, it is.

Ms. KELLY. Okay.

Ms. FRANKLIN. Yes. All of that is tracking. Completely correct. Yes, with my knowledge base on this topic.

Ms. KELLY. Okay. For veterans who might have developed PTSD as a result of combat-related trauma, however, re-creating a battlefield environment might be unsafe or cost-prohibit to effectively replicate. However, with the recent advancement of virtual reality technologies, battlefield environments can be more easily simulated. And I'm very interested in how these and other emerging

technologies can be implemented to augment CBT and other exposure therapy treatments.

As chair of the congressional Tech Accountability Caucus, I'm always interested in learning how emerging technologies can be applied to address pressing societal concerns.

Dr. Stone, is the VA implementing virtual reality or any other emerging technologies for exposure therapy treatments for veterans suffering from PTSD?

Dr. STONE. Yes, we are. And we have a number of simulation efforts underway. And in conjunction with DOD on the Bethesda campus, there is the ability for traumatic brain-injured patients to restructure and create simulated realities.

Ms. KELLY. Dr. Orvis, the same question to you. What technologies, if any, are DOD utilizing to improve warfighter resilience to combat stress?

Ms. ORVIS. Thank you. I will defer to Captain Colston for the clinical interventions and treatment.

Captain Colston. So we have a number of evidence-based treatments for PTSD: prolonged exposure therapy, cognitive processing therapy, and as you mentioned, virtual reality or other exposure therapies. Also, medication works. And as a psychiatrist, I've seen people respond to medications which are both safe and effective.

I'd like you to know that it is DOD policy that people get evidence-based therapy for PTSD. And there is a nexus between PTSD and suicides. So it's vitally important that we always have a provider base that's ready to give that treatment.

Ms. KELLY. What additional funding or resources would either the VA or DOD need to improve research and development into technologies that can help treat PTSD and other mental health treatments? And whoever wants to answer that.

Dr. STONE. So in our 2020 and 2021 budget, we've asked for increases in funding for these areas. You have been quite gracious over the years in allowing us to work that.

We have just completed a funding request and institution with the Department of Energy to use their supercomputer methodology and capability in order for us to process data.

You know, in the current 18 years of warfare, there's been over 2 million man years and woman years of combat service. The ability to process data from that large a dataset is extraordinary, and we're quite pleased with the partnership with both DOD ourselves and Department of Energy that we've been able to undertake.

Ms. KELLY. Well, I, for one, believe that we need to give you what you need to get the job done, since so many people have made sacrifices for us.

So thank you. And I yield back.

Mr. LYNCH. The gentlelady yields back.

The chair now recognizes the ranking member, Mr. Hice from Georgia, for five minutes.

Mr. HICE. Thank you very much, Mr. Chairman. And I would request the two executive orders from the President dealing with our veterans and suicide issues be entered into the record.

Mr. LYNCH. Without objection, so ordered.

Mr. HICE. Thank you.

And also, I would like to just acknowledge we have, in Georgia, two new directors at VA centers in Duluth: David Witmer, and in Atlanta, Ms. Ann Brown. And I welcome them to Georgia in this new position. I look forward to working with them and have hope and confidence that they will do a good job, and specifically on this issue.

Let me pick up a little bit on what Mr. Green was talking about. Mr. Stone, let me just ask you. Of course, we're trying to look at a holistic approach here in dealing with the suicide issue.

What about the spiritual component? What kind of access do our veterans have to the Chaplin Corps.

Dr. STONE. As you're aware, on almost all of our campuses, there is a chapel as well as there are chaplains. The Secretary has been very clear that we need to provide robust spiritual support. All of us—as was so articulately stated by your colleague, all of us have anchors in our life. Spiritual faith is a deep anchor when present. It can be incredibly protective.

We know, in certain subpopulations, black female servicemembers and veterans from urban populations with deep faith almost never commit the act of self-harm, except in one case when there's been intimate partner violence. The presence of intimate partner violence can overwhelm that faith and break that anchor.

And I would defer to my colleague, Dr. Franklin, if she has other comments about this.

Ms. FRANKLIN. I just appreciate that—the Congressman's bringing spirituality into the equation, because we do, as Dr. Stone described, have over 500 chaplains—full-time chaplains across the VA. And we have—if you include part-time, we have over 800 chaplains. And they are part of the mission. We have them on our governance councils. They're part of our leadership consortiums. They are helping engage in making sure that veterans feel that sense of community and belongingness in whatever their spiritual or religiosity preference is. Absolutely.

Mr. HICE. Having chaplains present is one thing; really making an effort to deal with the spiritual issues is another. Is there something to go—of course, we don't want to force anyone, but to have the presence of dealing—of someone who can help deal with the spiritual component is important. Other than just us saying, "oh, they're over there; they have an office," is there something to go the extra step?

Ms. FRANKLIN. What we've done this year is we've trained our chaplains on suicide prevention so they understand the specifics related to suicide risk and the important role that they play when people might be having some sort of a spiritual crisis or when perhaps they have had a lag in their involvement so that the chaplains are more involved in the content.

But I do think that there's work that can be done in terms of educating family members and friends and veterans about the important role of spirituality if they've lost touch or something like that.

Mr. HICE. Okay. Thank you. I've got a ton of questions. There's no way to get to them all. Mr. Stone, let me go back to you real quickly. You were budgeted more than $6 million to engage in sui-

cide prevention media during 2018, and from what I understand, only about $60,000 was actually spent. I'm curious as to why that is.

Dr. STONE. It was a time before Keita arrived, before Dr. Franklin arrived, and before the Secretary and I arrived. As we arrived, we recognized this problem. Part of the problem was we took that additional funding, and it was lumped in with other funding for—of the $8.9 billion that were budgeted. And it was just not recognized. We have now pulled it out, separated it, and I can guarantee you, sir, that that money you give us will be spent during this fiscal year.

