

**THE U.S. DEPARTMENT OF VETERANS AFFAIRS  
SUICIDE HOTLINE**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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# THE U.S. DEPARTMENT OF VETERANS AFFAIRS SUICIDE HOTLINE

TUESDAY, SEPTEMBER 16, 2008

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 340, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Hare, Miller, and Buchanan.

## OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the Subcommittee on Health to order. I would like to welcome everyone today. We are here today to talk about the U.S. Department of Veterans Affairs (VA) suicide prevention hotline. In May of 2007, the Veterans Health Administration (VHA) mental health officials estimated 1,000 veterans receiving care from VHA committed suicide each year. Likewise, the rate of suicide among servicemembers appears to be on the rise. The Army recently reported that suicides among active-duty soldiers this year are on pace to exceed last year's all-time record. And that is of the general population, as well.

In July of 2007, VA collaborated with the Substance Abuse and Mental Health Service Administration (SAMHSA) to launch the VA Suicide Prevention Hotline. This hotline is a toll-free number that is manned 24 hours a day, 7 days a week. As of September of 2008, the hotline has served nearly 33,000 veterans, family members, or friends of veterans, that resulted in more than 1,600 rescues, to prevent suicide.

Over the past year, this Committee has held many hearings examining suicide among veterans and VA strategy for suicide prevention. Among the risk factors for suicide is Post Traumatic Stress Disorder (PTSD), a disorder that affects many veterans. While I commend the VA for implementing a suicide prevention hotline, I would like to hear how the hotline fits in with VA's overall strategy to combat suicide. Furthermore, I would like to investigate regarding the hotline staffing as well, and I look forward to hearing our panels today, to discuss how to improve the hotline to best serve our Nation's veterans.

I would like to now recognize Congressman Miller for any opening statement that he might have.

[The prepared statement of Chairman Michaud appears on p. 33.]

**OPENING STATEMENT OF HON. JEFF MILLER**

Mr. MILLER. Thank you very much, Mr. Chairman. I appreciate you holding this hearing today to assess the VA's suicide prevention efforts, in particular the establishment of a hotline for the veterans. There is nothing more tragic than a servicemember who has fought to defend the freedom of the United States of America to end their own life.

It is extremely disturbing to everyone that each year, VA estimates that there are about 6,500 veterans that commit suicide. It is well-known that there are a number of factors that increase the risk for a veteran to attempt suicide. They include combat exposure, PTSD, and other mental health problems, Traumatic Brain Injury (TBI), and access to lethal means.

That is why it is vitally important that the VA understands and responds to the needs and risks of the veterans, especially those who are the newest generation of our combat veterans today.

Last year, we enacted Public Law 110–110, the “Joshua Omvig Veterans Suicide Prevention Act,” requiring VA to establish a comprehensive program for suicide prevention among veterans.

I have other comments that I would like entered into the record, but I think it is more important that we move forward to today's discussions. Mr. Chairman, I ask that my full statement be entered into the record, and yield back.

[The prepared statement of Congressman Miller appears on p. 33.]

Mr. MICHAUD. Does any other Member have an opening statement?

If not, I would like to call our first panel, Captain Power, who is the Director of the Center for Mental Health Services in the U.S. Department of Health and Human Services (HHS). I want to thank you very much, Ms. Power, for your willingness to come here this morning, and I look forward to hearing your testimony.

**STATEMENT OF CAPTAIN A. KATHRYN POWER, M.ED., USNR (RET.), DIRECTOR, CENTER FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ON BEHALF OF ERIC BRODERICK, ASSISTANT SURGEON GENERAL AND ACTING ADMINISTRATOR, SUBSTANCES AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Captain POWER. Thank you very much, Mr. Chairman, Mr. Ranking Member, and Members of the Subcommittee. Good morning, I am Kathryn Power, Director of the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration. I respectfully request that my written statement be submitted for the record, and I am very pleased to offer testimony this morning on behalf of Dr. Eric Broderick, Assistant Surgeon General and Acting Administrator of SAMHSA, from the Department of Health and Human Services.

And as a captain in the U.S. Navy reserve, who just recently retired, I am a veteran.

Thank you for the opportunity to describe how SAMHSA is working to prevent suicides among our Nation's veterans. And I have the privilege of working with and developing a strong partnership with the members of the Department of Veterans Affairs. And we now have a current interagency agreement that focuses on helping to prevent suicides by veterans. Just last month, SAMHSA and the VA, along with the U.S. Department of Defense (DoD), sponsored a 3-day conference on meeting the mental and behavioral health needs of our returning veterans and their families, with a very strong focus on suicide prevention interventions.

Suicide is a major public health problem for our Nation. There is a suicide every 16 minutes. Thirty-two thousand people died by suicide in 2005. It is a leading cause of death across the lifespan among both veterans and non-veterans. To reduce suicide nationally requires that our efforts include a sustained focus on preventing suicide across all Americans, and especially on veterans to whom we owe so much.

SAMHSA provides national leadership for suicide prevention, and it is consistent with the national strategy for suicide prevention. We have three major prevention initiatives within the Center for Mental Health Services. The first of these initiatives is the Garrett Lee Smith Youth Suicide Prevention Grant Program. As of October 1st, 2008, more than 50 States, tribes, and tribal organizations, as well as 50 colleges and universities, will be receiving funding for youth suicide prevention programs through the Garrett Lee Smith Act.

The second initiative is a Suicide Prevention Resource Center, which is a national technical assistance Center that advances the field by working with States, territories, tribes, and grantees, and by developing and disseminating suicide prevention resources.

The third major initiative is the National Suicide Prevention Lifeline, the program that has been at the centerpiece of our partnership with the Department of Veterans Affairs to establish the Veteran Suicide Prevention Hotline.

The lifeline is a network of 133 crisis centers across the United States that receive calls from national, toll-free suicide prevention hotlines, primarily 1-800-273-TALK. The network is administered through a grant from SAMHSA to link to Health Solutions, which is an affiliate of the Mental Health Association of New York City.

Calls to 1-800-273-TALK are automatically routed to the closest of the 133 crisis centers across the country. Those crisis centers are independently operated and independently funded. They all serve their local communities in 47 States, and operate their own local suicide prevention hotline numbers. They have agreed to accept local, State, and regional calls from the National Suicide Prevention Lifeline, and receive a small stipend for doing so.

In three States that currently do not have a participating crisis center, the calls are answered by a crisis center in a neighboring State. All the calls are free and confidential, and are answered 24 hours a day, 7 days a week.

By utilizing a national network of crisis centers with a trained staff linked through a single national toll-free hotline prevention

number, the capacity to effectively respond to all callers is maximized. Early in 2007, SAMHSA and the VA began exploring strategies for a potential collaboration. It became quickly apparent that using the National Suicide Prevention Lifeline as a front end for the suicide prevention hotline would offer numerous, very important advantages. Callers in crisis would hear the following message: "If you are a U.S. military veteran, or you are calling about a veteran, please press one."

On the very first day of operation, callers were able to be connected. At both SAMHSA and VA, we have promoted the 1-800-273-TALK number, and the number of callers pressing one has increased dramatically. They can press one and be connected to the VA Center in Canandaigua, New York, or they cannot press one and be connected to their local crisis centers. We think that this connection is one of the best ways in which individuals who are veterans can receive follow-up services arranged by the VA's suicide prevention coordinators. It is the best, most extensive system for providing follow-up care to individuals who call the hotline.

We, in fact, know that in the future, we are going to continue to work with the VA to expand our efforts and to utilize the network of crisis centers to reach out to as many veterans as possible. We, in fact, know that our support of the lifeline, including ongoing evaluation efforts, will in fact continue to help us enhance the services that are available.

I will defer to Dr. Kemp to provide you with more specific information on the call volume for the veterans hotline. We are so pleased to have been able to work together with the Department of Veterans Affairs to help deliver the critically important messages that suicide is preventable, and that help is available. All Americans, veterans as well as the general public, have access to the National Suicide Prevention Lifelines at any time, and especially during times of crisis, and we are committed to sustaining this vital national resource.

Mr. Chairman, Members of the Subcommittee, I thank you very much for the opportunity to appear, and I will be pleased to address any of your questions.

[The prepared statement of Captain Power appears on p. 34.]

Mr. MICHAUD. Thank you very much for your testimony. You mentioned that pressing one will connect you to the VA counselor. How many veterans opt to connect to the local crisis center?

Captain POWER. I believe Dr. Kemp will have those statistics, because they are really the keeper of the statistics on the veterans' information. And we have a breakdown, but I would not want to give you the incorrect number, so I will defer to Dr. Kemp.

Mr. MICHAUD. Okay. And you mentioned that three States do not have it. What are the three States?

Captain POWER. Let me look here. That I will probably need to get for you. I don't have the three States. I have the list of the 47 States in front of me. How about if I give you the list of the 47 States? Then we can figure it out alphabetically who is missing. How about that, Mr. Chairman?

Mr. MICHAUD. Okay. We will follow up on that.

I noted in your testimony that VA had the most extensive system for providing follow-up care to suicidal hotline callers. Are there any other areas where the VA could improve their system?

Captain POWER. Well, I think we know that—we have discovered, actually, as we have done oversight on our network of crisis centers, that the follow-up to callers is hugely important, and we are understanding and learning more and more, and learning in a better way, the kind of follow-up that would work, and we actually are sharing that information with the VA, so that as they learn the kinds of contacts, the kinds of information, the kinds of engagement strategies that are necessary to keep veterans engaged, we are also learning that from the general public side, and I think that is information that we hope will be shared, where there are always better strategies to learn about engagement, there are always better ways to learn about how to keep people connected and keep people focused on their own survival, and moving into appreciation of their life moving forward.

So we are really exploring, with many of our other crisis centers, techniques for that kind of more intensive follow-up and research on that, and we are going to be sharing that with the VA, and they have asked to actually share that with us.

Mr. MICHAUD. So you will be researching that more?

Captain POWER. Absolutely, Mr. Chairman.

Mr. MICHAUD. Even though you didn't know the number of veterans that choose to access the local counselors over VA, do you know the reasons why they would prefer a local counselor versus a VA counselor, or is that something I had better ask someone else?

Captain POWER. Let me tell you what I remember from the most recent press releases, is that when we looked at the last year's calls, we know that there had—I think, and Jan can probably correct me if I am incorrect, but I think of the calls that were received by the hotline, there were about 55,000 calls that were received, and I think about 20,000 of them were identified as from veterans. And she can certainly verify the numbers. But that is what I recall from our press release at SAMHSA.

And what we find is that there are people who call who may have a family member who is a veteran, and they don't necessarily want to say that first, so they go to the local crisis center first to find that information. And one of the things that we found through the lifeline network is that even though the local crisis centers may not have had experience with veterans, we are doing a selective training program with the lifeline and with the VA for all of the crisis centers, so that even those people who do not press one will be fully informed about the potential for veterans or veterans' family members or veterans' loved ones calling in the hotline.

So of that percentage that identify themselves as veterans, I think it was 20,000 out of the 55,000, the other members who go elsewhere oftentimes there are individuals, and as now, as a former military member and as a veteran now myself, there are times when you perhaps want to think about whether or not you want to be connected into the VA system, or you want to understand what is available in the VA system first. And there are certainly people who may choose to say, "I really do not want to get

connected with the VA system. I really want to try some of my local resources or some of my family resources first.” And those are just natural human decisions that are made.

Mr. MICHAUD. My last question is, are there any peak periods when people tend to call in? Is it more at nighttime, in the morning, mid-afternoon?

Captain POWER. I think there are certainly cyclical times, when you can anticipate, and I actually used to operate a hotline when I did rape crisis and domestic violence work, and there are certainly cyclical times on the calendar, certainly during periods of time during holidays, during times of high emotion; in Thanksgiving season, in Christmas season, and Hanukkah season, those seasons that might remind people about the fact that they are missing family members, or that they are having—it may be a time when the stress is raised and they think about their economic situation or their social situation. You could really see that.

And also there are cyclical times during the 24-hour cycle, when people may be alone in the late evening hours, and may be more inclined to want to reach out to talk to someone because they are by themselves, or they are contemplating taking some action against themselves, or hurting themselves.

So yes, generally you have an understandable pattern. And actually, that is quite local. Generally, your local crisis centers will have a fairly good idea about their population, about the way their population responds, about what are the cultural and ethnic morays of the group that is in their crisis catchment area. And you have a very good way of anticipating when you might have an increase or decrease in calls.

Mr. MICHAUD. Great. Thank you very much.

Mr. Buchanan.

Mr. BUCHANAN. Thank you, Mr. Chairman.

You state in your written testimony that you were at a conference last month between three organizations, VA, and the DoD, focusing on working together to prevent suicides among veterans. What did you take away, I guess is the first question? And what did not get addressed that you think should be addressed to improve the situation working together between these three organizations?

Captain POWER. The conference was the second time that SAMHSA had sponsored a summit, really, on veterans' issues. And our purpose was to focus on behavioral health issues. We knew that many of the other organizations, of course, have responsibility; the DoD for the active duty, and the VA for veterans, for healthcare. And we really have developed I think a very close partnership, with seeing SAMHSA as an available resource, to both the Department of Defense and Veterans Affairs Administration, in the areas of mental health, mental illness, and substance abuse and addiction.

And the first conference we sponsored basically said, “You really need to get smarter about sharing with each other the kinds of interventions that work, the kinds of strategies that are effective, and start to share with each other evidence-based practices,” because frankly, the Department of Defense has some wonderful pockets of excellence on evidence-based practice that we at

SAMHSA didn't know about and perhaps the Veterans Administration didn't know about.

So the Department of the Air Force, for example, has a specific suicide prevention program. And we found that over the years, as we shared information under our Federal partners organization, that there was really opportunity for us to speak about, with each other, and begin to share that information with States and local providers, and that was really the purpose of the conference. We had State teams coming to the conference. There were States that applied to come to this conference, and we have a policy academy in which the Department of Defense, SAMHSA, and the VA, and State providers and local providers, talked about what were the most effective ways of reaching out to veterans, getting them into care, getting their families knowledgeable about community services, getting them connected to local VA or regional VA services, and sharing all of those practical logistics information, as well as what are the evidence-based practices that work? And that was really a marvelous opportunity to do that.

Mr. BUCHANAN. Another question, coming out of the private sector, there is a saying, "If you cannot measure it, you cannot manage it." I guess from a performance standpoint at SAMHSA, what are you using to evaluate the National Suicide Prevention Lifeline? Do private crisis hotlines utilize the same performance criteria? So, what are we doing to make sure that we are making progress? Do we have a way of measuring that?

Captain POWER. There are actually two things that we are doing. The first is the President's Management Agenda and the Department of Health and Human Services expects us to develop performance measures for our entire suicide prevention portfolio, and we have to report on those measures on a quarterly basis to the leadership at the Department of Health and Human Services. And we look at performance measures that address the suicide rate, the suicide incidence, and suicide prevalence. And most of that information is based on the Center for Disease Control and Prevention's (CDC's) statistics about suicide, so we respond to suicide data that is collected by CDC, and we are measured against whether or not we are able to prevent suicide in terms of the overall suicide rate.

Most of our programs, through the Garrett Lee Smith Act, have been focused on youth suicide prevention. And so we are measuring the reduction, or we are measuring the level of youth suicide attempts, and youth suicide activity, through the data-gathering efforts of the CDC. So we are doing that at a macro level.

At a more micro level, we have a very rigorous evaluation process that is in play for the lifeline. And so we do periodic evaluations of the quality of the crisis centers, and the quality of the responses, the quality of the training, the certification that the crisis centers go through. These are all measures that we use to help evaluate the crisis center networks, and the efficacy and quality of the engagement and communication, and certainly, we measure the fact that there were a number of calls.

And the evaluations, actually, we should share the latest evaluations with you because we found that of all the reported effects of a suicide hotline were that stress and distress reduced considerably during the period of the call, that over 12 percent of the callers

said that they did not complete suicide based on having a connection with a human being and having a conversation, and that the level of suicide ideation decreased over time, and having that opportunity.

So there are specific measures within the evaluation of the lifeline that we can show evidence that the intervention is working.

Mr. BUCHANAN. My last question is what type of outreach has been conducted to inform people about the National Suicide Prevention Hotline? What are we doing to make sure we are doing as much as we can to get the outreach out there?

Captain POWER. We have a suicide prevention priority area for SAMHSA, and we are working in conjunction with the VA, so we do both our own development of press releases, information, pocket cards, magnetic strips, a lot of those kinds of social marketing tools that we use we give out to providers, we give out to States, hundreds and hundreds of thousands of flyers, billboards—not hundreds of thousands of billboards, but billboards, and materials that we push out to the local level, to the State level, to college campuses. We did a particular, over half a million distribution of items after the Virginia Tech incident. And we mobilize our resources to get that kind of information in public messaging and in social marketing. We started to use places like *Facebook* and *MySpace*, and all of the Internet connections to get the word out about the availability of the lifeline.

And the VA has really taken on a tremendous public affairs advertising and awareness campaign about the lifeline. And I am sure they will talk to you about that. We are working in conjunction with them. They have their own constituencies and networks that they want to get this information to, and SAMHSA certainly has an interest in getting the information out, just from a public health, public access, public safety perspective.

So we use the works that we have in our communication strategy at SAMHSA to get the word out.

Mr. BUCHANAN. Thank you, Captain Power. Thanks for taking your time today, and I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you. Thank you very much for your testimony.

Captain POWER. Thank you very much.

Mr. MICHAUD. I would ask the second panel to come forward.

On the second panel we have Dr. Tom Berger, who is from the Vietnam Veterans of America (VVA); Dr. Rudd, who is with the American Psychological Association (APA); we have Mr. Ballesteros, the Office Manager for the National Veterans Foundation; and Mr. Butler from the Kristin Brooks Hope Center; and Dr. Shaffer, who is the Chief Medical Officer of MHN. I want to thank our panelists here this morning, and I look forward to hearing your testimony, as we deal with this very important issue.

I would like to start off with Dr. Berger and just work down the table.

**STATEMENTS OF THOMAS J. BERGER, PH.D., SENIOR ANALYST FOR VETERANS' BENEFITS AND MENTAL HEALTH ISSUES, VIETNAM VETERANS OF AMERICA; M. DAVID RUDD, PH.D., ABPP, PROFESSOR AND CHAIR, DEPARTMENT OF PSYCHOLOGY, TEXAS TECH UNIVERSITY, LUBBOCK, TX, ON BEHALF OF AMERICAN PSYCHOLOGICAL ASSOCIATION; TYRONE BALLESTEROS, OFFICE MANAGER, NATIONAL VETERANS FOUNDATION; HENRY REESE BUTLER II, FOUNDER, 1-800-SUICIDE, AND NATIONAL HOPELINE NETWORK; AND IAN A. SHAFFER, M.D., CHIEF MEDICAL OFFICER, MHN, A HEALTH NET COMPANY, SAN RAFAEL, CA**

**STATEMENT OF THOMAS J. BERGER, PH.D.**

Dr. BERGER. Thank you, Mr. Chairman, Mr. Buchanan and Mr. Hare. Vietnam Veterans of America thanks you for the opportunity to present our views on oversight of the Department of Veterans Affairs Suicide Prevention Hotline. We should also like to thank you for your overall concern about the mental healthcare of our troops and veterans. And with your permission, I shall try and keep my remarks brief and to the point.

The subject of suicide is extremely difficult to talk about, and it is a topic that most of us would prefer to avoid talking about. But as uncomfortable as the subject may be to discuss, VVA believes it to be a very real public health concern in our military and veteran communities. And as veterans of the Vietnam War and those who care for them, many of us have known someone who has committed suicide, and others who have attempted it.

As you are well aware, last week on September 9, the VA issued a press release that included information about the blue ribbon panel that Secretary Peake had formed to deal with the suicide issue in the VA. And among the items addressed in the draft report was information on the hotline including the following: nearly 33,000 veterans, family members, or friends of veterans have called the lifeline. And of those, there have been more than 1,600 rescues to prevent possible tragedy.

In the absence of any yet-implemented VA national suicide surveillance plan or program for veterans, the caller data seem impressive, and the VA is to be congratulated in this endeavor. But there are some very real questions that remain to be answered. Because one veteran rescued from suicide is certainly worth the effort.

What is the daily window of calls? How many calls have to be rerouted to high-volume backup call centers? What is the definition of "rescue"? Sixteen hundred rescues represent only .048 percent of the calls. What is the status of the rest of the calls? Is there a follow-up or tracking procedure? For 1 month, 3 months, 6 months? How many calls are from veterans already enrolled in the VA system? How many have attempted suicides vigorously? And how many veterans of those callers participated in actual combat operations?

The VA deserves congratulations on the implementation of the suicide hotline, as it represents a cornerstone in strategies to reduce suicides and suicidal behaviors among veterans, and I am

hoping that Dr. Kemp will provide information to answer the questions that were raised.

However, remember that the real first line of defense against suicide for the last 25 years in the veterans community has been the VA Vet Centers, the readjustment counseling service. There is still a need to hire professional counseling staff at existing VA centers, in order that the Vet Centers have the organizational capacity to meet all of the demands and needs of other generations of combat veterans.

Furthermore, the hotline can be improved upon significantly by instituting a better tracking system, linking into VA healthcare, better identification of where the veterans have served in terms of their military service, and other significant epidemiological markers. We encourage this Subcommittee, in particular, to exercise diligent oversight as the VA addresses the eight major recommendations of the blue ribbon workgroup on suicide prevention.

I would be glad to answer any questions you might have. And again, I thank you on behalf of the officers, Board, and members of VVA, for the opportunity to speak to this vital issue on behalf of America's veterans.

I would like to tell one story about the suicide hotline, and it is personal. Some of you may recall earlier this spring about one of the History Channel, the Military Channel, showed a program detailing life, 24 hours in the day of an emergency room (ER) combat hospital, we called them the Battalion Aid stations back in Vietnam. When Vietnam Veterans of America learned of this program, I personally called Dr. Kemp, and told her I had some concerns that the showing of this program might have an impact on the veterans community. Dr. Kemp responded very, very positively. In fact, for the two nights that the program ran, she hired additional counselors to man the phone lines.

Thank you.

[The prepared statement of Dr. Berger appears on p. 36.]

Mr. MICHAUD. Thank you.

Doctor Rudd.

#### **STATEMENT OF M. DAVID RUDD, PH.D., ABPP**

Dr. RUDD. Mr. Chairman and Members of the Subcommittee, I want to express my appreciation for the opportunity to testify on behalf of the 148,000 members and affiliates of the American Psychological Association regarding the newly minted and vitally important Department of Veterans Affairs' suicide prevention hotline.

