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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
VETERAN SUICIDE PREVENTION: CAPITALIZING ON WHAT WORKS AND INCREASING INNOVATIVE APPROACHES

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Good morning, Chairman Takano, Ranking Member Bost and distinguished Members of the Committee. Thank you for the opportunity today to discuss the department's efforts to reduce suicides among the Nation's Veterans. Accompanying me today are Dr. Matthew Miller, Executive Director, Department of Veterans Affairs (VA) Suicide Prevention, Office of Mental Health and Suicide Prevention and Dr. Lisa Brenner, Director, Rocky Mountain Mental Illness Research, Education and Clinical Center. We are fueled by hope, combined with a strategy and an action plan, to move together in the daily mission to end Veteran suicide. Together we are making a difference by implementing a public health approach, focusing on both on evidence-based clinical interventions and community-based, evidence-informed prevention strategies, to reach all Veterans—both those inside and outside of our system. Today, we report on current progress and the road ahead.

From our 2022 National Veteran Suicide Prevention Annual Report which just published this month, 44,298 adult Americans died by suicide in 2020. Of those, 6,146 were Veterans. The rate of Veteran suicide deaths per year—31.7 per 100,000—also remains substantially higher than the rate among non-Veteran US adults—16.1 per 100,000—in 2020. These numbers are more than statistics—they reflect individual lives prematurely ended which continue to be grieved by family members, loved ones and the Nation as a whole. We continue to rededicate our commitment to the mission to address suicide as a national public health concern in response to each life lost.

Suicide is a complex problem with a multifaceted interweaving of potential contributing factors. In addition to mental health risk factors for suicide, we must look at a broader array of socio-economic and socio-cultural risk factors. Unemployment, chronic pain, insomnia, relationship strain and death of a loved one are examples of individual factors outside the specific frame of mental health which may play a role in suicide. International, national, community and relational factors also impact suicide risk (e.g., inadequate access to care, global health concerns, war, economic crises,

homelessness)[1]. With no single cause, there is no single solution, and we must be comprehensive in our approach.[2]

Our national plan to address these complex contributing factors embraces a systematic, public health approach combining both community-based prevention strategies and clinically-based interventions, as outlined in our 10-year National Strategy for Preventing Veteran Suicide published in 2018.[3]

Critical work also emerged in 2019 with the publication of the VA and Department of Defense (DoD) Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide (VA/DoD, 2019), providing the latest summary of research on clinical interventions for suicide prevention to guide health care provider decision making. In 2021, the White House built further upon these foundational efforts at the national level with its publication of the Reducing Military and Veteran Suicide Strategy.[4] This strategy outlines a series of priority goals and executive actions to be pursued in collaboration with other Federal agencies, government programs, public-private partnerships and local communities in the following five priority areas:

1) Improve lethal means safety (LMS);
2) Enhance crisis care and facilitate care transitions;
3) Increase access to and delivery of effective care;
4) Address upstream risk and protective factors; and
5) Increase interagency research management, data sharing and evaluation efforts.

These guiding documents have been operationalized through VA's Suicide Prevention 2.0 initiative (SP 2.0); Suicide Prevention Now initiative (Now); new laws including the 2020 Commander John Scott Hannon Veterans Mental Health Care Improvement Act (Hannon Act); the Veterans Comprehensive Prevention, Access to Care and Treatment Act of 2020; the National Suicide Hotline Designation Act of 2020; and emerging innovations combined with research and program evaluation that are further described below.

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[1] Turecki, G., & Brent, D. A. (2016) Suicide and suicidal behavior*. Lancet, 387*, 12271,227–39.
[2] Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., Sáiz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*, *3*(7), 646–659.
[3] Department of Veterans Affairs (2018). National Strategy for Preventing Veteran Suicide. Washington, DC. Available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.
[4] White House (2021). *Reducing military and veteran suicide*: *Advancing a comprehensive, cross-sector, evidence-informed public health strategy.* Military-and-Veteran-Suicide-Prevention-Strategy.pdf (whitehouse.gov).

These plans, build upon a foundation of three major tenets that drive our efforts: (1) Suicide is preventable; (2) Suicide prevention requires a public health approach, combining clinical and community-based strategies; and (3) Everyone has a role to play in suicide prevention.