Mr. HICE. Okay. Without—I mean, this is taxpayer money and has been designated to address a specific issue. I know there's been some changes in leadership, I get that. But I'm pleased to hear that money is going to be spent to specifically to address this problem.

Dr. STONE. Sir, of the $206 million that is in outreach, in the six different buckets that it's in, we've executed just about 61 percent of it in the first 7 months of the year. And so I'm quite comfortable that we're going in the right direction as we do this.

Mr. HICE. Okay. Thank you.

I yield back, Mr. Chairman.

Mr. LYNCH. The gentleman yields back.

The chair recognizes the gentleman from California, Mr. Rouda for five minutes.

Mr. ROUDA. Thank you, Mr. Chairman, and thank you witnesses for coming to testify today. Appreciate your attendance here today. First thing I want to talk about are just some of the new outreach programs that are under consideration, and I bring this up because, as was stated earlier, 20 veterans a day die by suicide, and 14 did not seek treatment from the VA.

So, obviously, there's a desire and an opportunity to figure out how to reach out to those 14 who have not—14 per 20 who have not sought treatment. And toward that end, in the national strategy for preventing veteran suicide, the VA said the suicide crisis is a problem, and I quote, the agency by itself cannot adequately confront, unquote. The strategy also said, and I quote: To save lives, multiple systems must work in a coordinated way to reach veterans where they are, unquote.

Ms. Tanielian, hopefully I pronounced that correctly, can you talk a little bit about maybe, from your perspective, what some of these outreach programs should be or could be?

Ms. TANIELIAN. Sure. Thank you. Thank you very much. As I mentioned in my written testimony and as I reflected earlier, this is a complex issue that requires a multipronged approach, and it will be important to continue to lean forward aggressively in outreach, but recognizing that the majority of veterans in the United states do not rely on the VA for their healthcare, either because they are not eligible or they choose not to use the VA, we have to think about how to go out into the healthcare system across the U.S. and ensure that healthcare professionals are also trained in risk assessments, safety planning, and delivering evidence-based therapies for these challenges. We also have to acknowledge that the way in which we try to engage the veteran community in the United States has to understand that many of them do not use vet-

eran as their primary identity, and so that is why it's really critically important that we embed these strategies in the U.S. healthcare system so that no matter where a veteran goes for care, they will be greeted by a healthcare professional who has been appropriately trained, equipped, and incentivized to do the right thing.

Mr. ROUDA. Thank you.

Mr. Chairman, I'd like to highlight a pilot program run by the VA in Long Beach, the local VA Hospital for many of my constituents. They sent officers and clinicians off the VA grounds to respond to emergency calls or check on the veterans who have missed therapy appointments. The document is entitled "Veterans talking veterans back from the brink: A new approach to policing and lives in crisis."

Mr. LYNCH. Without exception—excuse me. Without objection, so ordered.

Mr. ROUDA. Thank you.

Dr. Stone, Dr. Franklin, if we were able to further implement greater community outreach, do you envision ways where we would have proper measurement and methodology to track progress in that area? Obviously, it's pretty easy from a top-line standpoint of bringing down deaths, suicide deaths by veterans. But any other ideas on how we can actually monitor success?

Dr. STONE. I think we can. I think we do that on our campuses. We've had almost 330 suicide attempts on our campuses. We know that about 90 percent of the time we are successful in deescalating the situation. The program that you reference in California is extraordinary in that there are unique pieces of our law enforcement force that understand the process of how veterans think and the complexity of how veterans react, and our ability to deescalate can be measured. And I would defer to Dr. Franklin for additional detail.

Ms. FRANKLIN. I think this is a very good question in terms of how we evaluate our metrics tied to our outreach as you describe, and we have an entire plan and strategy on this that I'm happy to share with the committee.

But, in sum, it involves how we measure how we reach veterans, and then we measure how we engage veterans. And so there are some tactics whereby we're measuring clicks that direct veterans when we do an outreach push on a website or a platform, we can then monitor based on our push whether or not they have connected directly into our healthcare system or our veteran crisis line. All of that is through this IT sort of software protocol that we have.

But then also we can measure website usage patterns. We have an online class called SAVE that teaches community providers about suicide prevention, and we can measure how many people have taken it, how long they have stayed on this site, have they completed it. Some examples.

Mr. ROUDA. Thank you. And I apologize for interrupting, but I did want to get one more question in——

Ms. FRANKLIN. Yes.

Mr. ROUDA [continuing]. with my time remaining. For the entire group, the opportunity for cannabis to play an important role as a therapy for our vets.

Dr. STONE. Well, you can see how quickly all of us jumped on that one. Let me say this: This is a country that thought it could control fentanyl, and we ended up in one of the greatest public health crises. This is also a country that thought it could control alcohol, and it remains a public health debacle.

Cannabis that was of the 1960's at two percent psychotropic content is not the cannabis we're seeing today at 23 and 24 percent.

Mr. ROUDA. I'm talking more CBDs.

Dr. STONE. I understand. What I'm saying is that we need the opportunity from you to do substantial research of what the right percentages are, what the actual effect is, before we can recommend anything. But simple licensure or allowing us to go forward is the wrong answer.

Mr. ROUDA. Thank you, Mr. Chairman.

Mr. LYNCH. The chair recognizes the gentleman from Arizona, Mr. Gosar for five minutes.

Mr. GOSAR. Well, I'm sure glad my friend on the other side started bringing this up because here I go. So Dr. Stone and Dr. Franklin, since it has been brought up, the clinical efficacy of medical marijuana to treat some mental health disorders, such as PTSD, is limited. I've got a couple here just as a matter of fact.