As a psychologist and a fellow veteran, the urgent need to prevent suicide among veterans has particular salience for me. As the recently released numbers indicate, the problem of suicide among active-duty service men and women and military veterans continues to grow, with the suicide rate for young male veterans escalating more than double that of the general population.

What is undeniable is that psychological casualties are very much a consequence of war. What is less clear is how the VA and mental health providers nationwide can work to meet the demand, providing appropriate and necessary mental and behavioral healthcare and preventative services, as an essential element of the VA system healthcare mandate.

Not only does the VA system face increasing numbers of veterans with multiple and complex mental and behavioral health problems, it is also challenged by a culture of shame, stigma, and fear, which complicate efforts to improve access to care. Whether or not the hotline actually has overcome this is an interesting question, and I think one that warrants very careful study and scrutiny. Misconceptions about the nature and effectiveness of mental and behavioral healthcare serve as a formidable barrier to engaging many veterans. Reaching veterans in need requires creativity and flexibility.

The recently implemented hotline is an important and potentially life-saving program. The latest usage figures confirm the need for such services, but only tell a part of the story. VA efforts to identify and flag the health records of high-risk individuals may well also save lives, hopefully improving communication across specialty and primary care providers something this critical.

One thing that the suicide literature has revealed is that very simple things can save lives. While I applaud the VA efforts for implementing the hotline, and am enthusiastic about the program, let me offer a few words of caution. It is critical for the VA to study the efficacy of the program, gathering data to definitively answer critical clinical questions. And this is consistent with what Dr. Berger just said. We need to know that the hotline is actually reaching the highest-risk veterans.

The available literature on crisis and suicide hotlines has provided some interesting findings, and they are not always positive. For example, in a study in which participants were aware that they were being monitored, it was discovered that 50 percent of hotline workers did not ask about suicidality during the call. And these are the same crisis centers that were referenced earlier. That is a remarkable finding. I think it is one that really speaks to the issue about careful training, careful monitoring, and in being sure that we track the system very well.

And if you are looking at the issue about training in overall effectiveness, I think it is important to look well beyond those numbers, in terms of a call. We need to think about things like wait times for face-to-face appointments for people that are not already in the system, subsequent emergency room visits, as well as suicide attempts, and suicides that follow hotline access. That ultimately is the critical question, does it reduce the number of ER visits? Does it reduce the number of suicide attempts? And does it reduce the number of deaths as a result of suicide?

It is important to consider how the hotline system is integrated into the existing VA system of care. Will VA mental health and other appropriate treatment providers be notified when one of their patients makes a call to the hotline? What and how much information is going to be transmitted about the call? How will the hotline information be recorded in health records to facilitate tracking and outcomes assessment? What if the individual asks for confidentiality, and does not want information to be recorded and released?

These are just a few of the questions to consider. It is also important to remember the challenge of not just getting veterans into care, but keeping them in care. As we learned about Vietnam, this is going to be a long-term problem, so it is more than just about

improving access to care; it is about keeping people in care over the long-term. If that happens, lives can be saved. The efficacy of treatment for the full range of mental and behavioral health problems is actually quite impressive. The VA also has an opportunity to be creative and expand its response to the critical problem of suicide among veterans. This can include reaching out beyond the VA system, coordinating care with community providers, and creating innovative suicide prevention programs for veterans on college and university campuses. You heard a little bit about that earlier in some testimony. The breadth and depth of the problem is staggering, cutting across virtually every community in the U.S. Many veterans enroll in a college and university after returning home, a figure that reached over half a million in 2007. The number is expected to increase significantly in the years ahead. College campuses are, and must remain, important places to address the issue of suicide prevention as it relates to the veteran population.

SAMHSA currently funds 50 programs nationwide in this area, and efforts are underway to allow SAMHSA to support direct services for students on campus, an increasing number of whom will be veterans, and the range of those mental health and behavioral needs can, as a result, be met. These investments in our veterans, as well as those of other students enrolled, will go a long way toward ensuring their future success in college, as well as the health and well-being of the Nation overall.

I thank you for the opportunity to speak here today, and look forward to the chance to answer any questions that you might have.

Mr. MICHAUD. Thank you.

[The prepared statement of Dr. Rudd appears on p. 37.]

Mr. MICHAUD. Mr. Ballesteros.

#### **STATEMENT OF TYRONE BALLESTEROS**

Mr. BALLESTEROS. Thank you, Mr. Chairman and Members of the Subcommittee. On behalf of the National Veterans Foundation I would like to express our appreciation for this opportunity to appear before the Subcommittee. I believe a short description of our organization is in order to put our concerns into perspective.

Briefly stated, the National Veterans Foundation came to existence in 1985 and was founded by Shad Meshad, a Psych officer with field experience during the Vietnam conflict, co-author of the VA Vet Center Program and currently, the President of the National Veterans Foundation.

As a component of our national toll-free lifeline, we provide training for our counselors in crisis management, including suicide prevention and intervention. In addition, we have two staff members who are mental-health professionals trained extensively in trauma, crisis, and suicide counseling, and are on call to assist our staff answering the lifeline, and intervene and follow up as need arises.

It should be noted that in addition to not having any contractual relationships with any government agency, we are not a contracted crisis center for the National Suicide Prevention Lifeline. More to the point, the task before this Subcommittee today, we have an area of concern we believe should be addressed by its Members to ensure the Veterans Suicide Prevention Hotline is performing to its potential. Our concern is whether or not personnel responding to

calls received at the National Suicide Prevention Hotline after a veteran caller is directed to the VA Medical Center in Canandaigua, New York, have received the proper training in both suicide prevention and the causes of suicidal tendencies specific to veterans.

We do raise this concern before the Subcommittee. Unfortunately, when our staff members called the National Suicide Prevention Lifeline to test the services offered, we were subsequently directed to the VA Center in Canandaigua. The results were not satisfactory, at least not to standards of our organization. The primary advice given to our staff members was to refer them to the closest VA medical facility, and advise them to hang on and be patient until the facility can contact them.

Our concern is the reluctance of the person advising the caller to address an immediate suicidal ideation, and lack of the exploration of other means to provide the caller with immediate assistance. This leads us to believe the personnel receiving these calls are not properly trained. We could have simply experienced an anomaly in the system, as we are not privy to the training guidelines used by the VA, and our survey was not done with approved statistical sampling as that is not a function of our organization.

But to ignore the problem we experienced could place veterans' lives in danger. If the caller simply receives a telephone number, address, and directions to the closest VA Medical Center, this would be wholly inadequate by anyone's standards. We offer the following questions to the Subcommittee, who may wish to investigate further, and which we believe can be answered in the affirmative if the proper training is provided.

Question number one: Are procedures in place to provide for follow-up communication with the caller, if the need is determined during the initial call?

Question number two: Has the attempt been made to determine whether the veteran's specific problems are the cause of the suicidal situation? If so, was the information used to provide the caller with proper guidance?

Question three: Are there mental-health professionals trained in suicide prevention techniques and causes of suicidal tendencies specific to veterans available to immediately intervene if necessary?

And question four: Are the personnel who staff the hotline adequately trained in crisis communication, listening skills, and suicide intervention?

We simply ask that the Subcommittee ensure the procedures, protocols, and training are in place to ensure that a suicidal veteran can make a telephone call to seek help, and know that properly trained professionals will answer their call.

Our organization remains available to answer any questions you or your staff may have to provide with the additional documentation. Mr. Chairman, again, thank you and the Subcommittee Members for allowing me to appear before you today.

[The prepared statement of Mr. Ballesteros appears on p. 38.]

Mr. MICHAUD. Thank you very much, Mr. Ballesteros.

Mr. Butler.

**STATEMENT OF HENRY REESE BUTLER II**

Mr. BUTLER. I would also like to thank you, Chairman and the Subcommittee Members, for inviting me to speak today. My name is Reese Butler. I am the Founder of 1-800-SUICIDE, and the National Hopeline Network. I started 1-800-SUICIDE in response to my wife Kristin's tragic, preventable suicide on April 7th, 1998. Prior to her death, there was no national hotline. There was also a common misperception in America that suicide was not preventable. Consequently, there was little motivation for potential donors and grant makers to fund such a service. For this reason, I sold my home and used my wife's life insurance premium to create the Kristin Brooks Hope Center in her honor, and start 1-800-SUICIDE. No national suicide hotline in 1998, and now we have too many.

Ten years ago this week, 1-800-SUICIDE went live. Since then, the National Hopeline Network has routed more than 3 million people to help and hope. In 2001, the Kristin Brooks Hope Center received funding from Congress to support and evaluate a national suicide hotline network for the very first time in history. Prior to that, through 40 years of crisis hotlines' existence, there was never one single study that was considered valid.

Congress, mind you, authorized SAMHSA to support and evaluate the effectiveness of an existing suicide hotline network, not create one, not compete with one. SAMHSA's own independent study concluded the National Hopeline Network, 1-800-SUICIDE, as owned by the Kristin Brooks Hope Center, was indeed effective. Then contrary to the findings of the President Bush's Mental Health Commission, that called for ending duplication and maximization of resources, SAMHSA attempted to seize control over the National Hopeline Network. And failing that, they created an anti-competitive, duplicative system, and has issued press release after press release distorting the truth about 1-800-SUICIDE and the veterans' suicide hotline, 1-800-273-TALK.

And evaluation call records demonstrates that few, if any, veterans are calling the government-controlled 1-800-273-TALK. This is despite the fact that SAMHSA has claimed more than 22,000 veterans have called that number. These agencies have issued press releases since the launch of the Veterans Suicide Hotline in July of 2007 that are at best, grossly misleading. In testimony given before the House Committee on Veterans' Affairs in May of 2008, statistics about calls to 1-800-273-TALK failed to include the fact that better than 50 percent of all calls going to VA Mental Health Center of Excellence in Canandaigua, New York, originated on the 1-800-SUICIDE hotline.

Since 1-800-SUICIDE is not marketed as a VA suicide hotline, nor in our 10-year history have veterans ever called it to any noticeable level, clearly the callers cannot be as SAMHSA claims. This is a critical point, as it drives home to the American public and Members of Congress that something effective is being done about this issue. It takes the pressure off government services at SAMHSA and allows things to return to status quo. Can SAMHSA demonstrate and validate the number of veterans served? Can SAMHSA demonstrate that any veterans have been helped and

linked to assistance through their control of 1-800-273-TALK and 1-800-SUICIDE?

With the vast evidence that peer counseling works more effectively, SAMHSA could instead of duplicating and competing with an existing suicide hotline, be creating or supporting the peer model which the veteran community is in great need of, as several other folks on this panel have testified. In addition, they could, and should, be evaluating the peer line's effectiveness against the routing option on the general suicide hotline.

Due to the nature of veterans' suicide and its stigma, what impact on existing calls would there be if it was disclosed that the Federal Government was receiving personal identifiable information on callers to 1-800-273-TALK, and also while it also continues to control 1-800-SUICIDE?

Peer counseling is required for any veteran suicide hotline to be truly effective. Law enforcement personnel die by suicide eight times more frequently than in the line of duty. They, like their veteran counterparts, do not generally confide in the clinical setting about suicide, or in any mental health issue, but would likely open up to a peer who has had similar thoughts and experiences.

SAMHSA is spending over \$33 million duplicating an existing hotline network created by the private sector, after both Congress and SAMHSA promised it would not happen. Funding had been assured for only 3 years, and for 3 years we were told every grant cycle the funding was coming to a close. We believed them. In reality, SAMHSA did little more than for their contract to link to health solutions then add a voice tree on their existing 1-800-273-TALK. When you call it, as you heard from several people already, if you or your family member are a veteran, press option one, you get a counselor. In reality, what has been occurring is that when people call in crisis, 1-800-SUICIDE, or 273-TALK, they often are pressing one. Why? Because they know it will get into a counselor, any counselor, faster.

Suicide hotlines can be effective, but only when there is a genuine empathy and good connectivity with the caller and the call taker. A study that the Federal Government funded at the cost of \$1.5 million and 3 years prove this. SAMHSA is waging a campaign of disinformation to discredit the Kristin Brooks Hope Center and 1-800-SUICIDE, while convincing the American public and Members of Congress they are doing something effective about suicide prevention.

Lastly, rescue by police of suicidal people is not only ineffective; it can be lethal, and it is unnecessary. Tragically, SAMHSA pays for over 800 psychiatric emergency response teams nationwide, yet none are networked with the VA hotline, much less any of the community-based crisis hotlines.

Meanwhile, at the Hope Center, we do ask Congress to use every means possible to persuade Secretary Leavitt to stop the campaign against 1-800-SUICIDE, return our lines to us, stop using tax dollars to unfairly compete with the private sector program that is 10 years old, highly effective, and confidential. We would welcome working with the Veterans Administration to prevent suicide through the appropriate use of our lines, such as 1-800-SUICIDA for Spanish-speaking veterans. And of course, our peer-to-peer vet-

erans Hotline, 877-VET2VET. We remain willing to work with SAMHSA for appropriate options and referrals for all risk populations, including veterans. We stand behind our record of building effective and successful suicide prevention crisis lines and community networks.

I thank you for this opportunity to speak with you.

[The prepared statement of Mr. Butler appears on p. 39.]

Mr. MICHAUD. Thank you very much. Mr. Shaffer.

**STATEMENT OF IAN A. SHAFFER, M.D.**

Dr. SHAFFER. Mr. Chairman and distinguished Members of this Subcommittee, I would like to thank you for inviting us to share our experiences with the VetAdvisor Support Program. This innovative pilot program is designed to assist Veterans Integrated Services Network (VISN) 12, Great Lakes Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans, in learning about and obtaining VHA mental health services. We appreciate the opportunity to offer our perspective on how this unique, proactive, telephonic outreach program serving veterans uses innovative solutions to help address physical and behavioral health issues common to those serving in combat. We thank the Committee for its leadership and interest in this important issue.

This outreach program, we believe, has the potential to assist veterans not only in VISN 12, but also in VISNs across the country. VISN 12 recognized the need to ensure that all veterans have access to healthcare services they need via seamless transition into VHA. To address these needs, VISN 12 established a pilot program awarded to the Three Wire, MHN team designed to reach out to these veterans. This pilot program provides vital outreach and screening for behavioral issues that might otherwise go unrecognized and unresolved. In addition to screening for the risk of suicide, we also screen for PTSD, traumatic brain injury, depression, substance abuse, and significant medical symptoms, all of which may be factors in suicidal risk.

VetAdvisers is a telephonic outreach program focusing on recently returned veterans within VISN 12, using contact information provided by the VA, we call these veterans and inform them of the healthcare programs available. If the veteran agrees, we will transfer them to a licensed clinician, our care coaches, who complete the screening process using nationally validated screens selected by VISN 12. If the veteran prefers, we can schedule a screening for a more convenient time.

Our overall goal is to talk with and screen veterans when they have time to listen and understand the services that are available to them, and to participate in screening for these key conditions. The results are provided to the VA, and our coaches work to motivate veterans to follow through with needed help.

The value of this telephonic outreach model is that it provides an important service, when convenient for veterans, in a less intimidating environment; one in which they may be willing to talk more candidly. Following the screening process, the care coach provides the results to appropriate individuals at the VA Medical Center, who then reach out from the appropriate clinics to the veterans. Now, let me talk specifically about the screening for suicide, which

is the focus of this hearing. When the program began in February, 2008, care coaches provided a basic screen for thoughts of harming oneself. About 25 percent of the individuals screened positive, but many were not suicidal. So working with VISN 12, a more specific screen was approved to use with any veteran who screened positive on the initial screen. This more specific assessment provides information on an individual's state of mind to better indicate potential risk, and any need for immediate intervention. About half of the individuals who screened positive on the first screen were also positive on the more sensitive one. Importantly, none of those were in imminent need of intervention. However, we do reach back and have a specific contact within the VISN, who will promptly reach out and engage all of the veterans who screen positive.

Before closing, let me share some of the results and successes so far. Results demonstrate that veterans are willing to acknowledge serious issues in a telephonic interview. Since these screenings identify issues that might not otherwise be acknowledged, the screening provides a useful way of beginning a referral process for getting veterans needed treatment. There has been high interest and gratitude from the veteran community for this program. In fact, in a recent sample survey, 97 percent expressed satisfaction with the initial caller, and 86 percent expressed comfort speaking with a care coach, recognizing they are speaking about uncomfortable issues in many cases. Fourteen percent screened positive for suicidal thinking during the initial screen, and 70 percent screened positive on one of the six screens.

Many of these veterans may not have come forward on their own until problems had become much more severe and debilitating.

In conclusion, VetAdvisor functions well as a stand-alone pilot, and is well-suited to complement a variety of VA programs and initiatives designed to contact combat veterans who have not registered or accessed services by the VA. The program represents an excellent example of using contact services to reach a broad audience of veterans, and provide tailored support and referral back to appropriate sources within VHA.

On behalf of MHN and Three Wire Systems, I would like to thank you again for your interest in the VetAdvisor program, and for your commitment in ensuring our veterans receive the care and services they may need. I welcome your questions.

[The prepared statement of Dr. Shaffer appears on p. 49.]

Mr. MICHAUD. Thank you very much, Doctor. And once again, I would like to thank all of our panelists this morning. This definitely has been enlightening, and I look forward to hearing your answers to some of the questions that we have.

I will start with Dr. Rudd. You had mentioned that the VA needs to provide careful training for their hotline workers. Could you explain what type of training that they could provide to make sure that the hotline workers are competent in handling their cases that may call in?

Dr. RUDD. Well, I think that actually, Mr. Ballesteros mentioned some of that I think very nicely. Several things. The hotline workers are appropriately trained. I think part of the question revolves around are they appropriately trained to handle veterans, and veteran-specific issues, in recognition that the veterans population is

different. And part of what makes the veteran population different is the nature of military culture, the nature of combat exposure, and some of the stigma and some of the shame issues that emerge in that culture around mental health concerns. And this has been an issue I am sure Dr. Berger could speak to from the Vietnam era, as well. And a recognition that very quickly you can lose those callers in the initial contact.

And so it has to branch beyond just traditional hotline training, to veteran-specific training, and that is a really big concern. My concern, and I think is a concern that is reflected by a number of us, is the issue that if these calls are referred to traditional hotlines, I am not sure they are being accessed by individuals that have that kind of sensitivity to veterans' issues.

Mr. MICHAUD. Mr. Butler, can you tell me more how you recruit your workers and train them to deal with the VET2VET situation?

Mr. BUTLER. Sure. The VET2VET hotline, 1-877-VET2VET is done in partnership with 1-800-COPLINE. And the only people that we recruit to be peer counselors are law enforcement officers or veterans, or even active-duty service personnel who are willing to volunteer when they are at home. Unless you have been in a situation where you had to use a gun to both defend your fellow comrades or yourself, and face a gun, you cannot ever really say, "I know how that feels." It is like a guy telling a woman on a rape crisis hotline, "I know how it feels to be raped," or tell a woman who is suffering from postpartum depression, "Yeah, I know what it is like to have a child and have to suffer postpartum depression." You can't. There is no credibility.

We use the Internet to do the recruitment. I thought it was interesting when Director Powers talked about using *Facebook* and *MySpace*. Their collective spaces have less than 3,000 friends and if you know what that means, it means not many people are accessing it. Our partners who we do the recruitment with have almost 300,000 friends on MySpace alone. So we are reaching. We put a request out for volunteers, we get 500 to 1,000 requests back saying actively, "We want to volunteer." And they run the gamut of everything from veterans, law enforcement officers, to teenagers.

And so what we do is we categorize them based on what their demographic is, and then what we do is put them through an online training program that was developed by Eastern Washington University; QPR "Question, Persuade, Refer," and we can do online training of these people. We can literally even certify them online. The only part we cannot do online is that face-to-face interaction, when they are dealing with an actual person in crisis, the simulated. So for that, we actually have to do face-to-face training.

Mr. MICHAUD. What data do you have that will indicate how well the VET2VET is doing to actually prevent suicide?

Mr. BUTLER. I wish I had good data to share with you. Unfortunately, VET2VET is a unfunded program, and for the last 4 years we have been struggling to keep 1-800-SUICIDE afloat after the loss of our Federal funding, and having to compete with the Federal Government. So most people in the nonprofit sector have not been willing to help us in this particular battle. We have just recently, in the last 6 months, been able to pay off all our debt related to the government grant, which almost crushed us. So we are

just building the VET2VET program. I would say in about a year's time, we should have some fairly good data to share with you as to the outcomes of the callers, how many callers. But at present it is not even being marketed, other than on the Internet.

Mr. MICHAUD. I understand you have some concerns with the Federal Government operating a suicide hotline.

Mr. BUTLER. Sure.

Mr. MICHAUD. What advice would you give to the VA in operating their hotline? And I know that the VA actually plans on establishing a VET2VET in December. What advice would you give to the VA?

Mr. BUTLER. Well, I think anything the VA does to help veterans hopefully is a good thing. The reality is that the people, especially when it comes to suicide, depression, issues of self-harm, outward, inward aggression; these people need to be dealing with people that are empathetic. So yes, a peer is a real good step in that direction. You cannot teach empathy. You cannot buy empathy. Empathy generally comes—people who care volunteer. Which does not mean all volunteers are good, either. But I would base on—volunteer model is actually more expensive than paying people. It is hard to believe, but it actually costs more to run a volunteer organization than it does to run a fully paid staff organization. The recruitment, training, management, all that stuff. But I would highly recommend that they utilize the volunteer method. That way, at least from the screening standpoint, they are getting people who really do want to care to do this.

The other thing is in this day and age we can do a virtual call center. There is no need to have it physically in Canandaigua, or any physical VA facility. And you can provide very highly encrypted supervision for these counselors via the Internet, voice-over-IP. The beauty of that is if you have disabled veterans who cannot physically go to a center to volunteer, they can do it from Nome, Alaska, anywhere that they happen to be located. So it would be a phenomenal opportunity to let veterans help their fellow veterans out. And it would be great if the VA got behind a program like that. And we would applaud it.

Mr. MICHAUD. My last question is for Mr. Ballesteros. What would you say would be the key components of lifeline to make it a successful tool for veterans in crisis?

Mr. BALLESTEROS. The key would be actually having veterans answer the phones. Veterans helping veterans, as Mr. Butler said. We are the only ones who can understand—specifically, combat veterans are the only ones that can really understand what another combat veteran has been through. We are the only ones who can really understand what it is like to go from battle to home in an environment, and to know what is going on. We think about our friends that are back there, that are back in combat. We have guilt coming home, and we think we are safe—but basically, it is having a trained veteran help another veteran. We have the suicide prevention hotline that has excellently trained counselors.