With the most recent publication of the 2022 National Veteran Suicide Prevention Annual Report earlier this month, we highlight several anchors of hope. 2020 saw the lowest number of Veteran suicides since 2006. From 2001 to 2018, the number of Veteran suicides increased on average by 47 deaths per year. However, 2019 and 2020 showed consecutive reductions, of 307 and 343 suicides, respectively, an unprecedented decrease since 2001. From 2018 to 2020, age- and sex-adjusted rates of suicide for Veterans fell by 9.7%. By comparison, the adjusted rate for non-Veteran U.S. adults fell by 5.5%. The age-adjusted suicide rate for women Veterans in 2020 was the lowest since 2013, and the age-adjusted suicide rate for Veteran men was the lowest since 2016. From 2019 to 2020, among Veteran men, the age-adjusted suicide rate fell by 0.7%, and among Veteran women, the age-adjusted suicide rate fell by 14.1%. Among non-Veteran U.S. men, the age-adjusted rate fell by 2.1%, and among non-Veteran women, the age-adjusted rate fell by 8.4%. Assessment of Veteran suicide rates by race showed decreases from 2019 to 2020 for all groups. Despite the 24.6% decrease in the Veteran population from 2001 to 2020, the number of Veterans with Veterans Health Administration (VHA) health care encounters in the year or prior year rose 55.0%, from 3.8 million to 5.9 million. Despite onset of the Coronavirus Disease 2019 (COVID-19) pandemic in 2020, age and sex-adjusted suicide rates among Veterans fell 4.8% from 2019 to 2020, versus a 3.6% decline among non-Veteran U.S. adults, and yet more work remains.

Suicide Prevention 2.0 (SP 2.0)

Our road ahead includes the implementation of SP 2.0, VA's longer-term effort to combine specific evidence-based clinical strategies across national, regional and local levels with community-based suicide prevention policy, plans and services. Most Veterans who die by suicide do not receive care in VHA. To reach Veterans both inside and outside our system, SP 2.0 includes an arm focused on Community-Based Intervention for Suicide Prevention (CBI-SP) and a clinical arm focused on broad dissemination of evidence-based psychotherapies as outlined in the recently updated CPG (VA/DoD, 2019).

SP 2.0 CBI-SP reaches Veterans by facilitating the development and expansion of community coalitions focused on ending Veteran suicide. The program merged VA/Substance Abuse Mental Health Services Administration Governor's Challenge initiatives, the Together with Veterans rural peer-to-peer model and regional Community Engagement and Partnerships Coordinators (CEPC) pilots to help local communities adapt an overarching model and strategy for Veteran suicide prevention to local needs and resources. These community-based strategies are supported by prior work in community-based prevention science and programs, which combine health promotion,

upstream approaches and a focus on improved clinical and crisis care delivery through partnerships.[5,6,7]

This evidence-informed community model works across these efforts to create strategic local community plans focused upon the following priorities:

- Identify Service members, Veterans and their families and screen for suicide risk;
- Promote connectedness and improved care transitions; and
- Increase LMS and safety planning.

CEPCs serve as subject matter experts in public health approaches across these efforts working in coalition facilitation and management, emphasizing public health planning and partnered and collaborative action based in evidence-informed strategies. The CEPC role enhances current VA suicide prevention efforts facilitated by over 500 VA suicide prevention team members nationwide. Significant progress has already been made, with 48 States and 5 territories involved in the Governor's Challenge, 29 rural communities with over 200,000 rural Veterans have been reached and there are now 600 Veteran suicide prevention coalitions operating in local communities.

Complementing community efforts are VA's clinical efforts and direct outreach to connect Veterans to VA care, including programs to assist in connecting Veterans to care during their time of trasnsitioning from the Service (e.g., VA Liaison Program, inTransition Program, and VA Solid Start). VA provides a continuum of forward-looking outpatient, residential and inpatient mental health services across the country. Points of access to care span 171 VA Medical Centers (VAMC), over 1,000 outpatient clinics, 300 Vet Centers and 83 mobile Vet Centers. Over 1.7 million Veterans received mental health services at VA last year—ranging in services from peer support with other Veterans to counseling, therapy, medication, or a combination of these options. VA's proactive, Veteran-centered Whole Health approach is integral to our mental health care efforts and includes online and telehealth strategies.