Furthermore, as you just spoke, the potency and doses of marijuana's major psychoactive components can have harmful psychiatric effects on individuals. Until sufficient research is done to evaluate the efficacy of medical marijuana and its long-term effects in supporting the treatment of mental health conditions, such as PTSD, there is not—not—clear evidence that medical marijuana may not cause more medical problems, psychiatric problems, schizophrenia, and suicide.

I want to highlight a recent sad story of a veteran in Arizona who lost his life. Before he took his life, he wrote, and I want to quote: I want to die. My soul is already dead. Marijuana killed my soul, and it ruined my brain.

How is the department involved with medical marijuana in treating mental health conditions, such as PTSD? Dr. Stone first and then Dr. Franklin.

Dr. STONE. By law, we can research the nonpsychoactive components within marijuana. We are not allowed under Federal law to do research on the psychoactive components.

Mr. GOSAR. Dr. Franklin?

Ms. FRANKLIN. The only piece I would add to Dr. Stone's comment is just the importance of following good research protocols and studying things rigorously and carefully over time before you implement them broad scale across an entire universal population, and taking great caution in all that we do to care for our Nation's veterans.

Mr. GOSAR. Well, and the reason I bring that up is I want to submit for the record a report from NIH, dated 2014, where they're starting to look at this very, very closely. And it may not be the cool thing to do, but it's showing a huge problem with long-term use of marijuana. There's some big, big warning signs here. They

are not latent. They are sitting out there in broad daylight. And this oughtn't be something that we start looking at really quickly. My friend Dr. Harris and I, wrote a letter to NIH, to update their studies in regards to cannabis. But this is a really big problem that we have, particularly when we are seeing states just wantonly opening this up. And particularly with the psychotic episodes that our veterans have been exposed to, this is troubling. Would you agree, Dr. Franklin?

Ms. FRANKLIN. I think—I have read the report, and I am familiar with it, and I know that there's a lot of mixed research in this space, and we're not prepared to execute any further than what Dr. Stone has already shared.

Mr. GOSAR. So, in your opinion, it's a premature move to start talking about anecdotal use by veterans in this arena. Would you agree?

Dr. STONE. Let me take this, with your permission, Congressman. We are deeply troubled by the reports of increased paranoid activity and major psychoses that are occurring where there is the presence of high percentages of psychoactive substances within marijuana and would absolutely like the opportunity to do further research before any additional activity is undertaken within the Federal delivery systems.

Mr. GOSAR. How could you—I'm just going to stay on that same line. So how can we promote advocacy to our veterans and to the caretakers out there and address this issue point blank? Because the research is not good. Regardless of what anybody wants to look at, the facts are the facts. And this is looking disturbingly wrong. And I think that we need to make a warning sign of this, is that—you know, as you said, the psychoanalytical components of this are much different than they were from the 1960's. So how do we get that message out to the veterans as well?

Dr. STONE. So, within our substance abuse review, we have the opportunity in each provider engagement to review with veterans their usage of illegal substances under the Federal laws, but that's as far as we can go with it at this time.

Mr. GOSAR. Is there anything that can be placed upon the crisis line that identifies that that might be able to help us, particularly out in rural podunk USA?

Ms. FRANKLIN. The crisis line staff are trained to stabilize any and all crisis regardless of the type or the form that it presents with.

Mr. GOSAR. And do they address marijuana?

Ms. FRANKLIN. Yes, absolutely. They address any substance abuse that exists as part of the crisis continuum.

Mr. GOSAR. And do they cite any of the current studies that actually show that there may be some detrimental applications to their condition?

Ms. FRANKLIN. Well, when they are engaging with clients, they are not really citing studies, but they definitely are fully aware of the role of substance abuse in crisis situations.

Mr. GOSAR. Well, I appreciate both of you here today. It is a definite problem, particularly in my district. Thank you.

Mr. LYNCH. The gentleman yields, and the request for submission of documents, without objection, is so ordered.

Mr. GOSAR. Sorry. Thanks.

Mr. LYNCH. The chair now recognizes the gentlewoman from the Virgin Islands, Ms. Plaskett, who has been an energetic and fervent advocate on behalf of veterans' health and active military health as well. For five minutes you're recognized.

Ms. PLASKETT. Thank you very much, Mr. Chairman.

And thank you, all of the witnesses, for being here. I wanted to just have you all talk for a few moments about how the VA and the Department of Defense share responsibility and work together for those servicemembers that are separating and how you work on the hand-off and the monitoring of individuals between the two agencies.

Ms. ORVIS. Thank you for the question. This is a critical time period for our transitioning servicemembers. I want to speak a little more broadly first in terms of what the Department of Defense is doing, not only with the Veterans Affairs but a variety of other inner agency partners: the Department of Labor, the Department of Education, Small Business Administration, just to name a few.

There is a robust process in place and help for our transitioning servicemembers. We know that there this is a major life change, and so being able to think about, what is your next step in your life? Are you interested in employment, going back to school, starting your own business? How are your finances going to change, and how do we need to adjust for that? What healthcare benefits do you need to look at, and what are your needs?

So there's a very robust program already in place that both our agencies as well as others are engaging in. In terms of mental health care in particular, and a warm hand-off there, we have a number of processes in place, and we are continuing to strengthen those. We're now introducing a new separation health assessment that servicemembers must complete prior to their separation, and part of that component is mental health. So, if we identify folks that are at higher risk, we're also going to be ensuring they receive an immediate handover to VA and other appropriate resources. Individuals that are already in mental health care, we're also ensuring that they have continuing care.

And I'll pause for a moment there and invite my colleagues to add additional information.