The other half of it, the VA side of it, has the veterans. If we can just train the veterans as we train the suicide counselors, that is really what we are looking for.

Mr. MICHAUD. I guess that should raise another question for you, as well, Mr. Ballesteros and Mr. Butler. Does it make a difference what type of veteran? For instance, you talked about using veterans who have been in combat and have seen their fellow soldiers either die or get wounded. Does it have to be that type of veteran, versus a veteran who might not have seen combat? Is there any particular type of veteran that would be better suited for this particular job? Or could it be any veteran?

Mr. BALLESTEROS. In some cases, it would. In some cases, a combat veteran, when there is a caller who has either survivor's guilt, or has feelings about what was done in combat, that certainly helps. Because then a counselor can say, "You know what? I know what you are talking about, yeah." And then they can share their stories. What it is is that the caller will then feel comfortable explaining what was going on. And sometimes that caller doesn't even have to explain, because us, as counselors, we will just simply say the, "You know what? I know what you are talking about." And then it will all be out in the open without actually having to admit, or to have to say what was going on.

In some cases, simply a veteran in the same unit. I was in the 82nd Airborne. So there are three other counselors—who were in the division, so you know, we know where we were, and the streets, and you know, even in some cases the command is the same. My drill sergeant was one of our counselor's command sergeant major. So we know exactly who it was, and in that particular case, it does not matter if I am a combat veteran or not; simply the fact that I am a veteran and I know where they have been, what they were doing makes a world of difference.

Mr. MICHAUD. Would you agree with that, Mr. Butler?

Mr. BUTLER. I would agree with that, and also add that if the peer counselor has also suffered PTSD and/or has been suicidal, has dealt with the PTSD, had received the proper therapy, had no longer had suicide ideation, was no longer suffering from the PTSD, they would have more credibility with that veteran. It is the same with postpartum depression. You can be a woman and not necessarily be a peer counselor. If you have not suffered postpartum depression, or never had a colicky baby, you cannot ever say to another parent, or a woman, "Yeah, I know what that is like."

And it really is important that you know what it is like. Not just you have been in combat. Not just that you are a veteran. But that you actually have suffered, that you have wanted to end your own life with your service revolver, that you have suffered PTSD, and that you have gotten through it. Because now, you are a success story, and now you can give them the steps that you took. Not that they will necessarily work for the person on the phone, but at least it gives them some hope, and it gives them some credible hope that they can follow.

Mr. MICHAUD. I would like to recognize Mr. Hare, who has been a true advocate for veterans, and I appreciate all the hard work that you have done over the years, Mr. Hare, when you worked for former Congressman Lane Evans, and you have definitely taken up the torch without a blink. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Dr. Berger, I just had a couple questions for you. You talked about the Vet Centers and about the VA being a real first line of defense against suicide. In addition to the readjustment counseling, what other services do you think should be included in a comprehensive VA national suicide prevention plan? What else do we need to do?

Dr. BERGER. I think it has been mentioned by several of my colleagues here at the table, that there needs to be clinical information collected as well during the course of the call, when that is proper. Obviously, I strongly support the idea of peer counseling. That is what has made the Vet Centers so cost-effective and effective in terms of their treatment programs. And so those are two suggestions I can make right up front.

Mr. HARE. Doctor, you also mentioned better tracking. How would we do that? How would you suggest doing that?

Dr. BERGER. Well, as you may be aware, Mr. Hare, in early May of this year, our Congressional Research Service published a report on suicide prevention among veterans. And in that report, there are a number of suggestions about how they might more effectively do that. And I would refer you to that.

Mr. HARE. Dr. Rudd—is it Dr. Rudd? I am sorry. The VA is reporting 33,000 calls and 1,600 rescues. How would you interpret the results of that?

Dr. RUDD. Well, I think it is difficult to interpret that data. And that is why tracking is so critical. You simply don't know who those callers are. You do not know whether those callers truly represent the high-risk individuals that we are attempting to reach. Are these at the highest risk group? Are those people already in the system, that are accessing the system, or those people that are already in care? Are these people that are thinking about getting in care, that are at high risk?

And so I think the tracking will help answer that question. And without the tracking data, I am not sure that realistically you can answer that question. And so it is important to know, are we bringing new people into the system? Are they going to the emergency room at any points after the calls? What are the rates in which they are being admitted into ongoing care? What are the suicide attempt rates after they have entered into care? What are the suicide rates after they have been connected to the system? I mean, those are probably the most critical questions to answer.

Mr. HARE. And Mr. Ballesteros, something in your testimony that I want to go through again, and hopefully I heard it correctly, but it disturbs me. You said that you had staff members call the national suicide line to test the services that were offered; correct?

Mr. BALLESTEROS. That is correct.

Mr. HARE. And your staff was told to wait for a phone call?

Mr. BALLESTEROS. Our staff was directed to the nearest VA facility that was closest to them.

Mr. HARE. These are people who called, saying that they had a problem—

Mr. BALLESTEROS. That is correct.

Mr. HARE [continuing]. That they were having suicidal problems, and they were told to wait?

Mr. BALLESTEROS. That is correct. They were specifically told to hang on and, "They will call you back," basically. Exactly what they were told varies from, "Don't worry, they will be right with you," or, "If you call this number, you will get a call back."

Now, what we do is we counsel the caller on the phone, get them to a zone that they are comfortable in, and then we start talking to them about going to see, or going into the Vet Center, or going into the VA, because as we know, for a veteran to receive their benefits, they simply have to go to the VA. You cannot just go to any doctor and just say, "I am a veteran, you know, give me my benefits."

So we encourage them to go in and seek counseling through the VA, through a Vet Center. We put it in terms that they can understand. You know, they want to help their buddies, so if I stand up and I say, "Yes, this is a problem," that in turn is making it easier for the next veteran to come behind me and say, "You know what? If he can admit it, then I can admit it, too."

And that is really what we are going for. That is what we are looking for. Unfortunately, what we found is quite different. We found that we were simply referred to the nearest facility who had either a social worker or a counselor, whether it be a Vet Center or a medical facility, and we were directed to call that facility and either ask for this person, or we were directed to leave a message and they will, you know, they will get back.

Mr. HARE. A person who is suicidal calls, and they are told, "We will get back to you"?

Mr. BALLESTEROS. Yes. After they press one.

Mr. HARE. After you press one. And "We will get back to you"?

Mr. BALLESTEROS. And you know, at that point, we stopped the conversation, we stopped the call. This was part of our training, to understand how we can do better. We will call facilities because we are constantly doing continuous, continuing training on suicide preventions and new technologies, new information that is out there, new statistics that are out there, however we can help veterans and anybody who calls, whether it is a family member. We have had mothers call and say, "How can I get my son to call?" We will just tell them straight up, "Just have him call us," and then sure enough, the veteran will call about 20 minutes later, "My mom told me to call you," and that is how we get him in.

Whatever it takes for us to get them in. The key to the National Veterans Foundation is we do have a person answering the phone who is a veteran, whether it be a combat veteran or a noncombat veteran, 12 hours a day, which we are funded for, 12 hours a day, 7 days a week.

Mr. HARE. Well, that just makes sense. I mean, here you have people who have served, and they are talking to somebody, and they understand it because they have been there. They have been there and done that, so to speak.

But I just have to tell you, to be told to wait, "We will get back to you," is absolutely unbelievable to me. It would seem that the logical thing to do would be to get that person help immediately.

Mr. BALLESTEROS. Absolutely.

Mr. HARE. And then maybe I am missing something here, but to have to be told to come back tomorrow, or "We will call you tomor-

row,” or, “Here is another number,” and bump you around; you may never hear from that person again, ever.

Mr. BALLESTEROS. And we have, at best, one chance to save a life, whether they hang up during the pressing of the “one,” or after they receive somebody. We were talking earlier, we have at best one chance to help this veteran out. And to have to go through that, simply to have to press one first is a problem. But the second thing is, is to not have a trained counselor on the other side to ask, if, you know, if I am going to kill myself, to ask me how am I going to do it? Do I have any plans? You know, what is going on? And to say “Why? What is going on? How can I help? Man, I have been there, I know what you are talking about. You know what?”

Several of our counselors are being treated for PTSD. They are service-connected for PTSD, so they do understand the procedures and what it takes to get a veteran to go in and ask for help. The VA is not a simple system to navigate. So once we get through the initial reluctance of going to the VA, then that is when we say, “You know what? You are going to be there”—once we get them into a zone that we can talk to them, and that we feel they will listen to us and we have their trust, then we start talking about going to the VA. If they are reluctant at that time, then we continue to talk to them. We make contracts with them, we have them call back.

The best-case scenario is we get their number, and then we call them back. Other scenarios are online chat rooms, a live community, our Web site, our MySpace, you know, all these other Internet sites and these social communities that we can go and reach out to veterans.

Mr. HARE. I apologize for going over, Mr. Chairman.

I appreciate your testimony. I am new on this Committee, but I just want to reiterate: if somebody calls, and they are suicidal and they are told, “We will get back to you tomorrow or the next day,” I think that is absolutely incredible.

Mr. BALLESTEROS. Another example. We received a call on Friday at 7:00 o’clock, from a female veteran, and ours was the fourth number that she was referred to. We had our four-tour Iraqi veteran on, and he just started talking to her, whether it was female or male, they were both there, they knew what was going on. Seventy-eight minutes later, from crying, she was laughing. She was more comfortable. And since then, we have had, you know, follow-up calls for our weekend staff. And I just called yesterday, and she is still calling back. The conversation is a lot shorter, but that is a good thing, because she is calling back, and we are there. And Freddy is there to continue to help her.

Mr. HARE. Thank you for what you are doing.

And Mr. Chairman, I am sorry again that I went over.

Mr. BUTLER. Congressman, I would like to address what Mr. Ballesteros said, because I understand more from the crisis center perspective what went on, and why it happened. Is that all right?

Mr. MICHAUD. No problem.

Mr. HARE. Sure. If my Chairman doesn’t mind, I don’t mind.

Mr. BUTLER. The fundamental problem with the 1-800-273-TALK and 1-800-SUICIDE with the option one, and mind you, both those lines, if you call them—and feel free to. There is just

a computer answering, it is not a human. You are not going to tie up the lines from people who are in crisis. The problem with that option one is you are feeding tens of thousands of people into the VA system that do not belong there, that are just choosing to get to the first counselor possible.

So what happened was about 6 months ago, because they were so flooded with calls—not from veterans, but from the general public, the Link To Health Solutions, the contractor for SAMHSA, opted to subcontract out the work for the VA out to a bunch of crisis centers around the country. But they were given very specific instructions on what to do, and what his staff experienced is what they were instructed to do. If it comes from the VA overflow, which is what is happening, they are instructed to give them the number of the local VA center. So all they are is a human answering machine for the person in crisis. They are not there to de-escalate the crisis, to send rescue, to provide help and hope. So that is why that happened.

And I would also like to address the question you gave to Dr. Rudd. While you may not have the data, the real data on the 22, or 33, or whatever the number they want to put out there, that are calling; the data we do have is the 2,000 rescues they are claiming that they have, the protocol when a rescue is done is done by talk. A police officer is rolled to the rescue. That means there is a record at the crisis center that does the rescue, that enacts the rescue, a record from the law enforcement officer, and all that gets back to the crisis center.

So we can find out several really key, critical things very quickly. Not years from now, but literally in weeks. We can find out how many of those 2,000 rescues were indeed veterans. I hope they all were, and I hope they were all positive outcomes. But more importantly, we can find out what happened on those rescues. Were they actually taken in, physically? Because sometimes the law enforcement officer will arrive and they will present, “Okay, I am fine. I was just acting out on the phone. I am really okay.” And then they go away, and then the person can shoot themselves at that point.

So if they are brought into a psychiatric facility, what happens to their lives after that? Are they helped, truly, by the system? They now have been rescued against their will. They have not asked for this. If they wanted rescue, they would have called 911 and asked for a cruiser to come and pick and them up and take them to a hospital. So now, they do not trust the system. They certainly do not trust the 1-800-273-TALK, or 1-800-SUICIDE hotline, or whatever the point of entry is. They are not going to trust the VA, and they are not going to trust the law enforcement officers.

So who is the next place they are going to reach out to after they get let out of a psychiatric facility, after their 72-hour hold? So that is a very efficient, tight study that could be done in a very short period of time, on those 2,000 rescues that they are claiming. And I hope that every one of those turned out to be a positive outcome, and that every one of them is writing a letter of support to the VA, to SAMHSA, and to Link to Health, and to Congress for funding it. But my guess is it probably will not be that pretty.

And it also will give you some really good insight as to what is broken in our mental health system in America, and how we can at least start to take steps to stop damaging people's lives. Sometimes it is better to do nothing. And in this case, I would say that what the system—they have got for option one needs to end. I am not saying disconnect, but they need to remove the option one off of there. If veterans want to call a veteran hotline, give them a veteran hotline, 1-800-VETERANS. You guys can do it. The FCC can pull that number and give it to whomever you want to give it to, and make it happen tomorrow and have a big press conference on Capitol Hill. Veterans deserve that.

Mr. HARE. Thank you.

Thank you, Mr. Chairman.

Mr. BUTLER. Thank you, Congressman.

Mr. MICHAUD. This has been extremely helpful. I want to thank each and every one of you for your testimony here today. Rest assured that we definitely will have some more questions, but because of the time we were not able to ask them today. Hopefully you will be able to respond to additional questions, as well. Once again, thank you very much for what you are doing.

And our last and final panel is Dr. Kemp from the Department of Veterans Affairs, who is accompanied by Dr. Knox and Dr. Zeiss. Once again, I want to thank you for coming and look forward to your testimony, Dr. Kemp. And you heard the testimony of our previous two panels, and especially the last one, we have heard some—not only thoughts, but good questions that were asked, and hopefully you will be able to address some of those, as well.

So, Dr. Kemp.

**STATEMENT OF JANET E. KEMP, RN, PH.D., NATIONAL SUICIDE PREVENTION COORDINATOR, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KERRY L. KNOX, PH.D., DIRECTOR, CANANDAIGUA CENTER OF EXCELLENCE FOR SUICIDE PREVENTION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND ANTONETTE ZEISS, PH.D., DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Dr. KEMP. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for inviting me to speak about the VA's suicide prevention hotline, and our overall program for suicide prevention. My name is Janet Kemp, and I am the VA National Suicide Prevention Coordinator. I am joined today by Dr. Kerry L. Knox, who is the Director of the Canandaigua Center of Excellence for Suicide Prevention, and Dr. Antonette Zeiss, Deputy Chief Consultant, Patient—Services Officer for Mental Health. I would like to request that my written statement be submitted for the record.

Mr. MICHAUD. Without objection, so ordered.

Dr. KEMP. Tragically, 18 U.S. veterans commit suicide every day. While all human life is precious, it is particularly devastating when those who have served this country in uniform take their lives. At VA, we are privileged to care for this group, and we are committed to fulfilling this responsibility.

A little more than a year ago, VA announced a plan to hire a suicide prevention coordinator for every VA Medical Center in the country. Today, I can say not only have we achieved that aim, but we are setting a benchmark for healthcare systems nationally in suicide prevention. Our suicide prevention coordinators receive specialized training in addition to their clinical expertise, and are employing evidence-based best practices. A blue ribbon panel recently praised the VA for its comprehensive strategy for preventing both suicide attempts and completions.

Last summer, we also announced the creation of a 24-hour National Suicide Prevention Hotline. We had the system up and receiving calls a month earlier than its targeted date of August 2007, thanks to our partnership with our colleagues at the Substance Abuse and Mental Health Services Administration. The call center is open 24 hours a day, 7 days a week, 52 weeks a year. The number, as you have heard, is 1-800-273-TALK, or 8255. Callers are prompted to press one if they are a veteran, or if they are calling about a veteran.

Our mental health professionals, including psychologists, social workers, nurses and others, receive specific training from one of the lifeline crisis centers who have longstanding and recognized expertise in suicide intervention. Our responders are linked into the network of suicide prevention coordinators in each facility, and can refer callers to direct local follow-up care.

The latest data would be on what an impact we have had, and you can look at the numbers both in your packets, and on the board. The call center has answered almost 70,000 calls. Thirty-two thousand callers have identified themselves as veterans or veterans' family members and friends. These calls have led to 6,000 referrals to suicide prevention coordinators, and 1,628 rescues.

Let me take a moment to define what "rescue" means, because I don't want the significance of this to be lost. It means someone was in crisis. There was a clear and imminent danger of suicide. And emergency or medical personnel were directed to the right location in time to save someone's life.

We understand these measures only work if people know that resources are available to them, which is why VA began its first-of-its-kind outreach program here in the Nation's capital. And you have a packet of information, with a sample of our outreach materials.

VA is advertising our suicide prevention hotline and VA's mental health services in 220 subway cars, 10 subway stations, and on 80 buses in the Washington, DC, area. This was originally intended as a pilot program to see if this kind of effort would work. What we found has been truly remarkable. In the short time this program has been in place, the number of calls received from the DC area has more than doubled. And we are now actively working to extend this campaign to other areas.

While these numbers speak to our success, I would like to conclude my remarks with a story that shows quite powerfully the incredible work our staff is doing.

Late one evening, only about a week ago, an older veteran called the VA suicide hotline. He had been receiving care at home from the VA, and the suicide prevention coordinator from his facility had

made sure that all the home-based primary care patients received a phone sticker magnet, and information on the VA suicide hotline. He had a loaded shotgun across his chest, and he said he planned to end it all. He refused emergency services and threatened that he would shoot himself and anyone who tried to enter his house.

The hotline responder identified his address and contacted the local emergency rescue providers, who immediately dispatched a team, but did not immediately go into the home. The VA hotline responder stayed on the line, negotiating with the veteran and the rescue team for 5 hours. Eventually, the veteran put down the gun and allowed emergency personnel to enter his home. He was then taken to a local hospital and later transferred to his local VA inpatient mental health unit, where he is being treated, and is significantly better.

While this is a dramatic example, it clearly demonstrates that our providers fully understand they are dealing with situations of life and death, and that they will go to extraordinary lengths to ensure our veterans receive the care that they need and deserve.

Mr. Chairman and Members of the Subcommittee, thank you for your time. I am prepared, and we are prepared, to answer any questions that you may have.

[The prepared statement of Dr. Kemp appears on p. 53. The VA sample packets of information are being retained in the Committee files.]

Mr. MICHAUD. Thank you very much, Doctor.

We heard in the end of your testimony that when they do call, they are better off getting a veteran immediately, because if you have a veteran who is considering committing suicide, the last thing they need to hear is, "If you want 'X,' please press one." I was actually out in Arizona and called that number. The first thing that ran through my mind is do I have to go through a whole litany of "press one," "press two," or "press three." By that time, you probably could lose a veteran, or a hang-up.

Would you agree with that statement? It should be a veteran, that it needs to be a live person when they call?

Dr. KEMP. When we put the hotline into place, we truly talked to all of our stakeholders that we could find, to ask them those sorts of questions. We worked with organizations—obviously, SAMHSA, but other suicide prevention organizations across the country. And one of the things that became very evident to us is that veterans deserve an immediate answer to their phone call.

The other thing that they deserve is not to have a special number; that there should be no reason why a wife and a veteran call a different number, why a worker and a coworker have different numbers; that veterans are people, and everyone in America deserves the opportunity to get immediate help in a crisis situation.

So we worked closely with SAMHSA and with the lifeline group, to be the number one option. And actually, the only option on lifeline number. If you call 1-800-273-TALK, you are given directions that if you are a veteran or calling about a veteran, push one. Otherwise, stay on the line. There is not a long list of one, two, three things that you need to remember to do. And we have been very pleased with that solution to the problem.

Mr. MICHAUD. That gets into Mr. Butler's concern about the validity of the number of veterans and their families that are calling. What evidence do you have that shows that the 33,000 calls are actually veterans?

Dr. KEMP. Well, I think it is evident that we have had over 70,000 calls. You know, Mr. Butler is correct; a lot of people push one. We ask people, and we take their answer at face value. If they tell us they are a veteran, we acknowledge the fact that they are a veteran.

For many of those veterans, and we do have these tracking numbers that are referred to, we know whether they are enrolled veterans or not. And with their permission, we have the ability to look into their medical records. And we always ask them if that is an all right thing for us to do. So there is verification there that they are getting help within the VA. So that group we do know are veterans.

If you look at the other graph that you have in your packets, as well as the one that we have up here on the board, we have done a fair amount of looking to see what happens to these people who call us. And we are able to track veterans that have been immediately evaluated, veterans who have been referred to additional services such as the OIF/OEF coordinators, Vet Centers. We do a lot of referrals back to Vet Centers for people who would benefit from and who want to talk to peers. We value that, and do feel that as a healthcare organization, we need to provide on-the-spot counseling by mental health professionals when someone calls in crisis, and refer them for the appropriate services that they need or want. But in a crisis situation, they deserve a mental health professional who can help them.

We know that veterans have been enrolled. So we do a fair amount of investigation for people who call us. We also very much honor their desire to remain anonymous. And I do think that a fair number of those other callers that do not identify as veterans, also are veterans, and are not ready to tell us that yet. And that is fine, and we will be there for them as many times as they need us to be there for them, before they identify.

We also provide public health services, and that is part of the VA's responsibility. So if people call having questions about veterans, or just need help, we need to be there for them, too.

Mr. MICHAUD. Can you explain what factors the VA considered in choosing to collaborate with SAMHSA versus the VET2VET providers that are currently out there?

Dr. KEMP. One was the availability of a national number for everyone, that gives options that people could choose. The other very important factor to us was the stability of the system. We needed a routing system that would transfer callers to the VA center without a queue, without a waiting area, and an immediate transfer. SAMHSA could provide that.

And we also needed to have a very strong backup system in place. And it is true. If someone calls the VA center, and because of the variety of things that we have no control over, such as a natural disaster, like an ice storm and a power outage, we needed the guarantee that those calls would be routed somewhere, and that people would never get a busy signal, they would never get a no-

answer. And the SAMHSA grantee system with Link to Link Solutions and Lifeline provided us with that stability.

We also needed some evidence-based factors. We needed to know that the system that we chose to partner with had done evaluation on their system, and had done some work in verifying what they were doing. And the SAMHSA people did allude to the evaluation program that they had in place. So we had the advantage of the findings of that research program before we even started the hotline. What we knew about the study, where people did not ask about suicide on the hotlines, that was a finding of that study. So we were able to use their findings and build into our very first initial policies and procedures some safeguards to protect us from those inadequacies. So it was the best that was out there, and that is why we chose it.