A core strategy for increasing access to mental health care is offering video-telehealth options. This is especially critical for Veterans who live far from any health care providers and far from health care providers who are trained in military cultural

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[5] Frieden, T. R. (2014). Six components necessary for effective public health program implementation. *American Journal of Public Health*, *104*(1), 17-22.
[6] Lai, C., Law, Y. W., Shum, A. K., Ip, F. W., & Yip, P.S. (2019). A community-based response to a suicide cluster: A Hong Kong experience. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *41*(3), 163-171.
[7] Oyama, H., Watanabe, N., Ono, Y., Sakashita, T., Takenoshita, Y., Taguchi, M., Takizawa, T., Miura, R., & Kumagai, K. (2005). Community-based suicide prevention through group activity for the elderly successfully reduced the high suicide rate for females. *Psychiatry and Clinical Neurosciences*, *59*(3), 337-44.

competence and evidence based mental health care. SP 2.0 Clinical Telehealth offers evidence-based psychotherapies to Veterans with recent suicidal self-directed harm, ensuring access to CPG-recommended treatments, including Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP); Problem Solving Therapy for Suicide Prevention; Dialectical Behavior Therapy; and the Safety Planning Intervention using a virtual care platform. As of April 2022, SP 2.0 Clinical Telehealth has hired 97 therapists across the Nation and received over 4,000 consults, providing the best evidence-based treatments for suicide prevention directly into the homes of Veterans. In addition to these suicide prevention specific evidence-based psychotherapies, during the pandemic, VA greatly expanded telehealth across the Veteran population and the mental health continuum of care. In fiscal year (FY) 2020, VA saw a 207% increase in telemental health visits and in FY 2021, that number doubled again with VA providing telemental health care to over 873,000 Veterans during 5.6 million visits. This trend continues in FY 2022, with current numbers on track to outpace previous years.

Suicide Prevention Now (Now)

The Now plan aims to develop and deploy interventions that are designed to reach Veterans at high risk for suicide, within each fiscal year. Led by staff in VA's Suicide Prevention Program and key VA collaborators, the plan includes key mental health and suicide prevention strategies to support Veterans, VHA providers and the community during the COVID-19 pandemic. The five priority areas of the Now plan are as follows:

(1) LMS, which promotes safe storage of firearms so that someone at elevated risk for suicide is less likely to use the firearm to attempt suicide;
(2) Suicide prevention in at-risk medical populations;
(3) Outreach to and understanding of prior VHA users;
(4) Suicide prevention program enhancements; and
(5) Media campaigns.

I would like to highlight some of the key innovations that have been advanced over the prior year as part of the Now plan.

Nearly 70% of Veteran suicides are by firearm, the most lethal method for suicide. Some studies have shown that the time between a decision to attempt suicide and a suicide attempt is fewer than 10 minutes for approximately 47-50% of individuals with a history of a suicide attempt.[8] VA has dedicated significant efforts to expand LMS related to firearms to provide more time and space between a person in a crisis moment

[8] Cáceda, R., Carbajal, J. M., Salomon, R. M., Moor, J. E., Perlman, G., Padala, P. R., Hasan, A., & Delgado, P. L. (2020). Slower perception of time is depressed and suicidal patients. *European Neuropsychopharmacology, 40*, 4–16, Deisenhammer, E. A., Ing, C., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2009). The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt? *Journal of Clinical Psychiatry, 70*(1), 18–24.

and their firearm and ammunition. In October 2020, a new LMS Counseling training course was launched nationally as a requirement for all VHA providers. As of July 31, 2022, 97% of providers completed the training within 90 days of the course being assigned. VA is also working with the National Shooting Sports Foundation (NSSF) to produce videos focused on gun safety, increasing gunlock distribution and expanding LMS training to community providers. In July 2022, VA collaborated with NSSF to host a Firearm Industry Meeting to advance joint efforts in promoting secure storage.

Further, VA released a toolkit, Suicide Prevention is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community, developed in partnership with the American Foundation for Suicide Prevention and NSSF to raise awareness about safe storage practices for local communities. Our Governor's Challenge Teams also received training on how to use the toolkit and are prioritizing its distribution through their State action plans.

Several clinical initiatives have also been implemented across VHA as part of the Now program. A few examples of these initiatives include Naloxone distribution, increased hiring of mental health staff, the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) program and Safety Planning in the Emergency Department (SPED). These initiatives are having an impact on patient safety—for instance, as of September 8, 2023, more than 43,600 VHA prescribers, representing all VHA facilities, have prescribed naloxone to over 386,500 Veterans resulting in over 3,190 reported opioid overdose reversals.