Ms. FRANKLIN. We're working hand-in-hand with the DOD on all the things that Dr. Orvis described in regular working groups in a series of efforts that are well tracked by a governance body called the Joint Executive Committee that brings together DOD and VA leadership to provide oversight for these efforts.

The one piece that I would add that I think we continue to need to work on as a community, both DOD and VA, is making sure that we're preparing the servicemembers for the social aspects of leaving the military. So, while Dr. Orvis well describes all the preparatory requirements to making sure that they're ready and full on up to take on their role as a veteran, we continue to have work to do to make sure that they know how to belong in their communities, they know how to connect with one another after they leave service, and they know what it's like to no longer wear the uniform and socially adapt to a new title and a new identity. There's work to be done.

Ms. PLASKETT. Thank you. Because in reading some of the literature on this and the studies, it says that, leaving that structured community of the military and heading back to life, express feelings of lonely—homelessness and abandonment. And I'm quoting something that says: The feelings of separateness, lack of sufficient social support system, or shared experiences with those systems, disconnection from family, deployment-related psychology or physical injury, and financial, educational, employment barriers.

So I'm glad that you all are working on that.

One of the things I'm concerned with is servicemembers who are leaving the military and heading back to areas that have fewer VA resources. For example, in the Virgin Islands, my constituents struggle to gain access to healthcare due to a shortage of qualified veteran doctors there. And while the Virgin Islands have two VA clinics, there's no VA Hospital, and this means that many of our veterans have to travel to Puerto Rico for medical care.

Dr. Colston and Dr. Orvis, what steps does your department take to make sure that servicemembers heading to areas with less VA resources know what's available to them?

Captain Colston. I think there's a couple things. First of all, I mean, it's the benefit. So the benefit needs to make sure that we take care of our servicemembers during the transition period and over to VA. It's DOD policy that there's a warm hand-off between clinicians. And often if we struggle with access to care downstream, that's something that we need to really engage. We need to do social—we need social work. We need to really have clinic-to-clinic connections.

I hear you about the Virgin Islands to Puerto Rico. That is quite a barrier to care, and I imagine that presents a struggle for the number of folks in the Virgin Islands right now.

Dr. STONE. Let me add the following. There were two suicides in the Virgin Islands, we don't know just because of the small number whether they were veterans or not, but there were two suicides from St. Croix and St. Thomas. Although we do have outreach programs, you are absolutely correct that the most comprehensive integrated mental health programs are in San Juan, and that is a problem.

We have increased our budgeting for telemedicine outreach for telemental health. Our criteria and our reviews of telemental health from servicemembers is extraordinarily well-accepted. About 13 percent of our engaged veterans are undergoing telemedicine in the mental health area. We'll expand that to 20 percent of our veterans engaged. And so we are dramatically increasing that.

We have the same problem in the Pacific in the American Samoa and the Mariana Islands as well as in Guam, and we're struggling in both areas. The Secretary is actually going out into the Pacific. And the other thing that many Americans don't recognize is the high rate of service amongst these populations. And so we need to do better, and we welcome your partnership in how to reach this population more effectively.

Ms. PLASKETT. Thank you. I just really appreciate the fact that you recognize the shortcomings and are willing to work on that and also recognize the propensity of individual American citizens that are living in the territories to join our service and to give to this

country in higher numbers than elsewhere, and particularly in the mainland.

Thank you, and I yield back.

Mr. LYNCH. Great questions. The gentlelady yields back.

And the chair recognizes the gentleman from Texas, Mr. Cloud, for five minutes.

Mr. CLOUD. Thank you, chairman. And thank you for being here. Thank you for your service. Thank you for your concern about this and the work that you're doing to help on this particular issue. It's refreshing to be able to sit in a committee like this where both sides of the aisle are extremely concerned about dealing with the situation. Ever since George Washington championed the importance of caring for veterans, thankfully our Nation is supporting that, and we have come to a place where, hopefully never again, we will see what we saw after Vietnam. Where we are at now, we see a genuine care and concern for veterans and servicing them.

When I've looked at the situation, it seems to me like one of the tricky parts is the lack of historical data available when it comes to creating a targeted approach in a sense. Do we really have an understanding as to why we're seeing the rates that we're seeing? In a sense, is it related to family dynamics? Is it related to medical conditions, their type of service, financial situations that they're finding—do we understand—have a clear maybe data-driven point on that? Are we able to cross data to——

Captain Colston. Absolutely. First of all, I would say all of the above. There are probably 200 or 300 forensic risk factors for suicide. Being male is a risk factor. Obviously, being a veteran is a risk factor. Having depression. Having a previous attempt is a very robust risk factor and, in fact, a place where we really need to intervene. Having rational thinking loss. Having substance use disorders. Struggling with a spouse, especially in regard to intimate partner violence, is a big risk factor for suicides. Being addicted to opiates and alcohol is a big struggle, and especially in this station as we—the number of opiate overdose deaths and suicides are roughly equal. It is a big, big public health problem.

There are many points where we can intervene. There are many points where we can take a public health approach to this problem. And it truly does need to be a global approach because we're going to save lives one at a time.

Dr. STONE. If I may, Congressman, 77 percent of America's 20 million veterans have been in combat. And I would ask everyone to remember that 21 percent of the suicides that are in the 20 a day are over 75 years old. Sixty percent are over 55. So we talked earlier about anchors. We talked about spiritual faith. We've talked about all of the things that the captain so articulately discussed that anchor us in our lives.

I talked in my opening statement about intense isolation and loneliness. I want you to think about, in the military, when my family PCS'd from one place to another, as the moving van was unpacking, every neighbor came up and introduced themselves, brought us food, made sure we were okay. And every weekend, we were filled with being invited to somebody's house.