Mr. MICHAUD. Have you seen any trends as far as the care of veterans, OEF/OIF veterans, versus the Vietnam veterans, when they call in? Are there any trends that are out there?

Dr. KEMP. One of the things that has been truly remarkable to us is that there is a huge variety of veterans that are using the services. There certainly are two major groups of people, and that is our recent internees, and our Vietnam veteran-era people. Those are both big groups of people, so logically, represents a good portion of our veterans. But there seems to be a need from everyone out there, for what we can offer.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. I want to commend the VA for the work it has done in preventing 1,600 veterans from committing suicide. I agree with Dr. Berger's comment that one veteran is one veteran too many.

I just wanted to ask a couple of questions if I could. If you can respond to some of the questions that were posed by Mr. Ballesteros. Are the hotline personnel provided with guidance on how to determine whether any veterans' specific problems are the cause of suicidal situations? He had listed a couple of questions, and I was just wondering if he might give you the opportunity to respond to those.

Dr. KEMP. Yes, we can provide you with the standard operating procedures and policies of the hotline. There is an extensive, and caring assessment that is done, that does ask people about the veteran's specific issues that they may or may not be dealing with, as well as current coping mechanisms, plans to try to identify their level of current risk.

We have, in the VA, a long history of being able to identify those particular veterans' needs, and we have gathered our counselors in PTSD, in other mental health areas, to get the right questions, and the right screening mechanisms in place.

Mr. HARE. I think Mr. Butler explained that in clinical studies he found that it takes an average of 10 minutes to gain the level of trust and confidence of the callers in crisis. The average duration of calls to the VA hotline is 8 minutes. How would you respond? In other words, there are studies out there that say it takes that long, yet we are looking at 8 minutes, is there—

Dr. KEMP. You know, I am not sure where that 8 minutes came from, to tell you the truth. We, like all hotlines, do get a fair num-

ber of prank calls; from young kids, you know, from a variety of people. And when we take the prank calls out of our system, our average of actual call with a veteran averages between 20 and 30 minutes. So I am not sure—I think maybe they are looking at overall calls that come in.

Mr. HARE. Doctor, is there a peak time that people call the hotline? During that peak time, do you adjust your resources to accommodate them, the number of calls that come in during that time?

Dr. KEMP. Well, one of the other things that we found out immediately upon opening this hotline is that it is a national hotline, which is somewhat different than the local community centers. And because of the time differences across the country, in those very early morning areas, when we were expecting maybe our downtime to occur, California is just maybe hitting their peak time. So we have opted to staff with our maximum number of lines 24 hours a day, 7 days a week.

The other thing that we have found out that rather than finding increased volumes during different parts of the day, we do see increased volumes more in relationship to specific events and things that are going on across the country. So it is helpful, very helpful, when we know that there is a national TV broadcast, or an event that is going to get a lot of news coverage about sensitive issues. And we do make every effort to increase staffing during those periods in time.

Mr. HARE. And then just one last question. I know you talked about doing a lot of advertisement in the Washington, DC, area. In a perfect world, how would we want to get this message out to more veterans, more of the families, to be able to broadcast this out to more people?

Dr. KEMP. We want more work.

Mr. HARE. Right. But how would we do this? Where would you suggest we do it, to get this message out, that there is this opportunity for veterans and their families to be able to get some help?

Dr. KEMP. I think that what we are finding out is that the media can be extremely useful in helping us do that. And we do see a big increase in calls after generalized news programs. The *Associated Press* articles, where the number is in there. We are working hard to develop some of these outreach materials, the kind of short, quick blurbs, with the number out there, and that we are available. And we struggle to reach people in rural populations.

Mr. HARE. I am glad you bring that up because my district is very rural.

Dr. KEMP. Right.

Mr. HARE. And for rural vets for a lot of vets, when they come back, they don't have that debriefing. They don't even know what programs are available in their own States.

Dr. KEMP. Right. So helping us with radio announcements in areas that don't have buses and subway cars, is very helpful.

I think that utilizing veterans to reach out to other veterans has been extremely helpful also. I know we have been on a number of radio broadcasts, Web sites that they can sponsor, a lot of them do publicize the number. We have public service announcements that we share with these groups. We tried to get promotional materials out to veterans groups, to pass them out, to hand them out. I think

that people in the second panel were right, and if you—if another veteran tells you you can get help here and gives you a magnet or a card, I think that is an extremely powerful tool. And we need to partner with community people to make that happen, and we are working hard to do that.

Mr. HARE. Thank you, Mr. Chairman.

Dr. ZEISS. And I might just add to that, if it is all right, a thank you to Vietnam Veterans of America. The publicity that we have that is filmed by Gary Sinise talking about the 1-800-273-TALK line, that you will hear more about in the upcoming hearing on the ad campaign, was immediately posted on the Vietnam Veterans of America Web site. It has been posted on some other veterans service organization (VSO) Web sites. So we are really trying to partner with veterans organizations, to ensure that, you know, the information is very broadly available.

Dr. KEMP. You know, we are very aware that it is going to take lots of different methods of communication to reach a lot of different types of people, and we are working hard to establish the web-based communication strategies. The hotline staff actually answers several e-mails a day from veterans, and it is a public health problem, and we need everyone's help.

Dr. ZEISS. And we do have packets here with all these materials just outside the door if anyone in the audience or any of you want; the bumper material, the refrigerator magnets, the Gary Sinise video, we are very happy to share this information with you. And for you to share it with your constituencies.

Mr. MICHAUD. Thank you. I have just a couple of quick questions, since you touched upon it. I know VVA touched upon it. When you look at the Vet Centers, they are very effective in the rural areas and do a very good job dealing with problems that veterans have. I know VVA was concerned about the staffing of the Vet Centers. Would you care to comment on that?

The second question I have is: Secretary Peak had told us about the VET2VET program when we went to Iraq. I heard very little on how you plan on implementing the VET2VET program. That is one of the things we heard from the previous panel, that is really an effective way of handling veterans. Would you comment on both of those?

Dr. KEMP. Yeah, I will talk to the second part first, and then refer the staffing issues to Dr. Zeiss. We have been working hard with the Vet Centers in a partnership for the development of the VET2VET line, and are really excited about this. We want it to be right; hence the December, sort of, opening. We are working with them in training their staff and helping them establish their policies and protocols. We will also have the ability to do more transfers back and forth between the two lines, so that if someone calls the VET2VET line at the Vet Centers and they are in immediate crisis, and needs rescue or immediate counseling, they will be able to transfer, with their permission, the caller to our mental health professionals. If someone calls our line and really wants to talk to a vet, we have the ability to warm transfer them back. I think the warm transfer process is extremely important. No one will ever hang up on that veteran and tell them to call another number. We will be able to just, you know, hand them off, talk to each other,

and make sure the right level of care is being provided at the right time for folks. So we are really excited about that opportunity.

Mr. MICHAUD. Is that pretty much on time, as far as—

Dr. KEMP. It is very much on time.

Mr. MICHAUD [continuing]. So December 1st, we will have a VET2VET line?

Dr. KEMP. Yes.

Dr. ZEISS. That is what we hear. That is what we are preparing for. And we have been consulting, as Dr. Kemp said, very closely with the Vet Centers, because they are really—just a vital component of the overall VA ability to deliver the right mix and complexity of services.

In terms of the staffing, I can say just a little bit, because the Vet Centers do not report to our office. We are partners. So I know that there are plans to open another, I believe it is 31 Vet Centers, and that there will be full staffing for those centers. And I know that there has been support for Vet Centers whenever they have requested additional staff, and they have hired both mental health professionals, and returning combat veterans, and we support that wholeheartedly, and are eager to partner with them, as they are fully staffed.

Mr. MICHAUD. You talk about collaboration. Actually, I think today the Office of Rural Health is meeting with the advisory Committee. You look at this suicide issue. Have you been collaborating with the Office of Rural Health, to get their thoughts and concerns?

Dr. KEMP. We certainly have talked with them. We are part of the group that plans with them, and one of the powerful things about the hotline is that anyone, anywhere in the country, can dial that number. And again, we do not have to train different numbers for different parts of the country. We can get out information about a consistent number, that everyone can know that they can reach immediately. So we are planning next steps in the advertising campaign and again, you will hear more about that when you have that hearing, but we have talked with rural health and are considering rural locations for future extension of that program, now that we have had the pilot, and see how valuable it is.

Mr. MICHAUD. Great. Well, once again I would like to thank you, Dr. Kemp, Dr. Zeiss, and Dr. Knox, for coming here this morning. We really appreciate it, and look forward to working with you as we move forward on this very important issue. Like the previous two panels, we will have some additional questions in writing, hopefully you will be able to respond in a timely manner.

Once again, thank you for what you are doing for our veterans. I thank the audience again for coming today. Since there are no further questions, this hearing is adjourned.

[Whereupon, at 11:48 a.m., the Subcommittee was adjourned.]

## A P P E N D I X

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### **Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health**

The Subcommittee on Health will now come to order. I would like to welcome everyone to our Subcommittee hearing. We are here today to talk about the Department of Veterans Affairs suicide prevention hotline.

In May 2007, VHA mental health officials estimated 1,000 veterans, receiving care within the VHA, commit suicide each year.

Likewise, the rate of suicide among servicemembers appears to be on the rise. The Army recently reported that suicides among active-duty Soldiers this year are on pace to exceed last year's all-time record and that of the general U.S. population.

In July 2007, the VA collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA) to launch the Veterans Suicide Prevention hotline. This hotline is a toll-free number and is manned 24 hours a day, seven days a week.

As of September 2008, the hotline had served nearly 33,000 veterans, family members or friends of veterans and resulted in more than 1,600 rescues to prevent suicide.

Over the past year, this committee has held many hearings examining suicide among veterans and the VA's strategy for suicide prevention. Among the risk factors for suicide is Post Traumatic Stress Disorder, a disorder that affects many veterans.

While I commend the VA for implementing a suicide prevention hotline, I would like to hear how the hotline fits in with the VA's overall strategy to combat suicide. Furthermore, I would like to investigate issues regarding the hotline's efficacy and staffing.

I look forward to hearing from our panels today to discuss how we can improve the hotline to best serve our Nation's veterans.

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### **Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health**

Thank you, Mr. Chairman.

I appreciate your holding this hearing today to assess the Department of Veterans Affairs (VA) suicide prevention efforts, and in particular the establishment of a national suicide prevention hotline for veterans.

There is nothing more tragic than for a servicemember who has fought to defend our freedoms to end one's own life. And, it is extremely disturbing that every year VA estimates that about 6,500 veterans commit suicide.

It is well known that there are a number of factors that increase the risk for a veteran to attempt suicide. These include combat exposure, post traumatic stress disorder (PTSD) and other mental health problems, traumatic brain injury (TBI) and access to lethal means.

That is why it is so vitally important for VA to understand and respond to the needs of at risk veterans, especially those of our newest generation of combat veterans. Vulnerable veterans should be assured that VA has the resources readily available and know that help is there and there is a road to recovery.

Last year, we enacted, the Joshua Omvig Veterans Suicide Prevention Act (Public Law 110-110). This law required VA to establish a comprehensive program for suicide prevention among veterans. One of the many initiatives in this comprehensive program was the requirement to establish a 24-hour suicide prevention hotline.

I am pleased to say that VA acted and launched the Veterans Suicide Prevention Hotline in July 2007, even before the law was passed. Designed to meet the special needs of veterans, the VA hotline is an extension of the National Suicide Prevention

Lifeline, a 24-hour toll-free suicide prevention service available to anyone in suicidal crisis.

Since it became operational last summer, the VA hotline has received almost 70,000 calls from veterans, their friends and family, and active duty servicemembers.

The hotline is just one of a number of prevention measures that are necessary. Suicide prevention begins with information and outreach. This past July, VA began rolling out a campaign in the nation's capital region about the hotline. While it is too soon to know the effect of this one ad campaign, we do know that the number of veterans calling the hotline continues to increase. As the ad says, "It takes the courage and strength of a warrior to ask for help."

I look forward to today's discussions to examine the effectiveness of VA's suicide prevention activities. We want to send a message to all of the brave men and women who wear the uniform that we care and seeking help can make a difference in their lives

Thank you and I yield back.

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**Prepared Statement of Captain A. Kathryn Power, M.Ed., USNR (Ret.), Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services**

Mr. Chairman, Mr. Ranking Member, and Members of the Committee, good morning. I am Kathryn Power, Director of the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA). I am pleased to offer testimony this morning on behalf of Dr. Eric Broderick, Assistant Surgeon General and Acting Administrator of SAMHSA, an agency of the U.S. Department of Health and Human Services (HHS).

Thank you for the opportunity today to describe how SAMHSA is working to prevent suicides among our Nation's veterans through the Veterans Suicide Prevention Hotline. It is also a privilege to be here along with my colleagues from the Department of Veterans Affairs (VA), Dr. Jan Kemp, the VA's National Suicide Prevention Coordinator and Dr. Antonette Zeiss, Deputy Chief Consultant, Patient Care Services Officer for Mental Health. SAMHSA and VA have developed a strong partnership, reflected in our current Intra-Agency Agreement, to work together to help prevent suicides by veterans. Just last month, SAMHSA and VA, along with the Department of Defense, sponsored a three-day conference on meeting the mental and behavioral health needs of our returning veterans. The conference included a focus on working together to prevent suicide among America's veterans.

Suicide is a major public health problem for our Nation. Suicide is a leading cause of death across the lifespan, among veterans and non-veterans alike. To reduce suicide nationally requires that our efforts include a sustained focus on preventing suicide among America's veterans, to whom all of us owe so much.

My testimony will focus on the National Suicide Prevention Lifeline, the rationale behind the VA/SAMHSA partnership, and our plans for the future.

SAMHSA provides national leadership for suicide prevention, consistent with the National Strategy for Suicide Prevention. We have three major suicide prevention initiatives within the Center for Mental Health Services.

One of these initiatives is the Garrett Lee Smith Youth Suicide Prevention grant program. As of October 1, 2008, more than 50 states, tribes, and tribal organizations, as well as more than 50 colleges and universities, will be receiving funding for youth suicide prevention through this program.

A second initiative is the Suicide Prevention Resource Center, a national resource and technical assistance center that advances the field by working with states, territories, tribes, and grantees and by developing and disseminating suicide prevention resources.

The third major initiative is the National Suicide Prevention Lifeline, the program that has been the centerpiece of our partnership with the Department of Veterans Affairs to establish a Veterans Suicide Prevention Hotline.

The National Suicide Prevention Lifeline is a network of 133 crisis centers across the United States that receives calls from the national, toll-free suicide prevention hotline number, 800-273-TALK. The network is administered through a grant from SAMHSA to Link2Health Solutions, an affiliate of the Mental Health Association of New York City. Calls to 800-273-TALK are automatically routed to the closest of 133 crisis centers across the country. Those crisis centers are independently operated and funded (both publicly and privately). They all serve their local communities

in 47 states, and operate their own local suicide prevention hotline numbers. They agree to accept local, state, or regional calls from the National Suicide Prevention Lifeline and receive a small stipend for doing so. In the three states that do not currently have a participating crisis center, the calls are answered by a crisis center in a neighboring state. Every month, nearly 44,000 people have their calls answered through the National Suicide Prevention Lifeline, an average of 1,439 people every day.

When a caller dials 800-273-TALK, the call is routed to the nearest crisis center, based on the caller's area code. The crisis worker will listen to the person, assess the nature and severity of the crisis, and link or refer the caller to services, including Emergency Medical Services when necessary. If the nearest center is unable to pick up, the call automatically is routed to the next nearest center. All calls are free and confidential and are answered 24 hours a day, 7 days a week.

By utilizing a national network of crisis centers with trained staff linked through a single national, toll-free suicide prevention number, the capacity to effectively respond to all callers, even when a particular crisis center is overwhelmed with calls, is maximized. This also provides protection in the event a crisis center's ability to function is adversely impacted, for example, by a natural disaster or a blackout.

Further, by utilizing the national number 800-273-TALK, national public awareness campaigns and materials can supplement local crisis centers' efforts to help as many people as possible learn about and utilize the National Suicide Prevention Lifeline. In fact, SAMHSA has consistently found that when major national efforts are made to publicize the number, the volume of callers increases and this increased call volume is maintained over time.

Early in 2007, through the vehicle of the Federal Working Group on Suicide Prevention, SAMHSA and VA began exploring strategies for a potential collaboration in providing Veterans Suicide Prevention Hotline services.

It quickly became apparent that using the National Suicide Prevention Lifeline as a front end for a Veterans Suicide Prevention Hotline would offer numerous, very important advantages. We knew that on the very first day of operation, by utilizing a number that had already been heavily promoted for several years as the national suicide prevention hotline number, more than 1,000 callers in crisis would hear the following message when they dialed 1-800-273-TALK: "If you are a U.S. military veteran or if you are calling about a veteran, please press 'one' now." Callers who press "one" are routed to the VA call center in Canandaigua, NY, staffed by VA professionals. On the very first day of operation, 73 callers pressed "one."

As both SAMHSA and VA have promoted the 800-273-TALK number, the number of callers pressing "one" has continued to increase. Further, every veteran who calls 273-TALK has a choice. They can press "one" and be connected to the VA center, or they can choose not to press "one," in which case they are connected to their local crisis center. The network also provides backup so that if all the counselors at Canandaigua are busy, the caller is automatically routed to one of five high capacity crisis centers, specially trained by VA in working with veterans. This also provides protection to the veterans hotline in case the center at Canandaigua is adversely impacted, for example, by a natural disaster or a blackout.

We also realized that through this partnership, veterans who call the National Suicide Prevention Lifeline, would be able to receive follow up services arranged by VA's Suicide Prevention Coordinators. This is the most extensive system for providing follow up care to suicidal hotline callers that exists anywhere.

With the support of VA, the Lifeline has also created a web-based "Knowledge Bank" on veterans issues, available for use by every crisis center in the network when they talk to local veterans who do not press "one" or veterans who call a crisis center through its local hotline number. This guarantees that every crisis worker in the network will have veterans information at his or her fingertips. If, during the call, the veteran decides that he wants to talk with a VA professional or receive care through a VA facility, the crisis counselor can do what is called a "warm" transfer: without disconnecting from the veteran, the counselor is able to call Canandaigua, introduce the caller to the VA counselor, and hang up, leaving the caller and VA connected.

In the future, we plan to continue and expand our efforts to work with the VA and to utilize the network of crisis centers to reach out to as many veterans as possible. We have been encouraging local crisis centers and our Garrett Lee Smith grantees to meet with their VA Suicide Prevention Coordinators for planning and training in veterans issues, and to refer veterans to Canandaigua, as appropriate.

In addition, SAMHSA and the VA have begun to examine how communications technologies popular among young people, such as social networking sites, chat, and text messaging, can best be utilized to promote suicide prevention.

SAMHSA is also currently in the process of awarding grants to six local crisis centers to assess and assist their important work of following up with suicidal Lifeline callers. This initiative is based on SAMHSA-funded evaluations that demonstrated the need for this type of assistance to prevent suicide. One of the requirements for these grants is that the crisis centers work with veterans as a priority population and coordinate with both the hotline in Canandaigua and with their local VA Suicide Prevention Coordinators. SAMHSA plans to continue its support of the Lifeline, including ongoing evaluation efforts so that we can continue to assess and enhance the services that are provided.

I will defer to Dr. Kemp to provide you with more specific information on the call volume statistics for the Veterans Hotline. We are pleased that we have been able to work together with the Department of Veterans Affairs to help deliver the critically important messages that suicide is preventable, and that help is available. All Americans, veterans as well as the general public, have access to the National Suicide Prevention Lifeline during times of crisis, and we are committed to sustaining this vital, national resource.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

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**Prepared Statement of Thomas J. Berger, Ph.D.  
Senior Analyst for Veterans' Benefits and Mental Health Issues,  
Vietnam Veterans of America**

Mr. Chairman, Ranking Member Miller, Distinguished Members of the House Veterans' Affairs Subcommittee on Health and honored guests, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on oversight of the Department of Veterans' Affairs' Suicide Prevention Hotline". We should also like to thank you for your overall concern about the mental healthcare of our troops and veterans. With your permission, I shall keep my remarks brief and to the point.

The subject of suicide is extremely difficult to talk about and is a topic that most of us would prefer to avoid. But as uncomfortable as this subject may be to discuss, VVA believes it to be a very real public health concern in our military and veteran communities, and as veterans of the Vietnam war and those who care for them, many of us have known someone who has committed suicide and others who have attempted it.

In 2003 media reports of suicide deaths and suicide attempts among active duty OEF and OIF soldiers and veterans first began to surface after a spate of suicides in Iraq during the first months of the war. Subsequent major television news stories, independent research studies and additional investigative reports (including the release of e-mails from a top-level VA administrator who seemingly suggested not disclosing veteran suicide information to the media) disclosed the high rate of suicides and suicide attempts in our Nation's veteran community. All this culminated in the announcement by VA Secretary Dr. James Peake in the late spring of 2008 that the Department of Veterans Affairs (VA) had formed a blue-ribbon panel of mental health experts to study and develop recommendations to help reduce the number of suicides among America's veterans.

On Tuesday, September 9, 2008 the VA issued a press release which stated that the panel had completed its draft report "praising the VA for its comprehensive strategy in suicide prevention that includes a number of initiatives that hold great promise for preventing suicide attempts and completions." Among the items addressed in the draft report was the VA's Suicide Prevention Lifeline or suicide hotline, initiated in July 2007 in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA). According to the press release, "nearly 33,000 veterans, family members or friends of veterans have called the lifeline . . ." and "Of those, there have been more than 1,600 rescues to prevent possible tragedy."

The Suicide panel report dated September 9, 2008, stated: "The suicide rate among young male veterans who served during the Iraq and Afghanistan wars reached a record high in 2006, the latest year for which records are available, according to data released by the Department of Veterans Affairs." The question that occurs is what impact, if any, have the measures taken by the Department of Veterans Affairs (including the "hotline") and/or the Department of Defense had on the apparent diminishment of the rate of suicides among this group in the last two years? Has there been any change in the way in which these statistics are gathered or compiled during this period?

In the absence of any yet implemented VA national suicide surveillance plan or program for veterans, these call data seem impressive, and the VA is to be congratulated in this endeavor because one veteran “rescued” from suicide is worth the effort, but real questions remain, for example—

- What is the daily number of calls?
- How many calls have to be re-routed to high-volume back up call centers?
- What is the definition of “rescue”?
- 1,600 “rescues” represents only .048 percent of the calls. What is the status of the rest of the calls?
- Is there a follow up/tracking procedure? For one month? For three months?
- How many calls are from veterans already enrolled in the VA system?
- How many have attempted suicide previously?
- How many veterans participated in combat?