Pain is a common factor among Veterans who die by suicide, and VA is taking a comprehensive approach to improving pain treatment. This includes a long-standing Opioid Safety Initiative that has incorporated use of the VA Stratification Tool for Opioid Risk Mitigation (STORM), a clinical decision support tool that leverages VA data and predictive modeling to identify patients at high risk for an overdose- or suicide-related event and improve opioid safety. A well-controlled evaluation of using STORM for very high-risk patients found a significant, 22% reduction in all-cause mortality risk for targeted patients during the 4 months following intervention over the next 4 months. In December 2021, based on these positive results, VA expanded the population receiving risk reviews to patients who have been discontinued on opioids as well as patients with a non-fatal overdose in the past year. Between January and June 2022, there have been 1,431 risk reviews conducted of patients with a past year non-fatal overdose. Another key part of VA's patient safety strategy involves improving uptake of medications for the treatment of opioid use disorder. This is critical given that VA's 2022 National Veteran Suicide Prevention Annual Report identified that patients with opioid use disorder consistently had among the highest rates of suicide (almost twice the rate of patients with depression).

VA is expanding the use of evidence-based care and the hiring of providers and peers throughout our substance use programs. This expansion coincides with efforts to strengthen staffing and peer support for women Veterans, including a Women's Mental

Health Champion at every VAMC to ensure women Veterans feel welcome and are treated equitably when they come to VA for care. These efforts complement the expansion of proactive mental health intervention in primary care, pain and oncology clinics to support VA's Veteran-centric, recovery-based emphasis on Veterans' whole health.

VA also implemented REACH-VET, which uses predictive modeling to identify Veterans at highest risk for suicide and then works to outreach and engage Veterans in care. REACH-VET has been associated with increased attendance at outpatient appointments, increased proportion of individuals with new safety plans and reductions in mental health admissions, emergency department visits and suicide attempts.[9] VA is exceeding benchmarks for all five REACH-VET metrics. The Now initiative has also enhanced implementation of SPED, an evidence-based practice shown to reduce suicidal behaviors by 45%.[10] The program promotes safety planning with Veterans who present to the emergency department with suicidal ideation, providing follow-up contact until treatment engagement occurs. Through technical assistance and individualized consultation, VA is exceeding SPED performance expectations and the new White House strategy focused on reducing military and Veteran suicide is now looking to implement the practice in non-VA community hospitals.

The Now initiative engages non-VHA users. In FY 2021, VA initiated a pilot program, Outreach to Facilitate Return to Care, to outreach to Veterans who had not used VHA health care in the last 2 years and who were identified in the top 1% level of risk in the REACH-VET algorithm prior to leaving VHA care. Promising initial results related to increased engagement in VHA health care and in mental health care within 6 months have led to the expansion of the pilot at other sites.

To reach Veterans wherever they are, VA has emphasized paid media campaigns as part of the Now and other mental health initiatives. These include: 1) Don't wait. Reach out; 2) Keep it Secure; and 3) the Veterans Crisis Line (VCL). To develop the "Don't Wait. Reach Out" campaign, VA entered into an agreement with the Ad Council, a national non-profit organization that uses donated communication industry resources to elevate messaging. The campaign strategy was informed by extensive research with Veterans and portrays real Veterans in all videos. For the "Don't Wait. Reach Out" Campaign, from October 2021-July 2022, we have had over 1 billion impressions with over $10 million in donated media value.

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[9] McCarthy, J. F., Cooper, S. A., Dent, K. R., Eagan, A. E., Matarazzo, B. B., Hannemann, C. M., Reger, M. A., Landes, S. J., Trafton, J. A., Schoenbaum, M., & Katz, I. R. (2021). Evaluation of the recovery engagement and coordination for health-veterans enhanced treatment suicide risk modeling clinical program in the Veterans Health Administration. *JAMA network open*, *4*(10), e2129900.

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

The “Keep it Secure” campaign is a national public health campaign addressing the need for safe storage for firearms as part of suicide prevention and has had over 1 billion completed video views and nearly 2 billion impressions from October 2021-July 2022.

Finally, the VCL campaign works to reach Veterans and those who love them to support them 24/7 during times of crisis. Since the launch of the VCL campaign in February 2020 until July 2022, there have been nearly 2 billion impressions with over 600 completed video views. When developing these and other campaigns, VA strives to represent the demographic and cultural diversity of Veterans. Together with ongoing campaigns like AboutFace and Make the Connection, VA hopes every Veteran will see themselves represented and know VA is here to serve them.