When I came off of active-duty, I moved into a neighborhood that, four years later, I knew the names of the people on either

side. I had been in their house a few times, but I didn't know anybody else on the street. If we're going to fix this problem of intense isolation in American society, we need to acknowledge the fact that the generational home that I grew up in many years ago that—not only did multiple generations of my family live in, but also every home in that neighborhood was a multigenerational home, is a different environment than what Americans see today.

And one of the things that we do in my family is we greet the Hero Flights. And when you take a World War II veteran who is now in their 90's, it doesn't take you very long to pull the scab off their combat experience and realize the emotion that is just underneath the edge. And as the loneliness and isolation of the elderly comes to be, these are times that all of us need to reach out to that veteran and recognize that the experiences of today's 18-to 24-year-old who is at Camp Leatherneck is not going to go away and needs all of American society to surround them and to take care of them.

Mr. CLOUD. Thank you, I appreciate your thoughts on that, and Mr. Green mentioning the important role of faith. I was going to, before he asked, ask you about that. Just this weekend I spent some time in Victoria where—Victoria, Texas, where I was at an event where they posted over 2,000 flags in honor of veterans. And I've seen firsthand what that's meant when a community surrounds veterans.

In Victoria, we have a vet center where the communities come together to provide an environment where vets can come and hang out and have that sense of camaraderie, and just sometimes talk and just hang out with people who have been through what they've been through. Also, the VA and the vet center in Corpus Christi have partnered together to provide counseling when needed, and we found that to be extremely very helpful as well.

One of the things that has been an issue is that right now all that's covered is counseling for combat veterans. Do you see a need for expanding that maybe to veterans who have not participated in combat as well or to family members of combat veterans? You know, in my experience, in talking to veterans, a lot of times this is a—it's a family dynamic, and everybody is learning how to deal with coming off the battlefield, so to speak.

Ms. FRANKLIN. Yes, thank you. Your—it's such a good question because these are the exact issues that we're studying in the office. And we have taken great strides this year to analyze the data and try to better understand who is at risk and where they fall in the continuum of combat or no combat. And just to give you one example of that, we've studied—of the 20 a day, we know that a little over three of them fall in this category of never federally activated former Reserve and Guard that have not faced combat, that have not been activated on Federal orders. And so we are working with the committees to look at the art of the possible on expanding our service reach to that population.

And I also appreciate you mentioning the important role of families because we know that, when you look at the evidence-based practices that Captain Colston mentioned prior, families are a key and integral part of that, and the ability to bring them into the care system and make them part of the treatment plan is—we know that's what works. And so, when we can do more of that, it

gets at some of the other issues that this committee brought up earlier, particularly related to lethal means and making sure family members know about the important role of keeping the environment safe, whether that's medication or firearms; it is a holistic approach. And so we are continuing to look at the data with regard to these authorities that you've mentioned.

Mr. CLOUD. Thank you.

Mr. LYNCH. I thank the gentleman for a very thoughtful line of questioning. The gentleman yields back.

The chair recognizes a very active member on this committee who cares deeply about the veterans in Vermont. The gentleman from Vermont, Mr. Welch, is recognized for five minutes.

Mr. WELCH. Thank you, Mr. Chairman.

I thank the witnesses.

Dr. Stone, I really thought what you just said about the community that you grew up in versus the community that veterans are returning to really is compelling. You know, in Vermont, and during Iraq and Afghanistan, our loss of combat causalities was, on a per-capita basis, the highest in the country for quite a period of time, and now we have the highest suicide rate.

And one of the things, you know, visiting with families, they're incredibly proud of their service, and the soldiers that go over, and they're everyday Americans who do great things, but they have all the challenges that all of us have. When they're over in Iraq or Afghanistan, they have this unit cohesion. There is a sense of incredible solidarity where it's all about helping their battlefield comrades. And then they come back to Vermont in some rural community and no one knows they were even gone.

There's no—we don't raise taxes to pay for wars. We don't have a draft. So it's people who volunteer, and it's an incredible experience for them serving their country and feeling that solidarity of doing something with others. How in the world can any organization—I, a lot of times, think we expect too much of the Veterans Administration. I mean, creating that sense of community that you described is what ultimately helps all of us get through those tough times, but if it's not there, how do we address that contradiction?

Dr. STONE. I think you hit the key issue, sir. And the key issue is, how do we build a resilience amongst all of us? And the answer is the military is excellent about building cohesion between very small formations and very small groups. Regardless of what faith we come from or what background we come from, it's about cohesion. And really preparing the servicemember for the transition to a community that will feel foreign to them as they come out is what we need to work on more effectively.

Mr. WELCH. But does it make sense to do a lot more, like what Mr. Cloud was talking about, where there's a lot of people in the community that just make it their business to try to be there and interact with the veterans? You know, my sense is that the best person to talk to a veteran is another veteran.

Dr. STONE. We agree with that.

Mr. WELCH. Dr. Franklin?

Dr. STONE. Do not underestimate the fact that just being there for a veteran has value, even if you didn't serve, and picking up the phone and calling a veteran that might be in need. We have

a program called Be There for exactly that reason. And I'll defer to Dr. Franklin.

Ms. FRANKLIN. This is such a good line of questioning and discussion because, as we move forward in the VA, one of the things we're trying to do—I call it broad sector engagement, but it basically defines making sure that we're touching every sector where a veteran works, lives, and thrives, not just where they get their healthcare.

So, if we think about the state of Vermont and we think about where veterans go to school, where do they go—university sectors, and are they prepared to engage with veterans who might be at risk of suicide. And the first responders in the state of Vermont, is every fireman ready to help us, whether they're a veteran themselves, because we know that many of our military become first responders, or they're responding to a veteran at risk? Are they prepared and ready to help them?