The VA deserves congratulations on the implementation of the suicide hotline as it represents a cornerstone in its strategies to reduce suicides and suicidal behaviors among veterans. However, the real “first line of defense” against suicide for the last twenty-five years has been the VA Vet Centers of the Readjustment Counseling Service of the Department of Veterans Affairs (VA). There is still a need to hire additional professional counseling staff at existing Vet Centers, in order that the Vet Centers have the organizational capacity to meet all of the demands and needs of every generation of combat veterans.

Further, the hotline can be improved upon significantly by instituting a better tracking system, linking into VA healthcare, better identification of where the veterans served, and other significant epidemiological markers. We encourage this Subcommittee to exercise diligent oversight as the VA addresses the eight major recommendations of the blue ribbon work group on Suicide Prevention.

I shall be glad to answer any questions you might have. Again, I thank you on behalf of the Officers, Board, and members of VVA for the opportunity to speak to this vital issue on behalf of America’s veterans.

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**Prepared Statement of M. David Rudd, Ph.D., ABPP  
Professor and Chair, Department of Psychology, Texas Tech University,  
Lubbock, TX, on behalf of American Psychological Association**

Mr. Chairman and Members of the Subcommittee, I want to express appreciation for the opportunity to testify on behalf of the 148,000 members and affiliates of the American Psychological Association regarding the newly implemented and vitally important Department of Veterans Affairs’ (VA) suicide prevention hotline. As a psychologist and fellow veteran, the urgent need to prevent suicide among veterans has particular salience for me. As the recently released numbers indicate, the problem of suicide among active duty service men and women and military veterans continues to grow, with the suicide rate for young male veterans escalating to more than double that of the comparable general population. What is undeniable is that psychological casualties are very much a consequence of war. What is less clear is how the VA and mental health providers nationwide can meet the demand. Providing appropriate and necessary mental and behavioral healthcare and preventive services is an essential element of the VA healthcare system mandate.

As has become evident, the unique characteristics of this war, including multiple deployments and intensive combat exposure, have resulted in arguably the greatest mental health challenge ever experienced by the military and VA. The RAND Corporation study released this past year confirms the magnitude of the problem, estimating that anywhere from a quarter to a third of previously deployed veterans present with mental health problems following discharge. Most prominent among the problems are major depression, Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and substance abuse, with many veterans experiencing multiple problems simultaneously and delaying or rejecting mental healthcare. Although we have known for some time that veterans with major depression, PTSD and substance abuse problems are at elevated risk for suicide, recent data on TBI are of particular concern. Estimated suicide rates for veterans with PTSD are in the range of 3–4 times that of the general population, along with markedly higher suicide attempt and ideation rates. One of the most troubling aspects of TBI as a suicide risk factor is the limited scientific foundation on which to formulate approaches to both assessment and treatment.

Not only does the VA face increasing numbers of veterans with multiple and complex mental and behavioral health problems, it is also challenged by a culture in

which stigma, shame, and fear compound and complicate efforts to improve access to care. Misconceptions about the nature and effectiveness of mental and behavioral healthcare serve as a formidable barrier to engaging many veterans. Reaching veterans in need requires creativity and flexibility. The recently implemented VA suicide hotline is an important and potentially lifesaving program. The latest usage figures confirm the need for such services. VA efforts to identify and flag the health records of high risk individuals may well also save lives, hopefully improving the communication across specialty and primary care providers. One thing the suicide literature has revealed is that simple things can save lives.

While I applaud the VA for implementing the suicide hotline and am enthusiastic about the program, let me offer a few words of caution. It is critical for the VA to study the efficacy of the hotline, gathering data to definitively answer critical clinical questions. The available literature on crisis and suicide hotlines has provided some surprising findings, not always positive. For example, in a study in which participants were aware they were being monitored, it was discovered that 50 percent of hotline workers did not ask about suicidality during the call. And this was on a suicide hotline! It will thus be essential for the VA to provide careful training and monitoring in order to enhance and ensure effectiveness of the hotline. In addition to providing numbers on overall usage, i.e. total number of calls, it will be important for the VA to track outcomes, including wait times for a face-to-face appointment, subsequent emergency room visits, suicide attempts, and suicides that follow hotline access.

Similarly, it is important to consider how the hotline system is integrated into the existing VA system of care. Will VA mental health (and other appropriate) treatment providers be notified when one of their patients has made a call to the hotline? What (and how much) information will they receive about the call? How will hotline information be recorded in health records to facilitate tracking and outcomes assessment? What if the individual asks for confidentiality and does not want information recorded and released? These are just a few of the questions to consider. It is also important to remember the challenge of not just getting veterans to providers but finding ways to provide ongoing care, as needed. If that happens, lives can be saved. The efficacy of treatment for the full range of mental and behavioral health problems is impressive.

The VA has an opportunity to be creative and expand its response to the critical problem of suicide among veterans. This could include reaching out beyond the VA system, coordinating care with community providers, and creating innovative suicide prevention programs for veterans on college and university campuses. The breadth and depth of the problem is staggering, cutting across virtually every community in the United States. Many veterans will enroll in a college or university after returning home, a figure that reached half a million in 2007. That number is expected to increase significantly in the years ahead. College campuses are and must remain important places to address issues such as suicide prevention as it relates to our veteran population. The Substance Abuse and Mental Health Services Administration (SAMHSA) currently supports education and outreach efforts related to suicide prevention on college campuses, and there are over 50 programs currently on campuses across the country designed to create greater awareness about suicide and strengthen suicide prevention. Still more can be done. Efforts are underway to allow SAMHSA to support direct services for students on campus, an increasing number of whom will be veterans, so that the range of their mental and behavioral health needs can be met. These investments in our veterans, as well as other students in need, will go a long way toward ensuring their future success in college, as well as the health and well-being of our Nation in the future.

Thank you. I appreciate the opportunity to speak with you today and welcome the chance to respond to questions.

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**Prepared Statement of Tyrone Ballesteros,  
Office Manager, National Veterans Foundation**

Mr. Chairman and Members of the Subcommittee:

On behalf of the National Veterans Foundation I would like to express our appreciation for the opportunity to appear before this Subcommittee.

I believe a short description of our organization is in order to put our concerns in perspective. Briefly stated, the National Veterans Foundation came into existence in 1985 and was founded by Shad Meshad, a psych officer with field experience during the Vietnam Conflict, co-author of the VA Vet Center Program, and the president of our organization. As a component of our own national toll free LifeLine, we

provide training for our counselors in crisis management including suicide prevention and intervention. In addition, we have 2 staff members who are mental health professionals trained extensively in trauma, crisis and suicide counseling and are on call to assist our staff answering the LifeLine and to intervene and/or follow up as the need dictates.

It should be noted that in addition to not having any contractual relationships with any governmental agency we are not a contracted crisis center with the National Suicide Prevention Lifeline.

More to the point of the task before this Subcommittee today, we have an area of concern we believe should be addressed by its Members to insure the Veterans Suicide Prevention Hotline is performing to its potential. Our concern is whether or not the personnel responding to calls received by the National Suicide Prevention Hotline after the veteran caller is directed to the VA medical center in Canandaigua, New York, have received the proper training in both suicide prevention and the causes of suicidal tendencies specific to veterans.

Why do we bring this concern before this Subcommittee? Unfortunately when our staff members have called the National Suicide Prevention Lifeline to test the services offered and were subsequently directed to the VA center in Canandaigua, the results were not satisfactory, at least not to the standards of our organization.

The primary advice given to our staff members was to refer them to the closest VA medical facility and advising them to "hang on" and be patient until that facility could contact them. Our concern is the reluctance of the person advising the caller to address any immediate suicidal ideation and the lack of exploration of other means to provide the caller with immediate assistance.

This leads us to believe the personnel receiving these calls are not properly trained. We could have simply experienced an anomaly in the system as we are not privy to the training guidelines used by the VA center in Canandaigua and our survey was not done with approved statistical sampling as that is not a function of our organization. But, to ignore the problems we experienced could place a veteran's life in danger.

If the caller simply receives the telephone number, address, and directions to the closest VA medical center, this would be wholly inadequate by anyone's standards. We offer the following questions that this Subcommittee may wish to investigate further and which we believe can be answered in the affirmative if the proper training is provided:

**Question Number 1:** Are procedures in place that provide for follow up communication with the caller if the need is determined during the initial call?

**Question Number 2:** Has an attempt been made to determine whether any veteran specific problems are the cause of the suicidal situation and, if so, was this information used to provide the caller with proper guidance?

**Question Number 3:** Are there mental health professionals trained in suicide prevention techniques and causes of suicidal tendencies specific to veterans available to immediately intervene if necessary?

**Question Number 4:** Are the personnel who staff the hotline adequately trained in crisis communication listening skills and suicide intervention?

We simply ask that this Subcommittee review the procedures, protocols, and training that are in place to insure a suicidal veteran can make a telephone call to seek help and know that properly trained professionals will answer their call.

The Congress and the President have been ardent supporters of training our active duty servicemembers to prepare them for any eventuality they might experience during combat. We believe the training of support personnel that help our servicemembers after they have left active duty is equally important.

Our organization remains available to answer any questions you or your staff may have and to provide you with any additional documentation you may request.

Mr. Chairman, again I thank you and the other Subcommittee Members for allowing me to appear before you today.

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**Prepared Statement of Henry Reese Butler II,  
Founder, 1-800-SUICIDE, and National Hopeline Network**

My name is Henry Reese Butler II, I am the founder of 1-800-SUICIDE and the National Hopeline Network of community crisis centers to which the calls are routed.

I started 1-800-SUICIDE in response to my own wife's tragic and preventable suicide on April 7th 1998. Prior to her death there was no national hotline for the prevention of suicide yet the common perception was that it already existed. There also was no money in the suicide prevention community to pay for such a service and the general belief in the United States was that you could not prevent suicide, so there was little motivation for potential donors and grant makers to provide the necessary funding. As a result, I sold my home, and used my wife's Life Insurance payment to create the Kristin Brooks Hope Center and start 1-800-SUICIDE. In 1998 there was only one crisis center in the network answering calls. By May of 1999 there were 8. By May 10th of 2000 there were 59 crisis centers in the National Hopeline Network. I mention this date because that was when Senator Domenici invited me to speak before a briefing on the Early Intervention and Mental Health Treatment Act of 2000. One of the outcomes of that speech was Senators Kennedy and Wellstone agreed to draft legislation to support 1-800-SUICIDE and the building of the National Hopeline Network.

Ten years ago this week 1-800-SUICIDE went live. It was called the National Hopeline Network and to more than 3 million callers in the United States it was and remains a lifeline, a source of hope and help in their darkest hour. However in the last 4 years the federal government through the Substance Abuse and Mental Health Services Administration (SAMHSA) has tried to snuff out that link to help and hope, tried to rename it, and in the end have issued press release after press release distorting the truth about 1-800-SUICIDE and the Veterans Suicide Hotline.

**Ten Reasons the Government owned and operated national suicide hotline for veterans cannot ever be effective**

1. Veterans are not calling the government owned suicide hotline-despite the fact that SAMHSA and the VA are claiming more than 22,000 veterans have called 1-800-273-TALK. This statistic is misleading at best. If you examine the **Chart #2** at the end of this testimony regarding the call volume on the entire network from July of 2006-July of 2008 and focus on the three months before the "veteran hotline" went live in July of 2007 and the three months after it went live the overall stats are statistically unchanged. Yet they claim in the three months after the VA Suicide hotline went live to have received an increase of 12,000 calls to the VA Center in Canandaigua NY. This would have to mean that all along (for years long before the VA Suicide Hotline was created) that our hotlines were getting 4,000 calls a month from veterans. We know this not to be true from our studies and evaluation of callers on the Hopeline Network. All the VA and the SAMHSA did through their contractor Link2health Solutions is add a voice tree on their existing National Suicide Prevention Lifeline that states if you or your family member is a veteran press Option #1 and you will get a Counselor. A much simpler explanation is that when people in crisis call 1-800-SUICIDE or 1-800-273-TALK they opt for pressing Option #1 because they know that will get them to a counselor faster. Our experiences with the Red Cross and the Salvation Army have historically shown that 10% of all callers who complete the call will press option #1 regardless of where it takes them.
2. Even if a Veteran calls 1-800-273-TALK the call takers (clinicians) violate the most basic fundamental rule of helper behavior. That is gaining the trust and confidence of the caller by showing genuine empathy. In clinical studies the length of time to gain the needed level of trust and confidence takes an average of 10 minutes. The calls on the VA Suicide hotline are an average of 8 minutes. In the governments own funded evaluation of 1-800-SUICIDE (not 1-800-273 TALK as has been misrepresented to the media and Congress) empathy and respect, as well as factor-analytically derived scales of supportive approach and good contact and collaborative problem solving were significantly related to positive outcomes . . . for a complete review of this landmark study go to: <http://www.atypon-link.com/GPI/doi/pdf/10.1521/suli.2007.37.3.308>
3. 1-800-273-TALK does not invoke any connection to the veteran community. It does not speak to the callers needs or suggest in any way this is a hotline for them. However, KBHC's 1-877-VET2VET (838-2838) is both easy to remember numerically as well as visually. It also speaks to the veteran community by invoking the peer connection—a Veteran talking to a Veteran. KBHC offered this line to the federal government to insure that this program would be a success, but they did not even acknowledge the offer. Even New Jerseys veteran peer hotline is closer to what veterans would expect a number to look like. 1-866-VETS-NJ4U. As difficult a number as this one is to remember it

is far better for Veterans than 1-800-273-TALK, where the veteran connection is only gained by calling the number and focusing on the veteran option. In this case, press Option #1 if you are a Veteran. This option may be overlooked by callers in immediate crisis.

Our veterans deserve far better than talk or a hotline that is for general crisis with a voice tree option for Veterans to choose from.

4. Chance of a misdial on the 1-800-273-TALK hotline. As this is not an easy number to remember like 1-800-SUICIDE there is a high incidence of calls ending up at 1-800-272-TALK, and 1-800-274-TALK.
5. In a recent survey of all 1-800-\*\*\*-TALK lines better than 50% were found to be adult sex lines. In fact the following numbers are all sex hotlines; 1-800-270-TALK, 1-800-272-TALK, 1-800-277-TALK, 1-800-278-TALK, 1-800-279-TALK, 1-800-280-TALK.

Case in point. The owners of 1-800-274-TALK, Radio North, have fielded thousands of misdialled calls. One of the key advisors of the 1-800-273-TALK line, Marcia Epstein, sent me an email just last week where she was asking questions about 800-SUICIDE and referred to 1-800-273-TALK as 1-800-272-TALK. If the hotlines own leaders and advisors cannot remember the number how can we expect a veteran with PTSD, or further any individual in crisis to remember it, and dial it properly?

6. The Veterans Administration and the Substance Abuse Mental Health Administration have been issuing press releases \*\*, (see p. 43) and giving interviews since the launch of the Veterans Suicide Hotline line in July of 2007, that have been grossly misleading. In fact in testimony given before the VA Committee on Veterans Affairs in May of this year, statistics about calls to the NSPL failed to include the fact that better than 50% of all calls to the VA Mental Health Center of Excellence in Canandaigua originated on the 1-800-SUICIDE hotline. As recently as yesterday the SAMHSA issued an additional misleading and inaccurate press release stating that the NSPL was founded in 2001, and that its call volume began at 1500 a month and now receives over 45,000 calls per month. This press release credits viral marketing and other Internet marketing for the significant increase. The chart at the end of my testimony clearly shows that the increase came as a result of the call volume/traffic on 1-800-SUICIDE to be routed to the 1-800-273-TALK network. This occurred as a result of the SAMHSA misrepresenting the facts regarding a manufactured crisis to the FCC; subsequently the control of 1-800-SUICIDE was taken on a temporary basis from the Kristin Brooks Hope Center, the founding agency and given to the SAMHSA in February 2007. With the launch of the Veteran Suicide Hotline just months away in July of 2007 it is now very evident why the SAMHSA was so eager to get control of 1-800-SUICIDE. That temporary order remains in effect 20 months later.
7. Because 1-800-273-TALK is government owned and controlled, innovation and creativity is naturally stifled by the bureaucracy that is self-preserving. What makes a hotline effective is first and foremost that your target audience is calling the number you market. Then the real job begins and it requires a building of trust, confidence and the call taker displaying genuine empathy.
8. In the ten years since I have founded and built the National Hopeline Network, 1-800-SUICIDE and 9 other prominent suicide hotlines such as the 1-877-VET2VET and 1-800-SUICIDA for Spanish speaking callers, there is one thing that has been a constant—and that is change. We have had to adapt to change as studies revealed new best practices. Not wait years for change but to make them sometimes on the fly as in the case with Hurricane Katrina. As we watched the storm head up the Gulf for New Orleans we rallied our crisis centers to take overflow from the Gulf Coast and reroute the calls to Nebraska, Atlanta and other points out of harms way. We did not flinch when Tipper Gore asked us to handle the crisis calls from the White House Conference on Mental Health that kicked off a campaign on MTV, VH1, Nickelodeon and other high volume channels. We went from 8 crisis centers taking calls at the beginning of the month and had 59 centers signed on board to take the calls by the end of the month. Sometimes it required waiving many of the rules and sticking points in our contracts. We still answer that line 8 years later with no funding from the government. We operated and still operate as an agile PT Boat. The 1-800-273-TALK is an Aircraft Carrier and cannot get out of its own way.

A case in point: During the first full month after the SAMHSA took over control of 1-800-SUICIDE, Oprah aired our number without warning to us. The area code for her show, in downtown Chicago was being routed to a clini-

cian on call via a pager instead of to the crisis center at which he worked. Oprah's front office was being slammed with complaints that 1-800-SUICIDE was not working. I called the SAMHSA to alert them and get the routing fixed.

Their response from SAMHSA Press Relations Office was to scold Oprah's people for using 1-800-SUICIDE instead of 1-800-273-TALK. The Director and his staff were all in China for a conference. No one at SAMHSA could make the executive decision or would make one. I got off the phone with the SAMHSA and called the CEO of the telephony company (which we were in the middle of a multi million dollar lawsuit regarding the taking of our hotline which they participated in) to solve the problem. I let them know that lives were at stake and to their credit in minutes the problem was solved.

9. In study after study peer counseling (see abstracts on p. 6-8) has proven to be more effective than clinical counseling. It does not matter if it is a teen hotline, breast cancer, AIDS, or rape hotline, the best outcomes are achieved when the caller can connect with the call taker. This involves understanding the real problems and issues the caller is facing. If the call taker has never experienced the things the caller has it makes it harder to relate in any credible fashion. For example if a man is taking a call from a woman who has been raped, or is suffering post partum depression how can he ever say to the woman "I know what that feels like?" It is no different for the veteran. Veterans who suffer PTSD have faced scenarios no one other than a veteran or active duty service man or woman has faced.
10. The worst results in the government owning the veteran suicide hotline is the reality that 1) confidential data on callers is being sent to the Federal Government and 2) the form of response they send when the crisis line worker determines that a "rescue" is necessary. Rescue is the police. Sending an armed untrained person to de-escalate a veteran suffering from PTSD is the worst possible solution and at best will result in the veteran not trusting the hotline, being humiliated, more stress added to the already stressed veteran. The worst outcome is of course suicide by cop that occurs more frequently than we would like to believe.

We are losing 5,000 veterans a year to suicide. They deserve better than option one on a generic crisis hotline and the response should be trained empathetic mental health professionals who can best de-escalate a psychiatric crisis. The ironic part is the SAMHSA helps pay for over 800 of these PET (*Psychiatric Emergency Team*) and ACT (*Assertive Community Treatment*) teams and yet none are even networked with the VA hotline much less any of the community based crisis hotlines.

#### **Why SUICIDE Crisis Lines should be owned and operated by NGO's**

- Individuals in crisis would not likely call a crisis hotline they knew was operated by the Federal Government
- KBHC purges individually identifiable information on callers to 1-800-SUICIDE on a monthly basis. Currently the federal government receives the phone numbers (caller id—even for those who block their numbers) and has not even identified the need for a plan to protect the personal information obtained on callers in crisis
- Without a strict confidential policy on data obtained on callers, information could be used against individuals who called suicide crisis lines who attempt to obtain credit, life and health insurance and mortgages.
- Even if the current Administration adopted a confidentiality plan for callers to suicide crisis line, nothing would prevent future Administrations from changing or abandoning this policy.
- KBHC has demonstrated a full commitment to national suicide crisis lines that connect callers in crisis to the closest crisis center to them so that effective referrals to social, community and health supports can be made.
- Over the past decade, the Federal Government has systematically been dismantling this nation's social safety net, Medicaid, Medicare and aid to families with dependent children. In 2008, Congress was unable to override a Presidential veto that significantly cut the number of children who received health insurance through SCHIP. These were children whose parents did not obtain health benefits through work, or who were unable to afford health insurance.
- The Substance Abuse and Mental Health Services Administration does not have the Congressional authority to operate a national suicide crisis line and given the current level of funding for the Wars in Iraq and Afghanistan, there is no certainty that subsequent Administrations will support current levels of support or any support at all.
- The government by its own admission does not provide care. It is an institution.

- KBHC founded 1-800-SUICIDE out of a sincere desire to prevent suicide and offer unconditional support and hope. The Federal Government wants 1-800-SUICIDE because no national mental health programs existed after the eighties.
- With the government's history of spying on its own people it cannot be trusted to protect the data on callers to 1-800-SUICIDE or 1-800-273-TALK.
- Rescue is sent in the form of police by the current network under control by the government.
- KBHC will work to move rescue to the psychiatric emergency response teams and improve the line/network in many ways that only innovative, non-bureaucracy driven advocacy organizations can do. For example using punk rock concerts to raise awareness, recruit volunteers to become trained peer counselors.
- When 1-800-SUICIDE was a grass roots advocacy effort the local agencies were happy to be a part of a positive movement. When the government took over the control they heaped reporting requirements onto the small non-profit agencies that made being a part of the network unattractive. It is safe to say that government ownership could in the end kill 1-800-SUICIDE. They could not conceive of it, nor create it, nor can replicate the good will generated by its amazing story, yet with the simple stroke of its bureaucratic might crush it and the spirit from which it emanated.
- Since when did the U.S. Government get an award for running anything efficiently and better than the private sector?