Innovations

In FY 2022, VA Suicide Prevention launched several demonstration projects to expand its public health approach through innovations. These projects were strategically aligned with priorities of both the VA National Strategy for Preventing Veteran Suicide (2018) and White House Reducing Military and Veteran Suicide (2021). Projects focus upon addressing individuals at risk for suicide across universal, selective and indicated categories and emphasize: 1) activation and engagement; 2) partnerships with key stakeholders—both within and outside of Federal Government; 3) amplifying dissemination of evidence-based strategies; 4) targeted and tailored approaches for reaching sub-populations (e.g., Native Veterans, geriatric populations, homeless Veterans); and 5) continuous quality improvement with an emphasis on the efficacy of intervention, prevention and education efforts.

In addition to these demonstration projects, VA launched “Mission Daybreak,” a Suicide Prevention Grand Challenge. Sourcing outside entities such as academia, industry experts, nonprofits and community organizations, can improve Veteran suicide prevention efforts by providing platforms to engage solutions for a multifactorial problem. This open innovation program creates an opportunity for a diversity of solvers, including Veterans, researchers, technologists, advocates, clinicians and health innovators, to offer solutions for Veteran suicide prevention. Through this $20 million prize competition, submissions were encouraged in the following potential areas of focus:

- Utilizing digital life data and early warning systems for suicide prevention;
- Creating improved access to and efficiency of VCL services through technological innovations; and
- Preventing firearm suicide and enhancing lethal means safety for suicide prevention.

More than 1,300 submissions were submitted by July 8, 2022, as part of Phase I, with finalists being announced to move into Phase II in September. Final winners will be announced in late 2022.

Recent Veteran Suicide Prevention Laws

Passage of recent legislation has helped fuel forward advancements in Veteran suicide prevention. Notably, the National Suicide Hotline Designation Act (2020) established a national three-digit emergency number to simplify access to crisis services, replacing the ten digit, 1-800-273-8255 National Suicide Prevention Hotline number (press 1 to reach the VCL). In preparation for the launch, VCL, has coordinated with the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services, and the Federal Communications Commission, around implementation of the National Suicide Hotline Designation Act. This law required full implementation of 988 by all telephone carriers by July 16, 2022 and reduces barriers to accessing care during times of crisis. To plan for this transition, VCL prepared for a significant increase in volume through expansion of staffing to support call, chat and text services, while simultaneously increasing staffing of primary care-mental health integration, general mental health and suicide prevention teams locally. From July 15 to September 18, 2022, VCL has received 143,093 calls while continuing to maintain an answer rate of less than 10 seconds. Compared with this time frame last year it, it represents an 11.31% increase in call volume. VA continues to prepare for the ongoing increased call volume anticipated of 122-154% with ongoing hiring for the VCL underway.

Preparation for 988 implementation included coordination across the Nation and Federal interagency, as VCL is a critical component of the Nation's largest Integrated Suicide Prevention Network. VCL links Veterans in crisis to more than 500 Suicide Prevention Coordinators at every VAMC for local follow-up within 1 business day.

Over the past 2 years in preparation for 988, VCL has also expanded its services "beyond the call." In June 2020, VCL implemented Caring Letters, an evidence-based intervention denoted in the CPG, for over 90,000 Veterans annually. Veterans receive nine letters over the course of a year after their call to VCL. Adding Caring Letters for VCL callers provides a unique opportunity to help save Veteran lives encouraging ongoing engagement in services after at a time of high risk for suicide. Since launch, VCL has mailed over 1.2 million caring letters to over 175,000 Veterans. In quarter 3, FY 2021, VCL launched its Peer Support Outreach Call Center (PSOC) to provide support, hope and recovery-oriented services to Veterans who are identified as being at increased risk for suicide. PSOC provides compassionate outreach via phone services, with several calls to identified Veterans over several months. PSOC is staffed by VHA Peer Specialists who are in recovery from a substance use or mental health disorder, and who provide hope and recovery-oriented support to Veteran populations. Together Caring Letters and PSOC provide additional support of expansion of services as part of the unified efforts for 988 implementation.

In addition to the law expanding Veterans Crisis Line services, the Hannon Act also expands access to critical mental health care resources. Section 201 of the Hannon Act established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, allowing VA to provide grants to eligible entities to expand suicide prevention services to eligible individuals and their families to reduce the risk of suicide. This September, VA announced the first grant awardees to significantly expand services provided to Veterans in the community.

Likewise, the Veterans Comprehensive Prevention, Access to Care and Treatment Act of 2020 (COMPACT Act of 2020) provides authority to VA to implement programs, policies and reports related to transitioning Service members, suicide prevention and crisis services, mental health education and treatment and improvement of services for women Veterans. Section 201 of the COMPACT ACT promotes the furnishing of emergent suicide care at either VA or community facilities, including reimbursement of an eligible individual when they receive these services in non-VA settings, while Section 202 fostered a close collaboration between the Office of Mental Health and Suicide Prevention and the National Alliance on Mental Illness to provide education to caregivers and family members of Veterans receiving mental health services.