Does every hospital in the state of Vermont know what to do when it comes to the screening protocols that my colleague to my left spoke about? Does every hospital know to implement the Columbia protocol when it comes to universal screening, not just the VA Hospital, but do our libraries, do our people that receive veterans everywhere they go——

Mr. WELCH. What about kind of—I appreciate that—low-tech support? You know, we had a program when the—when our National Guardsmen and—women were deployed, the Guard got some funding from Congress to set up a program to provide on-the-spot support so that when the family was running low on heating fuel in the winter, they knew they could make a call and make it happen.

But when that veteran comes back, if they don't have anybody to check in with them unsolicited, that's going to make it tough, and, you know, it's a little late—to you got to—having all the protocols in place is one thing, but you want to have some human interaction—I think that's what you're saying, Dr. Stone—that's sort of organic to the community.

Captain Colston, what do you say about a low-tech approach where we put veterans to work?

Captain Colston. And I'd add that the community is a large part of this. In my experience, MSOs and VSOs are a big part of fixing this problem. I know in Gurnee, Illinois; in Milwaukee; in Bonita Springs, Florida, there's an awful lot of life around veterans' lives because of those MSOs and VSOs. And I think that it's really important that we partner with those groups.

Mr. WELCH. I yield back. Thank you.

Mr. LYNCH. The gentleman yields back.

The chair recognizes the gentleman from California, Mr. DeSaulnier, for five minutes.

Mr. DESAULNIER. Thank you, Mr. Chairman. I want to thank you and the ranking member and the panelists for this important and informative hearing. I'm taken back to—my district is in the East Bay of the San Francisco Bay area just below Napa. And after reading the books "Thank You for Your Service" and "The Good Soldier," I went up to the Pathway Program, in I would say 2017, and it seemed at least to me that that was evidence of the VA, the

Department of Defense, really working with the affected and the protagonist, of course, in those books, having followed him to the surge being in combat, coming back, going through his own family pressures, and then getting to that program, which was sort of following the yellow brick road of best services, and then the tragedy that ensued at that facility, just strikes me as the complexity and the difficulty of what you all are dealing with.

And I say this in the context of having a family member take his life—he took his—it was 30 years ago my dad took his life. When law enforcement found him, one of the things left in his wallet, he didn't have much left of his wallet, was a Unit Certificate of Valor for when he was a combat veteran in World War II.

So, having spent a lot of time, from a personal standpoint and a professional standpoint, and having introduced bills here and in the state legislature, working with people like you and how can we promote this, my question to Dr. Franklin and to the RAND, is the stigma—the stigma that still surrounds the military, in particular, but also the general public about suicide and behavioral health. And in the context of the Bay Area and here—I go out to NIH; I go to the University of California in San Francisco and Stanford—and this remarkable period of discovery that we're going through in terms of behavioral health and identifying the genetic and the atmospheric, the environmental consequences. But one of the things that is our biggest stumbling block is still societally—and with all due respect to my colleagues who talked about faith, and I completely agree with them, with spirituality, but having grown up with my father in a devout Catholic family, that side of it, the dogma at least wasn't very reinforcing to him being able to go and talk about depression. Now that was his generation.

But this still strikes me, sitting here, and particularly with what I've read, which is limited but probably more than the general public about the people you're seeing and having seen the Pathway Program, the challenges to get through that first step and to sustain that so somebody gets the help that they need, strikes me as one of the real challenges of our lifetime.

At the same time, we're getting all this wonderful research that is showing us how we can deploy this. And I'm taken by psychologists, psychiatrists, providers who have come to me recently, and said, because they know I have an interest, that there's a sense the ACA—there's a 75-percent increase in the request for behavioral self-services, but there's a 25 percent decrease in young people going into these fields professionally.

So it strikes me, and you really have an opportunity, I think, because of the general public being sympathetic and respectful of the work you do and the clients you see, is to not just benefit them but significantly move forward to deploying really valuable resources that can save lives and get people to have wonderful and fruitful lives personally and professionally. So, Dr. Franklin, and then maybe whatever you can add.

Ms. FRANKLIN. Ms. Tanielian is going to start.

Ms. TANIELIAN. Thank you very much for raising the issue. There are multiple barriers to care and multiple barriers that individuals experience in their help seeking behaviors. And I think it's really

important that we put those barriers into different types of buckets, not lump them all under the concept of stigma.

We know from work that we've done, and I've studied barriers to care in mental health for several years, decades now, that there are concerns around the capacity of being able to actually find appropriate sources of mental health treatment. So we have to address the capacity issue if we are actually going to overcome barriers.

And while we do know that there are concerns about how others might think of you if you were to receive mental health services, that is often what we refer to as stigma. The higher concerns among veterans and servicemembers is the potential for negative career repercussions that they could experience as a result of that care seeking. It was mentioned in the opening remarks the potential impact on their security clearance and the potential impact that their leader will treat them different, that they may not be promoted. This continues into their veteran status. So it doesn't necessarily go away when they leave the military.

Mr. DESAULNIER. If I can interrupt you just because I am nearing the end of my time. But a lot of these, the stigma also is a community psychological problem, but then policies reinforce that. So we can change the policies. And specifically when you come to issues like that, and the support system professionally and personally, so we have a lot of research that shows the families, the communities, sometimes reinforce, and we can change that from a policy stand wise.

So stigma isn't just some amorphous that we should ring our hands about; it's reinforced by policy that we set.