**“Why would we ever want the government to run a social service that is designed to empathetically and unconditionally care about each and every person who comes in contact with the program?”**

**SAMPLE recent misleading Press Release by the SAMHSA**

\*\* Embargoed for Release                      Contact: SAMHSA Press Office, 240-276-2130  
12:01 a.m., Wed., Sept. 10, 2008              www.samhsa.gov

**More Americans Than Ever Turn to the National Suicide Prevention Lifeline Network Hotline (1-800-273-TALK) for Help with Suicide-Related Problems**

*Innovative support programs offer hope to an average of 43,000 people a month in crisis.*

The National Suicide Prevention Lifeline 1-800-273-TALK (8255) has become the nation's leading source of immediate help for those dealing with suicide-related issues, according to new figures from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA announced that the National Suicide Prevention Lifeline (Lifeline) received nearly 500,000 calls in the past year from people seeking help for themselves or someone for whom they cared. The Lifeline is operated by SAMHSA's grantee Link2Health Solutions, Inc., under a cooperative agreement. The Lifeline was established in 2001 to provide a system of immediate, round-the-clock, reliable, skilled assistance to everyone struggling with suicide issues.

Further information on the National Suicide Prevention Lifeline and other SAMHSA suicide prevention grant programs can be obtained by visiting SAMHSA's website <http://www.samhsa.gov/>. *SAMHSA is a public health agency within the U.S. Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions treatment and mental health services delivery systems.*

###

**Abstracts of Evaluation of Crisis and Peer Hotlines**

**Which Helper Behaviors and Intervention Styles are Related to Better Short-Term Outcomes in Telephone Crisis Intervention? Results from a Silent Monitoring Study of Calls to the U.S. 1-800-SUICIDE Network**

<http://www.atypon-link.com/GPI/doi/pdf/10.1521/suli.2007.37.3.308>

Brian L. Mishara, PhD, Franç Lois Chagnon, PhD, Marc Daigle, PhD, Bogdan Balan, MD, PhD, Sylvaine Raymond, MA, Isabelle Marcoux, PhD, Cécile Bardon, MA, Julie K. Campbell, BS, and Alan Berman, PhD

A total of 2,611 calls to 14 helplines were monitored to observe helper behaviors and caller characteristics and changes during the calls. The relationship between

intervention characteristics and call outcomes are reported for 1,431 crisis calls. Empathy and respect, as well as factor-analytically derived scales of supportive approach and good contact and collaborative problem solving were significantly related to positive outcomes, but not active listening. We recommend recruitment of helpers with these characteristics, development of standardized training in those methods that are empirically shown to be effective, and the need for research relating short-term outcomes to long-term effects.

\*This study was conducted under contract with the American Association of Suicidology in fulfillment of the evaluation requirements of Grant No. 6079SM54-27-01-1 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Thanks to Reese Butler, the Kristin Brooks Hope Center staff, Jerry Reed, and the Directors and helpers at the crisis centers who participated in this study.

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"The single most important environmental influence on student development is the peer group. By judicious and imaginative use of peer groups, any college or university can substantially strengthen its impact on student learning and personal development" (Astin, 1993, pxiv)

**ERIC #: ED399504 Title:** *Assessment—Service—Training: The Many Faces of a University Peer Hotline.* **Authors:** Curran, Jack

In this study, a peer-operated university-based anonymous hotline is a data source for the assessment of student concerns and needs, providing empirical information for prevention-oriented psycho-educational campus programming. This paper covers the collection and assessment of data from the anonymous hotline service of the Middle Earth Peer Assistance Program at the State University of New York at Albany. For the 1994–95 academic year, peer assistants recorded information on all calls to the hotline: demographic, call content, and counselor's response. Five tables reflect the patterns of usage of the hotline, representing the topic and frequency of calls and gender of caller. Data indicates that males used the hotline more than females, with most male repeat callers discussing sexual issues. Females, twice as likely to be non-repeat callers, were concerned with such issues as assault, rape, and eating disorders. Training undergraduate hotline staff to record calls with a data collection instrument is vital to the assessment of patterns of usage. Empirical analysis guides future curricula and the targeting of program intervention while acquainting students with the research aspect of the mental health profession. Appended are two recording instruments, and several tables which present statistical analysis. (LSR)

Paper presented at the Annual Conference of the American Psychological Association (103rd, New York, New York, August 11–15, 1995).

**Evaluation of a Peer-Staffed Hotline for Families Who Received Genetic Testing for Risk of Breast Cancer**

Authors: James C. Coyne; Pamela J. Shapiro; PENNSYLVANIA UNIV PHILADELPHIA

This study was prepared for U.S. Army Medical Research and Material Command Fort Detrick, MD 21701-5012

Abstract: This project proposed to develop, implement, and evaluate a peer-staffed toll-free hotline for individuals at high risk of developing hereditary breast cancer, either through family history or known BRCA1/2 mutations. The project is designed to demonstrate the acceptability and effectiveness of this tool for meeting the needs of these individuals and their families, and documents the range of problems for which assistance is sought. We have designed and implemented a refined peer counselor protocol that can be disseminated in larger multiple component peer-support packages. The Helpline Manual and Resource Guide was completed and distributed to our volunteers as part of an intensive training program. We successfully established the hotline, now called The Penn/F.O.R.C.E Telephone Helpline for individuals Concerned about Hereditary Breast and Ovarian Cancer," and opened the phone lines to the public on December 2, 2003. To date caller response to this service has been enthusiastically positive and has resulted in uptake of referrals to genetic counselors and gynecologic oncologists. Our counselors have addressed both psychosocial and practical issues associated with knowledge of mutation status, anxiety about personal and familial risk, communications difficulties with family and

health professionals, concerns about discrimination, and difficulties accessing appropriate medical and support services.

**The Mental Health Service at Harvard University HS**, in conjunction with the Bureau of Study Counsel, oversees the training and supervision of five undergraduate peer counseling groups and one graduate group of peer counselors. All five of the undergraduate peer counseling groups offer confidential hotline and drop-in counseling throughout the academic year; the graduate group offers a confidential hotline.

**Innovative training and evaluation at California hotline supports volunteer-driven, client-centered service.**

Heft L; International Conference on AIDS. Int Conf AIDS. 1998; 12: 697–8 (abstract no. 33550). S.F. AIDS Foundation, California, USA.

**ISSUES:** Ongoing evaluation, interactive training methodology, volunteer support and creative information management combine in the delivery of an HIV/AIDS information hotline. **PROJECT:** The California HIV/AIDS Hotline is a statewide service of the San Francisco AIDS Foundation. The trilingual hotline is staffed by 100 volunteer health educators who provide free and anonymous information, counseling and referrals to 120,000 callers annually. Volunteers access a database, consisting of over 5,000 community based organizations, via the Internet to provide resource referrals and collect caller demographic data. An Intranet, which will consolidate technical information with a mental health approach, is under development. Peer health educators trained as interactive presenters teach new volunteers (quarterly) in topics ranging from immunology to psychosocial issues. Materials and methods are constantly adjusted to reflect changing HIV information, peer evaluation and effective learning techniques. Hotline educators are evaluated by quarterly testing and call monitoring. Ongoing training includes weekly information memos, quarterly informational updates, individualized learning opportunities, and computer and Internet training. Volunteer support includes resume assistance, letters of reference, computer training, recognition of birthdays, illnesses and family events, and social opportunities. **RESULTS:** The Hotline documents caller gender, language, location, ethnicity, age, risk and caller concerns. A total of 1,297 or 92% of 1,392 callers sampled reported that their call increased their knowledge that some of their personal activities might put them at risk for HIV infection. One-hundred percent of callers sampled responded that they would use this service again and refer it to their friends and loved ones. Volunteer retention remains above a projected 70% retention rate. **LESSONS LEARNED:** The coordination of interactive training methodology, ongoing evaluation and training, volunteer support and creative information management combine to support a high-quality volunteer-powered, client-focused, free and anonymous resource for peer counseling, information and referrals for 120,000 callers annually.

**Government News**

**Peer Counseling, Family Education Could Ease Vets' Transition**

Aaron Levin

Mandatory readjustment counseling, more complete data on substance abuse treatment, and more responsive employees could improve VA services to Iraq and Afghanistan veterans.

The heavy reliance on National Guard and Reserve troops, with many units drawn from small towns, has increased the need for mental health services far from the usual sites of the Department of Veterans Affairs, Ralph Ibson of Mental Health America told senators in Washington, D.C., in April.

The stress of combat is only worsened by repeated tours of duty, he said at a hearing of the Senate Committee on Veterans Affairs.

"Half of all Army National Guard soldiers and 45 percent of Army and Marine reservists report mental health issues on their return from war," he said. "The VA can do more and should do more for them."

The VA health system has great strengths, he added. However, "it is a facility-based system that does not necessarily provide good access to care for veterans in rural America or in other areas remote from healthcare facilities."

Readjustment counseling could benefit most returning veterans, he said, but that help was usually limited to the 200 readjustment counseling centers (also called vet centers) and is not available at the VA's medical centers and clinics. There was no barrier preventing these larger sites from also providing such services, however, Ibson said.

Women make up 15 percent of the forces in Iraq and Afghanistan and even their “noncombat” roles—like driving trucks, flying helicopters, or serving as military police—frequently exposed them to traumatic episodes that would meet any definition of warfare.

“The jury is still out on care of women veterans and the perceptions of the VA as a welcoming, caring place for them,” said Ibson.

Ibson offered several suggestions for helping veterans and their families cope with the return of servicemembers.

The VA should develop peer-based outreach programs by training veterans of Iraq and Afghanistan to work at the VA or in the community to provide support for vets and make VA facilities welcoming environments. Families should also be offered services, at least for a specified period after a servicemember’s return home. Help for small-town or rural veterans might be offered at local community mental health centers, where they exist.

Finally, the window of eligibility during which veterans may sign up with the VA without proving a service connection for any complaints should be extended from two to five years.

Earlier in the hearing, the senators heard from families of a soldier and a Marine who had returned from Iraq and later died.

The parents of Spc. Joshua Omvig of Grundy Center, Iowa, an Army Reserve military policeman, told how their son was “unable to live with the physical, mental, and psychological effects” of his time in Iraq and committed suicide a year after he returned home from an 11-month tour in Iraq.

To avoid tragedies like their son’s, other troops need peer counseling before they come home, family education and outreach, increased training on recognizing symptoms that could lead to suicide, and substance abuse treatment, said Randall Omvig. While troops are still in uniform, their transition back into civilian life might be eased by having them spend days doing service-connected work while spending evenings and nights with their families.

“It helps them process their experience,” said Omvig. “It would help them live the American dream that they fought for.”

Justin Bailey, a Marine veteran of the invasion of Iraq, died on January 27 in the West Los Angeles Veterans Affairs Hospital of an apparent overdose of prescription drugs, his father, Tony Bailey, told the senators. Despite a history of overusing drugs prescribed for pain from a war injury and for PTSD, Justin was given two-to four-week supplies of benzodiazepines, antidepressants, and methadone. Tony Bailey blamed “apathy and complacency” in the VA for his son’s death.

“Nobody cared until I was on ABC News,” said Bailey, who served 20 years in the armed forces. Families of veterans needed to advocate for patients in the VA, he said. “Always ask questions. Don’t assume the VA will help without someone to push.”

Speaking on behalf of the VA, Ira Katz, M.D., Ph.D., deputy chief patient care services officer for mental health, said the VA was already hiring more suicide prevention coordinators and was working to integrate its approach to substance abuse and mental healthcare.

“We want accountability,” said Katz. “But we must go beyond narrow silos.”

The effects of the “invisible wounds” suffered by veterans of the current conflicts will be felt for many years, said Sen. Daniel Akaka (D-Hawaii), the Committee’s chair, but he expected that the VA would adapt to meet the mental health needs of those and all veterans.

#### **Veterans Counseling Hotline—1-866-VETS-NJ4U**

On April 13, Maj. Gen. Glenn K. Rieth, The Adjutant General of New Jersey and Colonel (Ret) Stephen Abel, Deputy Commissioner for Veterans Affairs along with John J. Petillo, Ph.D., President, University of Medicine and Dentistry of New Jersey (UMDNJ), and Christopher Kosseff, President and CEO, University Behavioral HealthCare (UMDNJ) to announce the creation of a new, mental health helpline for veterans returning from service in Southwest Asia.

The new toll free number will provide immediate assistance to veterans suffering from psychological or emotional distress as well as those having difficulty re-assimilating back into civilian life following the conclusion of their mobilization for active duty service.

The toll free helpline, which is accessible 24/7 by dialing 1-866 VETS-NJ4U (1-866-838-7654) will be coordinated by UMDNJ’s University Behavioral HealthCare, and will feature peer counseling, clinical assessment, assistance to family members and will provide New Jersey veterans and their families with access to a comprehensive Mental Health Provider Network of mental health professionals special-

izing in PTSD (Post Traumatic Stress Disorder) and other veterans issues. All services are free and confidential.

**Teen Line: 1-800-443-8336 1-800-735-2942 (TT/TTY) 24 hours a day, Confidential, Free!**

Provides Peer-to-peer counseling for teens in the following areas:

- Health
- Eating/Weight
- Relations with Parents or Friends
- Violence
- AIDS/HIV
- Alcohol or Drug Use
- Sexual Relationships
- Birth Control/Pregnancy
- Stress
- Sexually Transmitted Diseases

The line is a service of the Iowa Department of Public Health and answered 24 hours a day through a contract with Iowa State University Extension.

**Effectiveness of a peer counselor hotline for the elderly** Nancy Losee, Stephen M. Auerbach\*, Iris Parham Virginia Commonwealth University

\*Correspondence to Stephen M. Auerbach, Department of Psychology, Virginia Commonwealth University, Richmond, VA 23284

Funded by:

Administration on Aging (DHHS); Grant Number: #03AT106

Abstract

The effectiveness of a crisis hotline using elderly peer counselors was evaluated. Use of the agency's telephone services by callers over the age of 60 increased significantly with implementation of the hotline. Follow-up data obtained from callers indicated that the hotline successfully addressed caller problems in a significant proportion of cases and that those who contacted the service were generally well satisfied. Volunteers who achieved higher levels of Technical Effectiveness (TE) after training were more effective in helping callers resolve their problems and in generating appropriate referrals, but did not produce greater subjective feelings of satisfaction in callers. The reverse finding was obtained for volunteers who attained high levels of Clinical Effectiveness (CE) after training. Results are discussed in terms of the extent to which technical and clinical elements should be incorporated into elderly hotline volunteer-training programs, the utility of the TE and CE scales, and considerations regarding the need for elderly peer counselors in such a setting.

**Fenway's Gay, Lesbian, Bisexual and Transgender Helpline and The Peer Listening Line** are anonymous and confidential phone lines that offer gay, lesbian, bisexual and transgender adults and youths a "safe place" to call for information, referrals, and support. In addition to issues like coming out, HIV/AIDS, safer sex and relationships, our trained volunteers also address topics such as locating GLBT groups and services in their local area.

Gay, Lesbian, Bisexual and Transgender Helpline

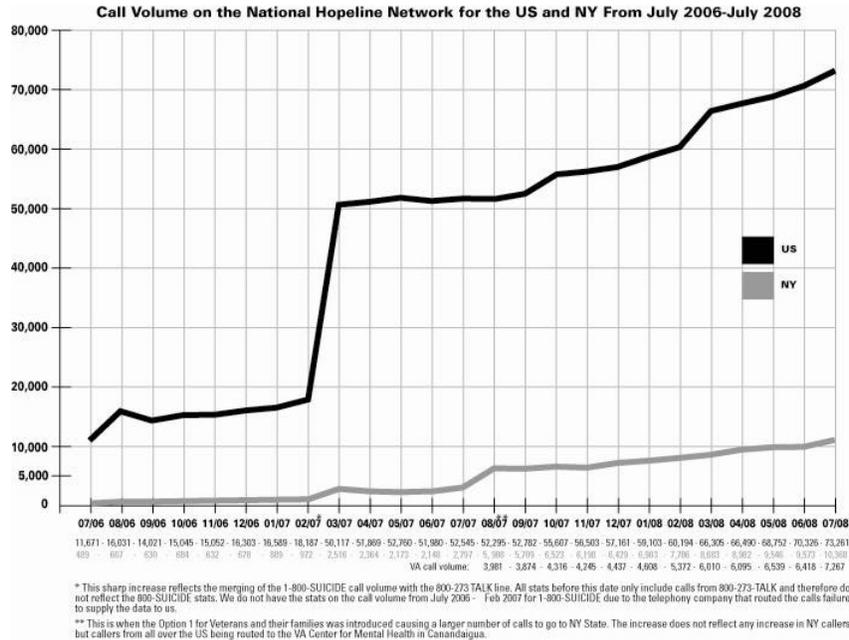
617-267-9001

Toll-free—888-340-4528

Peer Listening Line 617-267-2535 Toll-free—800-399-PEER

You can receive help, information, referrals, and support for a range of issues without being judged or rushed into any decision you are not prepared to make. Across the country, Fenway's HelpLines are a source of support. Talk to our trained volunteers about safer sex, coming out, where to find gay-friendly establishments, HIV and AIDS, depression, suicide, and anti-gay/lesbian harassment and violence. No matter what is on your mind, we are here to encourage and ensure you that you are not alone.

<b>Government Owned vs. Privately Owned Hotlines</b>	
<b>Government Owned</b>	<b>Privately Owned</b>
Fewer people will call if they know the hotline is owned and controlled by the government.	More people are likely to call and trust a privately owned hotline that promises confidentiality.
The government sends rescue in the form of police.	KBHC advocates the use of our <a href="http://www.pern.us">www.pern.us</a> which connects the crisis center to trained emergency psychiatric rescue teams.
The government has no transparency or proof that they are not storing or compiling data on callers.	KBHC's Board of Directors has adopted a policy that mandates purging of our data on a monthly basis.
The Government cannot assure funding past the current fiscal year or current Administration.	KBHC created and built the Hopeline Network and remains dedicated to support the line as its primary mission.
The government does not disclose to the public that it owns and controls the suicide hotline. The real decision-makers are not known or available to the public.	KBHC discloses its Board of Directors who are the decision-makers in all matters concerning the Hopeline Network.
The government does not have Congressional Authority to own and or operate a suicide hotline.	KBHC's entire incorporated mission legally binds it to the work of connecting people in crisis to community-based crisis centers.
The government typically runs programs in a slow and unresponsive bureaucratic manner.	KBHC is lean and responsive and takes immediate action to fix problems and move to meet the needs of the callers and the network.



**Prepared Statement of Ian A. Shaffer, M.D.  
Chief Medical Officer, MHN, A Health Net Company, San Rafael, CA**

**INTRODUCTION**

Mr. Chairman and distinguished Members of this Committee, I would like to thank you for inviting us to share our experiences with the VetAdvisor Support Program, an innovative pilot program designed to assist Veterans Integrated Services Network (VISN) 12 Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans learn about and obtain Veterans Health Administration (VHA) mental healthcare services. We appreciate the opportunity to offer our perspective on how this unique, proactive telephonic outreach program serving OEF/OIF veterans uses innovative solutions to help address physical and behavioral health issues common to those serving in combat.

We thank the Committee for its leadership and interest in this important issue and for allowing us to educate the Committee on a proactive behavioral health outreach program we believe has the potential to assist veterans not only in VISN 12, but in VISNs across the country. Recently, a blue ribbon panel praised the VA for its "comprehensive strategy" in suicide prevention that includes a "number of initiatives and innovations that hold great promise for preventing suicide attempts and completions." We believe that VetAdvisor plays a role in this strategy.

**PROGRAM OVERVIEW**

As the Committee is acutely aware, OEF/OIF veterans face many stressors and adverse situations—life-changing events that may impact their professional and personal lives for a long time. After returning home from deployment in Iraq or Afghanistan, veterans may suffer from health issues such as Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), depression, social withdrawal, drug/alcohol abuse, and suicide ideation. VISN 12 recognized the need to ensure that all OEF/OIF veterans have access to the healthcare services they may need via a seamless transition into VHA. VISN 12 also recognized the fact that, in order to be most effective at identifying and preventing behavioral health issues, mental health services must be integrated into the primary care system. To address these needs, VISN 12 established a pilot program designed to reach out to OEF/OIF veterans.

This pilot program, now called VetAdvisor, consists of two distinct programs:

**Program One—Welcome Home Program—Outreach and Screenings**

- Eligible OIF/OEF veterans are called, welcomed home and thanked for their service;
- Veterans are made aware of healthcare services available to them;
- Veterans are asked if they would like to complete a telephonic screening to assess for common health conditions associated with service as a combat veteran (TBI, PTSD, Suicide Risk, Depression, Alcohol, etc.);
- Screening results are shared with the VA Medical Center (VAMC) medical and behavioral health teams; and
- Veterans who screen positive on the assessments are offered more in depth evaluation, and guidance by the specific VAMC medical and behavioral teams.

**Program Two—The Total Health Program—Care Coaching**

- Veterans are identified whose behavioral issues may have an impact on their well-being;
- Once identified, they are encouraged to enroll in the Total Health Program;
- A Care Coach is assigned for regular contact, advocacy and support;
- Coordination continues with veteran, Care Coach, and Primary Care Physician for an extended period;
- Program design recognizes behavioral challenges and empowers Veterans to overcome these setbacks to successfully rejoin the civilian lifestyle utilizing existing support programs available;
- Care Coach and Veteran collaborate to support change by setting goals and objectives in response to the veteran's needs; and
- A proactive solution is developed to address specific issues, but in addition a total healthcare program is planned.

Three Wire, a Service Disabled Veteran-Owned Small Business (SDVOSB), and MHN, were honored to be chosen by VISN 12 to administer its VetAdvisor Support Program ([www.vetadvisor.org](http://www.vetadvisor.org)).

The VetAdvisor pilot program provides vital outreach and screening to veterans for behavioral issues that might otherwise go unrecognized and therefore, unresolved. Since eligible veterans may be busy focusing on re-integrating back to their jobs and families, or they may live in rural areas with no nearby VA medical facility, the program is based on a model where OEF/OIF veterans are proactively contacted. VetAdvisors' telephonic approach addresses these needs, providing service when and where the veteran chooses.

While VetAdvisor screens for a number of potential behavioral health conditions, the program has a strong suicide prevention component. When the program began in February 2008, Care Coaches were providing a basic screening for suicidal tendencies. In May, VISN 12 provided our Care Coaches with a more in depth 'Global Assessment of Risk' to complete for any veteran with an initial positive screening result. This detailed assessment provides more in-depth feedback on the individual's state of mind to better indicate any need for immediate intervention.