Ongoing Research and Program Evaluation

VA is committed to ongoing research and program evaluation of mental health and suicide prevention efforts and initiatives. The Office of Mental Health and Suicide Prevention conducts extensive program evaluation and collaborates with VA's Office of Research and Development, Mental Illness Research Education and Clinical Centers and Centers of Excellence to translate new research findings into practice (e.g., SPED), collaborating with them to provide technical assistance to the field and monitoring of progress in implementation. These evaluations are critical in assessing additional supports needed for program success and to inform revisions needed in national rollouts. Recently, VA Suicide Prevention's early demonstration pilot work showed the success of telehealth delivery of CBT-SP, supporting its further rollout as part of SP 2.0. Likewise, VA has designed a program evaluation for SP 2.0 overall to inform future efforts in community-based suicide prevention. A robust interrupted time series and a modified stepped wedge design are being used to assess short and intermediate outcomes of programs, and surveillance data are used to evaluate population impact on our ultimate goal of reducing Veteran suicide. VA conducts an annual review of the suicide prevention research portfolio to ensure alignment with the National Strategy and to set priorities for new research, which recently has included expansion of focus on lethal means safety and community-based suicide prevention efforts.

Conclusion

As VA has rolled out its public health approach for Veteran suicide prevention, more work is still needed. First, key to ongoing success is that suicide is not just a mental health problem. A recent analysis of 365 research studies across 50 years found that mental health indicators were only weakly correlated with suicide or suicide attempts.[11] Likewise, in 2019, for Veterans who died by suicide with recent treatment in the VHA, over 47% had not received mental health care in the year prior to their death. Non-mental health concerns contribute to the risk for suicide, including those associated with broader societal issues.[12] This means that mental health clinicians alone cannot address Veteran suicide.

Second, solutions focused on the individual alone will not end suicide. Our systems continue to tackle suicide primarily as a mental health problem and a problem at the individual level.[13] Much like reduction of traffic fatalities through development of seat belts for automobiles, societal interventions can address broader risk beyond the individual level (e.g., LMS efforts). Health care systems are called to engage in new models of care, which include public health campaigns, education and working outside the walls of a clinic addressing broader systemic issues through community-based efforts.

We must advance evidence-based clinical interventions focused specifically on suicide prevention and on known treatments which work, while continuing to innovate and study new interventions in clinical settings. The publication of the 2019 CPG was particularly timely, serving as a foundation of SP 2.0 Clinical Telehealth. Yet access to evidence-based interventions inside and outside the VA system for Veterans at risk for suicide requires significant expansion. An often quoted statistic is that it takes 17 years from research in health care to change practice in the field.[14] To advance faster implementation processes, VA has developed demonstration projects to fund new efforts combined with evaluation to assess for potential scaled implementation at the national level (e.g., CBT-SP telehealth). The Office of Mental Health and Suicide Prevention regularly works with with known implementation science experts, utilizing evidence-based strategies to support field implementation. We must continue to expedite translation of research into practice to reach all Veterans, while also combining innovation with program evaluation to advance our next steps.

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[11] Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, *143*(2), 187–232.
[12] Turecki, G., & Brent, D. A. (2016) Suicide and suicidal behavior. *Lancet, 387*, 12271,227–39.
[13] Bryan, C. J. (2021) *Rethinking suicide*. Oxford University Press.
[14] Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520.

Finally, we need all of us at the table and working in the same direction. To fully implement a public health approach that combines both community-based and clinically-based interventions, engagement of both clinicians and community members is required. Ongoing coordinated efforts at the Federal, State and community level with each of you will be critical for ongoing implementation of the Governor's Challenge, Together with Veterans and local community suicide prevention coalitions. As we continue to advance our initiatives in the community, we also move towards ensuring Veterans have access to evidence-based treatments for suicide prevention across the Nation. Work moves forward in ongoing research and innovation, as we continue to evaluate new programs and initiatives to reduce Veteran suicide. This requires both moving away from a belief that suicide is solely a mental health problem and moving towards engaging within and outside of clinical healthcare delivery systems, to decrease both individual and societal risk factors for suicide. Suicide is preventable and each of us has a role to play in this mission. The public health approach reminds us that we each can and do make a difference.

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