Ms. TANIELIAN. Absolutely, it's reinforced by policy. And so, in my testimony, I talk about the importance of enforcing mental health parity. Not only will that help make mental health care more accessible, it will increase the number of individuals who may join the work force because they would get adequate and appropriate reimbursement for the services that they provide. And so that is a policy that will have a direct impact on access and use of mental health care and will impact the rate of suicide as well.

Similarly, we need to really address, understanding that beliefs about the effectiveness of treatment are promulgated and supported. Treatment works. Evidence-based treatments for most mental health conditions exist, but we need to make sure that providers are equipped to deliver them.

Mr. DESAULNIER. Thank you. Thank you, Mr. Chairman.

Mr. LYNCH. I thank the gentleman for his powerful testimony. We have some further questions, so I'd like to recognize the gentleman from Texas, Mr. Cloud, for a question or such time as you may consume, I guess.

Mr. CLOUD. Yes. Thank you very much. I just had another question I wanted to ask. One of the—this is a little more general, and just the general access to care, but relating to this is the—I guess the interrelation between the DOD and the VA, since we're all here in this one room, I that I'd ask.

For example, somebody comes to a vet center and they need help, but the very first thing we have to do is go get their service records. Now, thankfully we have good—at least where we're at, we

have good people who care, and they'll sit there and talk to that person anyway. But the protocol would be for them to wait for weeks until they get service records and such, before they could actually provide any sort of care.

So what is the DOD and the VA doing? It seems like that transition from going from a servicemember to a veteran should be much more of a streamlined transition from a record standpoint, from a service standpoint, and that my—we talk about the number of veterans who aren't part of the VA, I mean, if that process was a little more streamlined, that might help with that.

If you could speak to maybe what's being done, what could be done. And I realize in this context that there's some administrative issues and there's probably also some legislative hurdles as well that would need to be addressed. So if you speak to that.

Dr. STONE. So, Congressman, you mentioned the vet centers. The vet centers are open access. If you come to a vet center, we're going to take care of you first and verify your eligibility later. By the same token, if you come to a VA hospital in crisis, we're going to care for you first, and then figure out your eligibility later. That is——

Mr. CLOUD. Well, for our office, for example, when we're doing case work, we can't proceed any further until we're able to—the very first thing we have to do is work with people in getting their records, which is not always——

Dr. STONE. So this goes into the transition assistance program, which is part of the first executive order that the President signed that has allowed us to stand up these joint efforts in order to register servicemembers well before they get out of uniform. That first executive order has been incredibly effective at allowing us to interact with servicemembers well before they come out and to assure that there is a warm hand-off, as Captain Colston referred to, in all of their issues.

I think the second thing I would bring up is the new electronic medical record that we'll share between the two Departments. It will go a long way to allowing us to do seamless work. Today, we have to use various, what we call a joint legacy viewer, in order to see each other's records. That health information exchange will continue to simplify this process. And I would defer to Dr. Orvis if she has other comments.

Ms. ORVIS. Sure. I would just add, in addition, when we're speaking about mental health care, another program that we have in the DOD is called In Transition, and that's for if a servicemember has been seen in terms of mental health care in the past year prior to the separation, they are automatically contacted for In Transition, and they're encouraged to help—it's a support to help them seek care, whether that's with the Department of Veterans Affairs or it's another resource that they're interested in, but that is a very promising program in terms of making sure we have that continuing of care.

Mr. CLOUD. And I know the President has done a lot of work on this already, but what about legislative hurdles that you could recommend that we get to work on our end? Any on the top of mind?

Dr. STONE. Probably the toughest issue that we're working with right now is the fact that over 900 former servicemembers that

were never federally activated in the Guard and Reserve, in the age range of 35 to 54, are part of that 20 a day. So nearly three of those are really not in the category of veterans because they were never federally activated.

I think a robust discussion of the role of the guardsman who may have had state service, but never came on Federal service, it needs to be discussed. And, second, the role of the reservist who was never called to Federal service needs to be discussed.

Now, we have robust relationships, and the Secretary has been extraordinarily proactive in allowing us to go out with our vet centers and our mobile vet centers to weekend formations. But even finding someone who served 20 years ago in the Guard is not easy, especially in areas like Vermont or North Dakota or Montana. These are tough areas to find those servicemembers.

But I think if you were embarking on an area for discussion, this would be one that we have to figure out a way to tackle.

Mr. CLOUD. Thank you. Thank you, Chairman.

Mr. LYNCH. The gentleman yields back. So myself and Mr. Green have just a couple of quick questions. You know, when I first came to Congress we had long, long lines at the VA, to the point where, you know, this is—waiting for an appointment with the VA, and this is back probably 14 years ago. And we did a pilot program, and we said to all the veterans: You can go to private hospitals and skip the line, just go to whatever hospital you—and we'll—the VA will pay, but you can go to private hospitals.

And in my district, the line didn't go down at all because my veterans came to me, and said: I'm a veteran; I want to be seen at the VA.

And I firmly believe that there is a medical benefit for veterans to be treated by veterans.

And in my VA Hospitals, and I'm down in Brockton pretty frequently, Brockton, Massachusetts. I've got one down in Jamaica Plain and one in West Roxbury. There is a tangible medically valid benefit to those veterans who are treated by other veterans. And I go through those halls, and more often than not, it's well over 50 percent of the people working at the VA are also people who have—men and women who have served.

So I just think that there is a real need to pay attention to that dimension of this. The question I have is really for Ms. Tanielian. RAND has a unique ability, you and your colleagues at RAND have a unique ability to sort of look at this from a distance. You have a good perspective on what is working and what is not working. And you work virtually hand-in-hand with the VA and DOD. Are there any lessons learned here that you think should be amplified? And on the other hand, do you think there are some things that are not working that we ought to discontinue? Do you have any—I know this is really complex stuff, but I just wanted to get your perspective on that.