The VetAdvisor Support Program uses VA-approved screening tools to help identify those veterans who might be thinking about suicide. With early identification, the VA can assist veterans who screen positive in obtaining needed support services. If a veteran is identified as being in a crisis situation while completing the suicide screening, the Care Coach follows approved protocols to provide help and ensure the veteran is safe. After resolution of the emergent situation, the Care Coach follows up directly with the specific VAMC to provide notification on a 24 hour a day basis, 365 days a year.

**HOW VETADVISOR WORKS**

VetAdvisor provides telephonic outreach to recently returned OEF/OIF veterans within VISN 12. They are reached at home, or on mobile phones, and follow-up screenings can be scheduled at a time convenient to the veteran. By design, this program attempts to reach veterans when they have an opportunity to really listen and to understand the services that are available to them. Moreover, it is designed to help motivate veterans who realize they may benefit from help—to seek that help.

An outbound call made by a counselor overcomes any reluctance a veteran may have to call for help. Moreover, by calling all OEF/OIF veterans, it helps to reduce the "stigma" of accessing mental healthcare. The call is completely private and confidential—only 'duty to warn' (risk to self or others) applies and is explained to the

veteran. Further, the contact presents an opportunity for the veteran to think about the issues that are being screened, permitting them to look at their struggles in a safe, non-threatening way.

#### *Identification of Eligible Veterans*

Each VA Medical Center in VISN 12 provides contact information for OEF/OIF veterans on file in the VAMC's catchment area. Our customer service representatives (CSRs) then review the veteran information prior to placing the outbound call to familiarize themselves with the veteran and his or her background. This review also allows the CSRs to identify veterans who recently were called by the VAMC to avoid duplicating efforts and to minimize the amount of calls veterans receive.

#### *Outreach Activities*

Once the veteran's data is received, it is entered into a VetAdvisor database that resides on the VA system and is protected by VA security measures. The CSRs and Care Coaches are able to access specific veteran information. This allows them to track attempted and completed outgoing calls, as well as to update veteran contact information. All updated contact information is shared with the VAMC so that the veterans' records can be updated.

The "Welcome Home" component begins with outreach calls to OEF/OIF veterans. With the first call, our customer service representatives extend a warm welcome home to the veterans and thanks them for their service to our country. As the conversation continues, the CSR will inform the veteran of VA healthcare programs for health conditions that are often a result of serving in combat.

Proactive outreach action is a major plus of this program. The veteran is contacted where they live and offered a friendly 'thank you' and 'did you know about the medical services available to you free of charge from the VA?' CSRs approach the initial call in a friendly, matter of fact manner. A typical call begins: *"Hi, I'm calling on behalf of the Department of Veterans Affairs and just wanted to say 'Welcome Home' and thanks for your service. I've been talking to a number of veterans who have told me that they are not sleeping very well, or they are feeling a little withdrawn or they might be drinking a little more than usual."* The CSR then explains the screening process and provides an overview of services available at the VA.

If the veteran agrees to participate in the VetAdvisor program, our CSRs will immediately "warm" transfer the veteran to a licensed clinician (Care Coach) for the completion of the screening process. Alternatively, if the veteran prefers a more convenient time, the CSR will schedule the veteran for a future telephonic appointment. The database allows the CSR to schedule the appointment as well as make any appropriate notes. It also allows the Care Coaches to retrieve the appointment information and to call the veteran back at the designated time for the screening process.

The CSRs' goal is to make contact and to schedule a screening by a Care Coach. They do this utilizing a warm, non-threatening approach in welcoming the veteran home. The screens they use are designed to elicit feedback from the veteran in a manner that encourages dialog. The Care Coaches' goal is to successfully contact the veteran, complete the screenings and provide those outcomes to the VA. They employ a more clinically disciplined screening process since the initial contact with the CSR has prepared and put the veteran at ease for this component of the interview/discussion.

Should the veteran screen positive for medical conditions, PTSD, depression, TBI, substance abuse, or suicidal thoughts/tendencies, the Care Coach sends a general e-mail screening notification (containing no personal health information) to the appropriate individuals at the specific VAMC for follow-up. All positive screenings are placed in a secured shared folder where VetAdvisor and VAMC personnel can retrieve the comprehensive screening results.

The screening results are then discussed with the veteran. The purpose of this feedback is so veterans will have a better understanding of the evaluation and will be more likely to accept help following the interview. Our experience suggests that in a private call where the veteran is not face to face with a clinician, the veteran is likely to open up and provide more candid responses.

#### *Transfers to the VHA*

The overall goal of VetAdvisor is to help the Veteran attain access to healthcare services at the proper point in the continuum of care. Veterans who screen positive for any of the six conditions will receive follow up from VA personnel at the appropriate clinic. Care Coach screenings are completed from scripts located within the VetAdvisor database (housed within the VA's IT systems). The results of a positive

screen are automatically generated to a 'positive screening folder' and a generic email is generated to individuals identified by the VA as points of contact at the impacted VAMC. These individuals can access this screening report and provide appropriate follow-up from VA clinics within that VAMC.

*Early Intervention—Identifies Those With The Potential To Be At Risk*

VetAdvisor operates independently of Post Deployment Health Risk Assessments (PDHRA) (required by DOD) that are usually conducted 60–90 days following deployment. Thus VetAdvisor may reach the veteran prior to the PDHRA or at a later time when the veteran is ready to talk, particularly since individuals may be more apt to provide information regarding their transition in a private (i.e. telephonic) setting. This follow up also could reach veterans who separated from the service and were not provided the PDHRA.

*Where Implemented To Date*

The pilot program was initiated to contact 5,000 OEF/OIF veterans in VISN 12. It was first implemented within the North Chicago VAMC beginning with "Welcome Home" calls in February 2008. It has been expanded to include Madison and Milwaukee, and we expect to include all remaining VAMCs (for a total of seven VISN 12 VAMCs) by the end of the year.

*Staff Qualifications*

VetAdvisor employs customer service representatives who are skilled at reaching out to individuals and are specially trained in working with veterans, with special emphasis on veteran issues related to serving in combat. They are able to demonstrate great tact in talking to veterans about potential physical and mental health problems they may be encountering post deployment. Our clinicians are licensed behavioral health clinicians with the experience and training to conduct effective telephonic assessments and are trained in the special needs of veterans who have served in combat.

## **PROGRAM SUCCESSES/RESULTS**

The success of VetAdvisor stems from the proactive, personalized approach to contacting veterans and welcoming them home, setting the stage for a more thorough assessment of the veteran's behavioral health status. Key points of its success include:

- The program provides a method of reaching out to patients in their homes where they are comfortable and allows for the veteran to be more willing to share some of their concerns.
- This program demonstrates that veterans are willing to admit to serious issues in a telephone interview.
- The screenings are identifying veterans with issues, and the screening can be a useful way of beginning a referral process for getting veterans the required treatment.
- There has been a high interest and gratitude from veteran community for the VetAdvisor Program. Of the veterans contacted to date, many have expressed their interest and appreciation of the program.

### ***Program Statistics***

#### **Demographic Data:**

- 32% aged 21–25; 31% aged 26–30, and 37% over 30.
- 89% male; 11% female.
- Over half the group never married; 33% were married.
- 49% ended active duty in 2006 or 2007. Others ended duty between 2003 and 2005.

#### **Overall Screening By Issue For The Entire Group:**

- 47% screened positive for substance abuse.
- 67% screened positive for medical symptoms.
- 17% screened positive for traumatic brain injury.
- 28% screened positive for PTSD.
- 11% screened positive for depression; 23% showed possible indications.
- 14% screened positive for suicide—if the veteran screens positive on an initial suicide screening the VA has provided and asked that the Care Coaches com-

plete a more in depth 'Global Assessment of Risk' to better identify an individual's risk of suicidality.

- **70% screened positive on at least one issue.**

\*\*These statistics are for NCH and Madison VAMCs, which have been completed to date. However the statistics also include Milwaukee data, which may skew the results slightly as we are in the early stages of calls and have not collected comprehensive data.

### CONCLUSION

VetAdvisor is identifying veterans who have not yet, and possibly never would, reached out to VA, assessing their issues, helping them understand the power and benefit of the VHA system and encouraging them to participate. Because the program is tailored to recognize the common strengths of the VISN, as well as specialized services of each VAMC, veterans receive the kind of guidance that encourages them to use the system rather than lead to frustration.

VetAdvisor functions well as a standalone pilot and is well suited to complement a variety of VA programs and initiatives designed to contact combat veterans who have not registered or accessed services by the VA. VetAdvisor clearly provides the next level of care and is therefore well suited to serve as a follow on program. VetAdvisor represents an excellent example of using contract services to reach a broad audience of veterans and provide tailored support and referral back to the most appropriate resources within the VHA.

#### Program Advantages:

- Outreach provided to a population, who for many reasons, will not seek help.
- Willingness of the veteran to answer questions openly in the privacy of their home.
- Ability of the veteran to listen as screening results are reviewed and recommendations made.
- Prompt referral to the VA for an initial evaluation for treatment fosters increased program participation, which can lead to better outcomes.
- Continuing access to a care coach means the veteran has someone to reach out to when unsure/needed, rather than to just drop out of treatment.
- The Program offers support through a robust call center, providing 24x7 coverage allowing for access most convenient for the veteran and a source of help should the veteran need to talk with a clinician at anytime.

On behalf of MHN and Three Wire Systems, I would like to thank you again for your interest in the VetAdvisor program and for your commitment to ensuring that our veterans receive the care and services they may need. I welcome your questions.

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#### Prepared Statement of Janet E. Kemp, RN, Ph.D., National Suicide Prevention Coordinator, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman, Mr. Ranking Member, and Members of the Committee:

Thank you for allowing me to testify on behalf of the Department of Veterans Affairs on the Department of Veterans Affairs' (VA's) Suicide Prevention Hotline and on VA's overall program for suicide prevention. I am pleased to report to you today on the programs and methods VA has developed that are saving lives and improving the quality of care our veterans receive. My name is Jan Kemp and I am the VA National Suicide Prevention Coordinator. I am accompanied today by Dr. Kerry L. Knox, Director, Canandaigua Center of Excellence for Suicide Prevention and Dr. Antonette Zeiss, Deputy Chief Consultant, Office of Mental Health Services. Before beginning a description of the programs we have implemented, I want to acknowledge that every veteran suicide is a tragedy for the veteran's family, friends, and our Nation as a whole.

In his testimony before the House Committee on Veterans Affairs on May 6 of this year, Secretary Peake announced the formation of a Blue Ribbon Work Group of Federal Partners to review VA's Suicide Prevention Program, and to make recommendations for enhancing it. On September 9, that Group praised VA's current program, noting that VHA has developed a comprehensive strategy to address suicides and suicidal behavior that includes a number of initiatives and innovations that hold great promise for preventing suicide attempts and completions. Moreover,

the Work Group also noted VHA is optimizing care through best clinical practices and is exploring additional system-wide policies to further reduce suicide risk. The Work Group complimented VA's efforts of incorporating new treatment modalities, such as cognitive behavioral therapy interventions, into clinical care based on emerging research. The Work Group made several recommendations addressing both the clinical and public health activities to further enhance VA's suicide prevention programs. VA is committed to following these recommendations and to ongoing review of its program for suicide prevention.

VHA's program for suicide prevention is based on the general principle that prevention requires ready access to high quality mental healthcare, as well as programs that target suicide prevention more directly. Regarding overall mental healthcare, VA has previously testified about increases in the budget for mental health services, from approximately \$2 billion in Fiscal Year 2001 to over \$3.5 billion this year and projected costs of over \$3.8 billion for FY 2009; about VA's hiring of almost 4,000 new mental health staff members since 2005; and for the successful implementation of a new standard of care last August requiring that new referrals or requests for mental health services be met with initial assessments within 24 hours and complete diagnostic and treatment planning evaluations within 14 days. The VHA standard is that 90 percent of new mental health patients must be seen within 14 days of the initial contact; every VISN is meeting this standard, while nationally, performance is at the 95 percent level.

I will focus now on our activities directly related to suicide prevention.

Suicide prevention requires both clinical and public health approaches. My testimony will first cover information about the VA National Suicide Prevention Hotline (the Call Center) and will later discuss the Hotline as a component of a clinical prevention program and a public health strategy.

#### **VA and the National Suicide Prevention Hotline:**

In July, 2007, VA launched a Veteran's Suicide Prevention Hotline as a collaboration with the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration and its Lifeline program. Through this partnership, VA's program benefits from several years of publicity for the Lifeline program. In turn, through the partnership, VA has been able to support awareness of the program for all Americans, as well as for veterans.

When someone calls the national Hotline number, 1-800-273-TALK, they receive a message saying that if they are a U.S. military veteran, or if they are calling about a veteran, they should press "1." When they do so, they are connected quickly to the VA Hotline Call Center in Canandaigua, NY.

When VA established this Call Center, we carefully reviewed the existing and emerging literature and identified training standards that all responders should meet. Consequently, the VA Call Center is staffed exclusively by mental health professionals, nurses, social workers, and psychologists with specific training as responders from one of the Lifeline Crisis Centers, in addition to their professional expertise. Moreover, by using VA's electronic medical record, responders are able to access the medical records of enrolled veteran callers willing to identify themselves. Additionally, responders maintain contact with Suicide Prevention Coordinators at each VA medical center and are able to refer callers for follow-up care. Finally, collocating the Call Center with the Center for Excellence in Suicide Prevention ensures a critical mass of staff to direct VA's current programs and to contribute to the research, education, and training that will guide us in the future.

The VA Call Center is staffed to respond to six call lines on a 24/7 basis. We are receiving more than twice as many calls, have more than doubled our staff, and tripled the number of lines we have over the past year and are able to conclude that some specific increases in demand can be attributed to the efficacy of public health messages. Occasionally, when the VA Call Center has reached capacity, veterans are transferred to one of several community-based "overflow" centers where the staff has received special training in veteran-specific issues; this tends to happen once or twice a day. However, VA constantly monitors the number of calls we receive and is prepared to respond and adjust our resources as necessary.

From its inception through August 2008, the Call Center responded to more than 69,300 calls. 32,854 callers identified themselves as veterans or veterans' family members or friends, while the rest of the calls were from others or from individuals who declined to disclose their veteran status. Among veteran-callers who identified their era of service, 35.8 percent were from OEF or OIF. Calls from veterans led to 5,980 referrals to Suicide Prevention Coordinators for follow-up for the problems that led to the call, and 1,628 rescues, calls to police or ambulances for immediate responses for those judged to be at imminent risk. Calls from those who were not identified as veterans led to 3,266 direct transfers where VA staff contacted a com-

munity-based call center while the caller was still on the line to transfer care. Calls from 789 active duty service men and women led to interventions to help them access Department of Defense (DoD) resources and to engage in care.

The Hotline has already demonstrated its success through the number of rescues made. A sample of these is submitted as appendix material. Another source of evidence comes from the follow-up on those referred to the Suicide Prevention Coordinators. There have been two known suicides from among the 5,980 referrals. From the start of Fiscal Year 2008 through the end of July 2008, the Coordinators engaged in care for 91.8 percent of those referred; the other callers gave incorrect information. VA engages with every veteran we can reach. Contact led to new enrollment in VA for 2.6 percent of referrals, immediate evaluations for 6.6 percent, and hospital admission for 18.5 percent, while the rest were referred to a coordinator who facilitated access to other program; 1.8 percent of service men or women were ineligible for VHA services as a result of the nature of their discharge and for them, the Coordinators identified appropriate services in the community and arranged a referral.

### **The Hotline as a Component of a Clinical System**

For a substantial number of veterans, the Hotline has directly facilitated mental healthcare; for others it has provided information and support that may facilitate care less directly; and for still others, it has provided problem-solving about perceived problems with ongoing care. From a clinical perspective, the Hotline is a vehicle for engaging and retaining veterans in mental health services, especially those veterans at risk for suicide. In general, the path by which this happens is through referral from the Hotline to the Suicide Prevention Coordinator at a VA Medical Center, who then provides referrals to specific providers or programs at the Medical Center or its Clinics.

VA's Suicide Prevention Coordinators have related roles within each medical facility and within their communities. By design, VA's Suicide Prevention Coordinators manage efforts within the facility and the community, just as the National Hotline and the Center of Excellence coordinate activities across the Nation and within VA. The Coordinators receive mentorship and guidance from the National Suicide Prevention Coordinator who also directs the Hotline. Specifically, Suicide Prevention Coordinators facilitate care for veterans at risk of suicide and serve as an advisor to facility staff on suicide prevention strategies. By promoting awareness and implementing other specific suicide prevention activities, these Coordinators help advance VA's goal of reducing veteran suicides and increasing access to mental health services.

Within each Medical Center, the Suicide Prevention Coordinators also help evaluate suicide risk among veterans and augment care for those found to be at high risk. They are charged with developing relationships with community agencies and providers and facilitating referrals to a VA medical center for veterans found to be at risk in the community.

The Suicide Prevention Coordinators at each facility maintain listings of veterans receiving care within the facility who have attempted suicide and others at high risk. They also maintain an internal chart "flagging" system to support enhanced care and report this information to the National Suicide Prevention Coordinator. They are charged with ensuring veterans identified as high risk receive enhanced monitoring and care, regardless of whether the information about risk comes from the Hotline, from the community, or from providers within the facility. These responsibilities include ensuring:

- The veteran's mental health diagnoses and care plan are reviewed in light of the evidence for suicide risk and that the care plan appropriately addresses the veteran's condition and functional limitations;
- Specific treatments for reducing suicide risk have been considered;
- The care plans include ongoing monitoring for suicidality and plans for addressing periods of increased risk. These plans must include specific processes for follow-up for missed appointments;
- There is an individualized discussion about reducing the means for completing suicide that addresses issues such as medication storage, gun safety, and high risk behaviors;
- A family member or friend has been identified, either for involvement in care or for contact as necessary;
- There is a written safety plan, reviewed periodically, developed in collaboration with the veteran that is included in the veteran's chart; and
- The veteran receives letters from the provider or the Coordinator on a regular basis to reinforce the message that compassionate care is available through VA.

### **The Hotline as a Component of a Public Health Program**

The public health components of VA's Suicide Prevention Program include training organized by each facility's Suicide Prevention Coordinators about risk factors and warning signs for suicide for individuals and organizations with veteran contact within the community and VA staff. In both local and national presentations, VA focuses on increasing awareness of the Hotline to communicate that veteran suicide is a preventable public health problem and that effective care is available, without stigma, from VA.

By serving as a reminder that suicide is preventable and that care is available, the Hotline is valuable to all veterans and Americans, not just those who call. This message is being delivered by VA senior leadership and staff from all facilities and has been targeted to the media, consumers, professional organizations, and members of the community. It is essential that VA, other federal partners, and community organizations collaborate and coordinate their efforts so the general public and veterans alike have a single system which they can safely and reliably access in moments of crisis. Our collective mission is to listen with a single pair of ears and speak with a single voice to deliver a shared message consistent with the best practices for suicide prevention.

During this past summer, VA implemented a public service campaign promoting the Hotline and suicide prevention in Metro trains, stations, and buses in the Washington, D.C. area. Washington was chosen for this pilot project because it is a community with a large population of veterans and active duty service men and women and because VA leadership is embedded in this community in a way that allowed us to monitor its impact.

Based on the data, VA received more than twice as many calls (increase of 20 per week to 50 per week) from the Washington area after these advertisements appeared. A comparable area (Baltimore) remained steady during this same period (20–25 calls per week). This demonstrated increase leads us to support the extension of the campaign to other areas. However, these numbers reflect only part of the impact. VA hopes other benefits of the campaign include enhanced knowledge of the availability of mental health services for veterans in need and increases in the probability that veterans in need in the future will seek care, either through the Hotline or other means.

VA has also established a national Suicide Prevention Awareness Week to ensure all staff are aware of available resources and now how to use them to help veterans. Each medical center is required to recognize VA National Suicide Prevention Awareness Week. This year's programs will focus on presentations from the facility's local suicide prevention coordinator about the program's activities and directions about how staff can interact with it.

### **Program Evaluation**

VA is evaluating its Suicide Prevention Program on many levels. The most important evaluation will be a test of whether there are decreases in the rates of suicide among veterans. Given that the program is a component of a healthcare system, this effect would be greatest and most rapid among those who utilize VHA healthcare services. However, even in VHA utilizers, it will be several years before we can evaluate the direct impact of the program.

VA's Program maintains that prevention requires ready access to high quality mental healthcare and programs are needed to directly target suicide prevention. Our evaluations, then, must include VA's quality monitors for mental health services, as well as measures related to more direct activities, including:

- The number of community informational and educational outreach programs conducted by each facility;
- The number of calls to the Hotline, and reports developed from re-contacting callers;
- Follow-up and treatment engagement for Hotline callers referred to each facility's Suicide Prevention Coordinators;
- Development, charting, and review of a safety plan for patients found to be at high risk; and
- The number of repeated attempts in patients who have survived a suicide attempt.

As VA's Suicide Prevention Program continues to evolve, we will also continue to develop our evaluation measures. One of the program's future goals is to develop valid and reliable outcome measures based on real-time monitoring for veteran suicides in the community to support a rapid response to any identified trends. However, further research is necessary before this can occur.

**Moving Forward**

VA's Suicide Prevention Program has been enhanced substantially since May 2008. We have added staff to develop Suicide Prevention Teams at each medical center, hired more responders and increased staffing for the Hotline, and implemented an electronic chart "flagging" system to facilitate increased monitoring and enhanced care for those at high risk.

VA's Suicide Prevention Hotline is an important step forward and is a component of a comprehensive program for suicide prevention. It reflects VA's overall mission of providing high quality mental health services to America's veterans.

Thank you for your time. I will be pleased to answer any questions from the Committee.

**VA National Suicide Prevention Hotline Call Report Totals YTD**

	<b>Total calls</b>	<b>Identified as Veterans</b>	<b>Identified as family/friend of vet</b>	<b>SPC referrals</b>	<b>Rescues</b>	<b>Warm transfers</b>
Oct 7-27	2,943	950	206	222	56	174
Oct 28-Dec 1	4,952	1,773	242	354	122	224
Dec 2-31	4,111	1,703	237	283	70	161
Jan 1-31	4,544	1,800	262	385	97	217
Feb 1-29	5,324	2,094	340	436	115	259
March 1-31	5,984	2,508	381	500	127	332
April 1-30	6,057	2,668	457	545	159	342
May 1-31	6,250	2,940	418	515	163	343
June 1-30	5,925	2,690	423	615	173	366
July 1-31	6,804	3,332	435	624	193	355
August 1-31	7,038	3,551	526	762	214	308
FY 08 totals to date	59,932	26,009	3,927	5,241	1,489	3,081
FY 07 totals	9,379	2,918	not avail.	739	139	493
<b>TOTAL to Date</b>	<b>69,311</b>	<b>28,927</b>	<b>3,927</b>	<b>5,980</b>	<b>1,628</b>	<b>3,574</b>

**Center of Excellence Mental Health Crisis/Suicide Hotline YTD 08 Referral Breakdown**

Month	October 07 Totals	November 07 Totals	December 07 Totals	January 08 Totals	February 08 Totals	March 08 Totals	April 08 Totals	May 08 Totals	June 08 Totals	July 08 Totals	August 08 Totals	FY08 YTD
Follow-up findings:												
Immediate Evaluation at VA or CBOC provided	21	8	7	63	51	58	25	28	23	15	24	323
Admissions to inpatient hospitals	47	40	47	72	73	106	92	99	131	125	131	963
Care provided and treatment plan developed for ongoing care	263	253	248	333	399	469	498	469	569	598	696	4,795
Referral to other VA Services such as OIF/OEF program, substance abuse program or homeless program, etc	25	15	22	285	250	255	279	297	240	353	438	2,459
Enrolled in VA Health Care System	3	7	16	25	7	11	17	11	12	8	4	121

**Statement of Tom Tarantino,  
Policy Associate, Iraq and Afghanistan Veterans of America**

Mr. Chairman, Ranking Member and distinguished Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America, and our more than 100,000 members nationwide, I thank you for the opportunity to submit written testimony regarding veteran suicide, and the Department of Veterans Affairs' outreach efforts.

Since the beginning of the conflicts in Iraq and Afghanistan, we have witnessed a dramatic upswing in suicide rates among troops on active-duty and veterans. In 2006, the suicide rate for active-duty soldiers reached its highest level in decades, with 97 Army suicides. In 2007, this disturbing trend escalated beyond all expectations to 115. And just last week, it was revealed that the suicides among active-duty soldiers in 2008 are likely to be even higher, as there have been 62 confirmed and 31 suspected suicides already this year. Tragically, for the first time since the Vietnam War, the Army suicide rate is on track to exceed that of the civilian population.

While the rate of military suicides is closely monitored, the VA only just recently began tracking the suicide rate for veterans. From 2002–2005, 141 veterans who left the service after September 11, 2001 took their own lives. In 2006 alone, there were 113 suicides among Iraq and Afghanistan-era veterans. The suicide rate for male veterans ages 18–29 in 2006 was about 46 suicides per 100,000, compared with about 20 suicides per 100,000 for their nonveteran peers. And these are just the cases that are being tracked by the VA. For veterans of all generations, data on suicide is equally troubling. While veterans make up only 13% of the U.S. population, they account for 20% of the suicides. As evidenced by these statistics, suicide is likely to be a long term problem for veterans of Iraq and Afghanistan.

Multiple tours, inadequate dwell time between tours, strained relationships, and financial difficulties have all contributed to the rising rate of suicide among active-duty troops and veterans. Mental health injuries are also a major risk factor. According to a RAND study, 300,000 of the 1.7 million veterans of Iraq and Afghanistan will develop combat-related mental health issues. Many of these cases will go untreated, and if allowed, develop into severe Post Traumatic Stress Disorder.

Suicide is the end result of multiple failures in our military and veterans' mental healthcare systems. Inadequate mental health screening upon redeployment, professional and personal stigma attached to mental healthcare, and inadequate VA outreach have brought us to this crisis, with little to no end in sight.

The establishment of the VA suicide hotline last year was a critical first step in reversing this trend, and with over 55,000 calls received, it is clear that the VA is moving in the right direction in getting the message out about this service. The success of the VA hotline is admirable and we applaud them for making this toll-free hotline available to veterans in need. But with the hotline averaging 250 calls per day from troubled veterans and concerned family members, it is clear that more needs to be done to reach out to vulnerable veterans and get them the help they desperately need.

The VA is currently testing outreach advertisements in the Washington, DC region. While these efforts are necessary, the execution leaves much to be desired. Appearing on buses and trains, these print ads do not adequately relate to veterans of this conflict and are not as effective as they could be. The silhouette employed in the ad is clearly not of a modern soldier, and the ad itself blends into the background of ads that litter our public transportation system. It is clear that while the VA had the right idea with their outreach efforts, they have not done sufficient advertising research to connect with veterans of the current conflicts.

IAVA is doing its part to reach out to new veterans, and ensure that they know about the services available to them. IAVA has recently partnered with the Ad Council for a historic 3-year Public Service Announcement campaign set to launch on Veterans Day. It is our belief that through extensive research, testing and the use of multiple mediums, including TV, radio, print, and the Internet, we will be able to reach those veterans who need and do not typically seek help.

However, outreach alone will not stem the rise in veteran suicide. IAVA believes that a mandatory and confidential mental health screening with a mental health professional pre- and post-deployment is the first and most critical step in the early detection and prevention of combat-stress injuries that so frequently lead to suicide. Additionally, IAVA believes that the VA must open its doors to the families of veterans so that they can receive and participate in the recovery and reintegration of our service men and women. Coupled with a targeted and thoughtful outreach campaign by both the VA and the VSOs, these critical actions can begin to stem the tide of suicides that is tragically affecting our Nation's heroes.

It is clear by the success of the VA hotline that there are those out there who want to reach out and need to receive care. Now, we must redouble our efforts to reach out to those who are reluctant, yet need care nonetheless. IAVA looks forward to working with the VA and the VSO community to ramp up outreach and formulate a message that modern veterans will respond to. The alarming trend of suicides can be reversed and we are committed to providing any and all assistance needed to the VA to improve their outreach efforts. Together as a community, we can help our brothers and sisters return from war and readjust from warrior to citizen.

**MATERIAL SUBMITTED FOR THE RECORD**

Committee on Veterans' Affairs  
 Subcommittee on Health  
 Washington, DC.  
*September 24, 2008*

Honorable James B. Peake, M.D.  
 Secretary  
 U.S. Department of Veterans Affairs  
 810 Vermont Avenue, NW  
 Washington, DC 20240

Dear Secretary Peake:

Thank you for the testimony provided by Janet E. Kemp, R.N., Ph.D., National Suicide Prevention Coordinator who was accompanied by Kerry L. Knox, MS, Ph.D., Director, Canandaigua Center of Excellence for Suicide Prevention and Antonette Zeiss, Ph.D., Deputy Chief Consultant, Office of Mental Health Services, at the House Committee on Veterans' Affairs Subcommittee on Health oversight hearing on the "VA's Veterans Suicide Prevention Hotline" that was held on September 16, 2008.

Please provide answers to the following questions by November 5, 2008, to Jeff Burdette, Executive Assistant to the Subcommittee on Health.

1. The National Veterans Foundation (NVF) raised some good questions about whether the VA's hotline staff is properly trained to help veterans in crisis.
  - a. Please describe the procedures in place for follow-up communication with the caller if the need is determined during the initial call.
  - b. Are there mental health professionals trained in suicide prevention techniques and causes of suicidal tendencies specific to veterans and who are available to immediately intervene if necessary?
  - c. Do you train the hotline staff in crisis communication listening skills and suicide intervention? And if so, how can you assure the Subcommittee that this training is adequate?
2. Please explain, in more detail, what happens when veterans are transferred to the community-based "overflow centers." Specifically:
  - a. What type of training is provided to the staff at the "overflow centers"?
  - b. Do the staffs have access to the patient's electronic health record?
  - c. How effective are the staffs at choosing the appropriate care, such as referring veterans to Suicide Prevention Coordinators or calling for immediate response?
  - d. How many calls have been transferred to the "overflow center" and does this indicate a need to increase staffing?
3. Your data indicates that over half of the callers to the hotline are not veterans or family or friends of a veteran.
  - a. How do hotline personnel handle these calls?
  - b. How much time is consumed with these callers?
  - c. How can this number be decreased?

Thank you for taking the time to answer these questions. The Committee looks forward to receiving your answers by November 5, 2008.

Sincerely,

MICHAEL H. MICHAUD  
*Chairman*

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**Questions for the Record**

**Honorable Michael H. Michaud, Chairman**  
**Subcommittee on Health**  
**House Committee on Veterans' Affairs**  
**September 16, 2008**

**U.S. Department of Veterans Affairs Veterans Suicide Prevention Hotline**

**Question 1(a):** The National Veterans Foundation (NVF) raised some good questions about whether the VA's hotline staff is properly trained to help veterans in

crisis. Please describe the procedures in place for follow-up communication with the caller if the need is determined during the initial call.

**Response:** All of the call responders at the Department of Veterans Affairs (VA) Hotline are mental health professionals who are trained specifically in the areas of suicide and veterans. The procedures that are in place for both assessing risk and follow-up communication are provided in the attached Behavioral VA Health Care Line (BVAHCL) procedure number 31 (telephone call center guidelines). The response to each caller is determined by the caller's identified level of risk. All callers are assessed for suicidality or other crisis type issues. Immediate counseling is done for all callers, and callers are kept on the phone as long as necessary to ascertain their risk and ensure that measures have been taken to guarantee their safety and well-being.

There are several VA patients who use the line for regular periodic "checking-ins." Some of these patients call during times of Post Traumatic Stress Disorder (PTSD) exacerbation and are counseled according to their treatment plans. In addition, there are a number of callers who ask for information or to "just talk." These callers are worked with, given information and provided counseling to deal with their immediate needs. With the veteran's permission, every effort is made to obtain enough information to refer them to a local suicide prevention coordinator, vet center, or other appropriate VA program to provide on-going, continuing service. Hotline staff follow-up with suicide prevention coordinators and check medical records to ensure that callers have been contacted, and care is being provided. Some callers are called back by the hotline staff to make sure that they are still safe, have gotten what was needed, and to see if the call was helpful for them. Prior permission from the veteran is always obtained to make follow-up calls.

**Question 1(b):** Are there mental health professionals trained in suicide prevention techniques and causes of suicidal tendencies specific to veterans and who are available to immediately intervene if necessary?

**Response:** All of the call responders at the hotline are mental health professionals who are trained specifically in the areas of suicide and veterans. This training occurs at multiple levels, both in orientation and as an ongoing activity. Examples of specific training modules include:

- Battlemind PTSD.
- Characteristics of adults with psychological distress.
- Combat injured soldiers.
- Human immunodeficiency virus (HIV) with alcohol and lifestyle associated problems.
- Major depressive episodes and work stress.
- Mental health problems with active/reserve troops returning from Iraq.
- Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) stress and Traumatic Brain Injury (TBI).
- Strategies for preventing suicide in TBI patients.
- Suicide mortality, treatment for depression.
- The Veterans Health Administration (VHA) and military sexual trauma.
- Treatment of clients with acute suicidal ideation.
- War and military mental health.

The training completed by each staff member is recorded in their individual training record. These records are reviewed on a regular basis by hotline supervisors. Monthly staff and education meetings are also conducted to stay current on all these issues.

**Question 1(c):** Do you train the hotline staff in crisis communication listening skills and suicide intervention? And if so, how can you assure the Subcommittee that this training is adequate?

**Response:** All staff are trained in crisis intervention skills using the Lifeline Network training recommendations. The training received by hotline staff far exceeds the recommendations set forth by the American Association of Suicidality standards for certification. Records of training are kept in staff member's individual training file. The training is done in two phases. The first phase is conducted by the local lifeline crisis center in Rochester for all employees during the orientation phase prior to being allowed to answer hotline calls. It entails an extensive 5-day training program. The second phase is applied suicide intervention skills (ASISTS) training. The hotline staff have trained trainers for the ASISTS program. These trainers have been trained by the ASISTS crisis center network program and are certified to give

this training. Staff is currently receiving this refresher training, which will continue on an ongoing basis.

**Question 2(a):** Please explain, in more detail, what happens when veterans are transferred to the community-based “overflow centers.” Specifically: What type of training is provided to the staff at the “overflow centers?”

**Response:** Five “back-up centers” were identified before the hotline began taking calls. These sites were chosen because they demonstrated adherence to the standards determined by the Lifeline Network, their 24/7 response capacity, and their desire to work with veterans in the community. Prior to the hotline’s launch, the centers were supplied with fact sheets and tip sheets, and several audio conferences to review specific issues, hotline procedures, and VA policies. A web-based “knowledge bank” has subsequently been developed to provide the centers with ongoing information about veterans’ issues and resources. The center receives current lists of facility suicide prevention coordinators on an ongoing basis and monthly conference calls are held to ensure that all centers have the most current information. A face-to-face training program was held with all Lifeline Network Centers at its annual conference this fall by the National Suicide Prevention Coordinator. Ongoing face-to-face trainings will be held at annual meetings.

**Question 2(b):** Do the staffs have access to the patient’s electronic health record?

**Response:** For security reasons, the back-up centers do not have access to the patient’s electronic health record. However, the centers always have the opportunity to transfer the call back to the VA hotline after ensuring that the veteran is safe and determining that the call would be better responded to by a VA call center professional. They also have the ability to make referrals to the local suicide prevention coordinators at each site.

**Question 2(c):** How effective are the staffs at choosing the appropriate care, such as referring veterans to Suicide Prevention Coordinators or calling for immediate response?

**Response:** All calls by veterans to the back-up centers are logged and reported back to the VA hotline center. Some of these callers are not veterans nor are they calling about veterans. These callers are referred to their local crisis centers for follow-up. Veteran callers are referred to their local suicide prevention coordinators for follow-up and then tracked at the local sites. The hotline receives a fax of this consult and also follows-up to ensure that these veterans receive the needed follow-up attention. Notification of any rescues is also sent to the hotline. To date, there have been no identified instances when an inappropriate intervention was initiated.

**Question 2(d):** How many calls have been transferred to the “overflow center” and does this indicate a need to increase staffing?

**Response:** The volume of calls that go to the back-up centers is monitored on a daily basis. Anytime the number is greater than five per day, the circumstances are investigated and staffing needs will be evaluated. The number of available lines for the VA national suicide hotline has increased over the past year from two to six, and there are plans to increase to 10 by the end of fiscal 2009. It is our desire to keep the number of calls going to back-up centers at one to three per day. The centers need to keep answering a very small number of calls to maintain their expertise and knowledge of available resources. To date, there have been no instances when telephone lines were down or unusable. We need to keep this back-up system viable and the staff well equipped on the rare chance that there are geographic or VA-specific outages or down times. A total of 604 calls were forwarded to the back-up centers from December 1, 2007 through August 31, 2008. This represents less than 2.2 calls per day, well within our established guidelines.

**Question 3(a):** Your data indicates that over half of the callers to the hotline are not veterans or family or friends of a veteran. How do hotline personnel handle these calls?

**Response:** Hotline responders do the same level of assessment for these callers to determine the immediate risk. If it is determined that the caller can be safely transferred to a community crisis line, then the call is warm transferred to the assigned community center. These assignments are done according to area code. If the caller is in imminent danger, a rescue is started. The call is then transferred, if needed, and the receiving center is given the information needed to complete the

service. If a caller is active duty military and in crisis at the time of the call, we stay with the caller until the rescue has occurred.

**Question 3(b):** How much time is consumed with these callers?

**Response:** It is variable, but the average warm transfer takes less than 5 minutes. The average length of time spent as a whole on non-veteran calls has not been determined.

**Question 3(c):** How can this number be decreased?

**Response:** This number is decreasing over time as more publicity about the hotline and how it works is disseminated. Many of our “repeat non-veteran” callers have stopped calling the hotline. There will always be a number of callers who choose the push one option just because it is the number one choice. During the initial months of the hotline, approximately three-quarters of the calls were from non-veterans, and over time we have decreased that number. This past month, less than one-half were from non-veterans. We also suspect that at least a percentage of these “non-veteran” callers are indeed veterans and not willing to identify as such for now. It is our intent to treat everyone who calls the hotline as a person in need and respond accordingly. Continued publicity and education will continue to help with this issue.

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VA Medical Center  
Canandaigua, NY 14424  
July 25, 2008

**BEHAVIORAL VA HEALTH CARE LINE  
MENTAL HEALTH CRISIS/SUICIDE HOTLINE  
TELEPHONE CALL CENTER GUIDELINES**

I. Purpose:

This BVAHCL MENTAL HEALTH CRISIS/SUICIDE PREVENTION HOTLINE POLICY ESTABLISHES direction governing the numerous Mental Health Crisis/Suicide Hotline telephone practices.

II. Policy:

All staff of the Mental Health Crisis/Suicide Hotline will follow the guidelines set forth in this policy.

III. Responsibility:

All staff of the Mental Health Crisis/Suicide Prevention Hotline will follow these standard procedures as they engage callers to attempt to deescalate crisis situations, modify immediate stress, perform clinical lethality assessment, offer options, refer to appropriate resources at the local VA or community services, provide call follow-up, refer those expressing physical symptoms to appropriate resources, able to contact the nearest law enforcement agency or dispatcher in cases of rescue, are trained on the automatic backup Call Center system via Lifeline 211 and maintain a high level of integrity and follow VA confidentiality requirements.

IV. Procedures:

A. Answering Crisis Suicide Calls

a. Receiving a call

I. All calls will be answered within five (5) rings

II. All calls will be answered with: “Thank you for calling the Veteran’s Crisis Hotline, this is (*agent’s name*) how can I help you?” All calls will be answered in a professional, caring manner.

III. Read the caller ID number and document to assure call back potential

IV. If caller is willing obtain demographic information.

V. Caller may wish to remain anonymous

b. Assess for risk

c. Determine if caller is a veteran or non-veteran, family member or third party

d. Is veteran enrolled

e. If veteran consents, consult completed and sent to Suicide Prevention Coordinator (SPC) nearest to veteran’s location. Staff member will leave

a voice message and send an email alerting SPC indicating a veteran from that area contacted the Mental Health Crisis/Suicide Prevention Hotline and a consult was sent.

#### B. Physical Symptoms

- a. A caller with emergent situations (chest pain, shortness of breath, bleeding etc.) will be advised to hang up and call 911, in order to facilitate immediate access to the EMS system, and instant demographic recognition by the EMS system.
- b. If the caller cannot be instructed to call 911, i.e. lost consciousness, etc. the agent will remain on the line with the caller and will ask the health technician or another agent to call 911 while he/she continues to assist the patient or family. The hotline rescue process will be initiated.
- c. If the symptoms are not emergent, or the caller has clinical questions requiring medical advice or recommendations, he/she caller will be advised to call their local VAMC or medical call line for assistance.

#### C. Suicide Risk/Lethality Assessment

- a. Each call center staff member received suicide assessment training and written guidelines
- b. All callers received are assessed for signs of depression, suicide and protective and risk factors.
- c. Staff members are to complete the caller contact log sheet and the suicide risk assessment/lethality assessment sheet.
- d. If the caller is considered high lethality or high risk the rescue procedure will be implemented.
- e. **Attachment—Suicide Risk/Lethality Assessment and log sheet**

#### D. Rescue 911 Emergency Calls and Emergency Resources

- a. Hotline responder will initiate rescue procedure with health technician assistance.
- b. Health technician will utilize emergency dispatch phone and read the telephone software displays caller ID unless it is blocked by caller—caller may wish to remain anonymous.
- c. If caller ID is available health technician will back track phone number for location. If telephone number is blocked health technician will initiate a trace call with local authorities.
- d. Lists of law enforcement agencies and 911 numbers are available both online and in written format in the Call Center.
- e. Internet protocols are available to trace location using the caller ID.
- f. In the event the caller is using a cell phone it may be traceable by the local law enforcement agency through the cell phone provider.
- g. Maintain caller online until rescue services arrive. If caller disconnects, attempt to “call back” until follow-up is determined with rescue services.
- h. **Attachment—Emergency Dispatch Form**

#### E. Call Follow-up

- a. If veteran consents a consult will be sent to the Suicide Prevention Coordinator (SPC) in veteran’s area via CAPRI. If veteran does not consent to consult he/she will be offered telephone contact information for SPC at nearest VA facility and encouraged to follow-up. Consult will be sent on all rescues.
- b. Email and voice mail message will be left with SPC to respond to consult.
- c. Staff will document call on log sheet and confirm email was sent.
- d. Veteran’s name will be placed on white board for health technicians to follow-up.
- e. Health technician will follow-up with **Hotline follow-up record (see attachment)** and connect with SPC to log follow-up call to veteran and check CAPRI computerized record for consult.

#### F. Disaster or Inclement Weather

- a. During an internal, external or national disaster, Hotline Staff will follow the established Canandaigua VAMC policy. The policy and procedures are spelled out in the Canandaigua VAMC Emergency Preparedness Plan Manual. All Employees are required to read and sign off on the manual annually.

- b. In the event of disaster or inclement weather where the hotline does not have the ability to receive calls the automatic 2-1-1 Lifeline backup centers will be notified that calls will be routed to the backup centers lines. Callers will be seamlessly transferred to a backup center that will provide service to the veteran until hotline service is restored.

G. Confidentiality

General Principles:

1. It is essential that only those people who have a “need to know” have access to confidential files, data or information. ANY CONFIDENTIAL INFORMATION, REGARDLESS OF FORM, MUST BE PROTECTED TO ENSURE THAT IT DOES NOT BECOME AVAILABLE TO INDIVIDUALS WHO HAVE NO RIGHT TO ACCESS IT. Failure to comply with the terms of the confidentiality policy may result in disciplinary action up to and including forfeiture of position.
2. Every consumer known to be served by the VHA Mental Health Crisis/Suicide Hotline will be assured that personal and/or family data, either given to a staff member during interviews or procured through reports or inquiries, will be maintained in the strictest professional confidence.
3. Information pertaining to employees and staff members also must be guarded with the same level of confidentiality. This applies to information related to personnel, payroll, performance, and personal matters. Only those with a bona fide “need to know” are to have access to such information.

V. References:

- A. CARF 2008 Standards
- B. JCAHO Accreditation Manual for Hospitals 2007
- C. American Association of Suicidology 8th Edition

VI. Follow-Up Responsibility: Victoria Bridges, LCSW

VII. Recession:

VIII. Expiration Date:

(Signed)

Victoria Bridges, LCSW

BVAHCL Mental Health Crisis/Suicide Hotline Program Manager

SHARLENE SACCO, HSS

BVAHCL Manager

Patricia Lind, MS

Associate Director for Patient Nursing Svc

Attachment:

- A. Electronic Log Sheet
- B. Risk/Lethality Assessment
- C. Consult Template (Paper Version)
- D. Emergency Dispatch Form
- E. Referral Follow-Up Form