Ms. TANIELIAN. Sure. Thank you for that question. Everything that has been mentioned is critically important to make sure that we continue to pursue more research, more activities and strategies to deploy engaging veterans in high-quality care and addressing those that are at high risk. We need to continue to push forward,

but we also have to get left. We have got to think about new strategies, be creative and innovative, and try to get left of this problem.

We have had the National Action Alliance Strategy for Suicide Prevention since 2012. DOD's was modeled after—in 2015, and now VA has one in 2018. It's time to reexamine and take stock of how well some of these strategies are working. We need to do some research and evaluation to actually understand where we are moving the needle. Are we improving the use of self-care skills? Are we delivering high-quality care? And are we reducing access to lethal means so that we can save lives? So we need to lean in and dedicate the resources that this complex problem deserves.

Mr. LYNCH. Thank you very much.

I yield back, and recognize the gentleman from Tennessee for his line of questioning.

Mr. GREEN. Thank you, Mr. Chair. Just a couple of observations and then a question. When I got out of the Army, I ran a healthcare company that basically ran emergency departments for hospitals. And we grew that company to 52 emergency departments in 12 states. And I wanted to just agree with as observation that Ms. Tanielian, am I pronouncing that correctly?

Ms. TANIELIAN. Yes.

Mr. GREEN. Agree with something that she said. Our civilian providers out there don't understand veteran issues. And since the Federal Government funds most GME across this Nation, we ought to do something about helping to educate those physicians who are in residencies when they see veterans out there.

And I just want to let you know that I heard what you said. The idea has come to me, and we will work perhaps with some of the military specialty training programs to make sure there's something that we can teach these physicians about the issues confronting veterans.

I also wanted to kind of say there's been a common theme, I think, that I've noticed throughout a lot of the testimony today, and it's about a continuum of care that begins, you know, when they're in the military and then as they transition into the VA and then for the rest of their life. You know, the Army had this thing, and we tried really hard, soldier for life, and we wanted it to be this program where soldiers would go out of the Army and tell the Army story, and it would make recruiting easy, and it was bigger than just their healthcare.

But I want to submit that we really—that vision can be achieved, and we should shoot for that vision. That vision of loving, serving, caring for that soldier, that sailor, that airman, marine. And the Marines I think are pretty good about it. You're a Marine; you're always a Marine, right? But the rest of us have got to get a little better about that and help in that continuum of care throughout the rest of their lives.

I do want to encourage the active-duty folks that are here, total force folks, to think about quantifying for those soldiers and sailors and airmen and marines who consider themselves to be spiritual beings, how do you quantify that they are really ready to handle killing somebody and surviving when their friends aren't? Survivor guilt is a very incredibly powerful thing. I have seen it so many, many times in emergency departments across this country where

guys are so ashamed of having survived, but faith in a sovereign God solves that.

So I want to encourage you to consider, how do you quantify that for those individuals who are, again, not compelling—we should never compel anybody who isn't religious to adhere to anything like that.

The question I have, though, is really to you guys, and my concern is about the increased incidents in adjustment disorders and some of the pre-trauma—pre-service traumas, and we're admitting folks into the military. How effective are our screening tools in assessing those folks that might have a preponderance or predisposition for behavioral health issues and then suicide?

Captain Colston. Well, yes, sir, adverse childhood experiences and inability to weather the vicissitudes of military life is one of the biggest issues we see in the first year. When I was at Great Lakes, I mean, mental health issues were the No. 1 reason for separation. Where we struggle is—of course, it's an employment exam. So, when you're trying to assess service, generally, we don't get positive endorsements.

Now, we see—and I'm sure you're exposed to this, Dr. Green, we see folks who can't hack it the first day. But the things that, you know, that I struggled with, and one of the things I look at is we look at things longitudinally, is we've got an awful lot of folks that just don't have the wherewithal to be—to survive in the military.

Now, what did we used to do with those folks? Well, we used to separate them, typically under a personality disorder rubric or an adjustment disorder rubric or something along those lines, and we used to do that to about 4,000 folks a year. And, obviously, there were injustices in the way that we did that, and we decreased it to 300. The question is, how do we meet those folks' needs?

As a psychiatrist, folks who struggle with personality disorders, you know, I found it's extremely hard for them to manage their problems while they're in the military. Increased violence, increased substance use disorders, poor performance, things along those lines. And we throw an awful lot on those junior officers and those senior enlisted folks.

So we need to find the answer, and where the answer really is, is in research. I think that our colleagues at RAND have really done a ton in this area. And what you said about chaplains and availability of spiritual care, the No. 1 portal for me as a deployed psychiatrist was the chaplain. So more people came to see me from—of all the places, even being in the troop medical clinic, was the chaplain. So it was crucial that I had a good relationship with him. And I would say in my deployments on aircraft carriers back in the 1980's and 1990's, we really had availability for every spiritual faith, and there were services for everyone.

Mr. GREEN. Mr. Chairman, I just want to say thank you again for your work in helping set this up. I want to thank all of our witnesses on behalf of the ranking member and the members of the minority party for coming today. It's not easy preparing for this and sitting in those chairs for several hours, but we do appreciate your commitment to this effort and to helping serve those that are willing to write that blank check for us. Thank you for being here today.

Mr. LYNCH. The gentleman yields back. I thank him as well for his participation, and some great testimony and some great questions from the members and input as well. So I'd like to thank our witnesses for their testimony today.

Without objection, all members will have 5 legislative days within which to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their responses. I ask our witnesses to respond as promptly as you are able.

This hearing is now adjourned. Thank you.

[Whereupon, at 4:12 p.m., the subcommittee was adjourned.]