STATEMENT OF

BARBARA STANLEY, PH.D.
PROFESSOR OF MEDICAL PSYCHIATRY AT
COLUMBIA UNIVERSITY

AND

DIRECTOR OF THE SUICIDE PREVENTION TRAINING, IMPLEMENTATION AND EVALUATION PROGRAM AT
NEW YORK STATE PSYCHIATRIC INSTITUTE

WITH RESPECT TO

"Veteran Suicide Prevention: Maximizing Effectiveness and Increasing Awareness"

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Chairman Roe, Ranking Member Walz and members of the committee, thank you for the opportunity to provide remarks on the critical issue of how to address the suicide epidemic among our veterans, including effective treatments and increasing awareness.

The hearing's aim, to examine the findings of the Department of Veterans Affairs' (VA's) most recent suicide data reports as well as the efficacy of ongoing efforts to prevent suicide among veterans receiving care in the VA healthcare system, is of critical importance. An additional goal, identifying actions needed to lower the rates of suicide among at-risk veterans, is within reach.

Suicide is one of the ten leading causes of death in the United States and, unfortunately, has increased by nearly 30% in the past 15 years. This increase stands in stark contrast to most other western countries where the suicide rate has either declined or remained the same. Furthermore, while suicide deaths have risen, other leading causes of death in the United States have mostly declined in this same time frame.

Among suicide victims, Veteran suicide remains a persistent problem. Veterans die by suicide at a significantly higher rate than the non-Veteran population with Veteran suicide 2.1 times higher than non-Veteran adults with about 2/3 of suicide deaths in Veterans by firearms.) This is dramatically higher than the overall firearm suicide rate in this country that stands at about 50%.

Despite the seriousness and complexity of the problem, simple actions can be taken that can help reduce suicide in the Veteran population that already have established effectiveness. While there are many strategies can and should be employed to address suicide in Veterans, this statement focuses on low burden intervention strategies with established effectiveness. Much has been done to identify those Veterans within the VA at greatest risk of dying by suicide. However,

outreach to Veterans in the community who are not within the VA system can be increased by identifying those at risk using simple assessment tools like the Columbia Suicide Severity Rating Scale (C-SSRS), an assessment tool that is widely used within the VA.

Furthermore, once identified, Veterans need help to deal with their suicidal feelings to avoid acting of them. But the transition from identification of risk to asking for help is a challenge for Veterans. The majority of Veterans are male with females comprising only about 10% of the Veteran population. In general, males are much less likely to seek help than females particularly for emotional problems. Efforts made to encourage them to seek help should include care models that are consistent with a military approach that includes systematic problem solving, implementation of predetermined action plans and teamwork. These models are more likely to be acceptable and employed.

One such approach is the use of the Safety Planning Intervention. This intervention coupled with follow-up phone calls, called SAFE VET, has been found to reduce suicidal behavior almost in half in Veterans at risk for suicide. My colleague, Dr. Gregory Brown from the University of Pennsylvania, and I developed this simple, easy to use intervention that is consistent with a military approach to problem solving and includes identification of simple strategies to use in a crisis, people who can provide support and acceptable ways to reduce access to lethal means that the Veterans would use to kill themselves.

As one Veteran who used this intervention reported when asked about the usefulness of safety planning reported, *"How has the safety plan helped me? It has saved my life more than once."* This Veteran's reaction has been echoed by many others who have used safety planning. While this intervention is used in the VA, the quality of its delivery is variable and needs to be improved. Furthermore, while we have established effectiveness of the safety planning intervention with phone follow-up for at risk Veterans discharged from the emergency room, large scale implementation in the VA with adequate resources for training to ensure high quality health care delivery has not been done.

Additionally, outreach efforts to implement safety planning with at risk Veterans who not in VA care are negligible. Finally, simple interventions can be readily translated into electronic modes of delivery in the form of apps with or without assistance of health care professionals. For example, a safety planning app could easily be developed, tested and disseminated to all Veterans whether or not they received healthcare within the VA. This app could be paired with additional suicide prevention apps such as insomnia apps, problem solving apps and depression apps.

Recommendations:

1. Systematic implementation of the SAFE VET intervention which includes the Safety Planning and telephone follow up in Emergency Departments, Behavioral Health and Substance Use Disorder Programs throughout the VA.

2. Couple training and dissemination of safety planning with efforts to screen for at risk Veterans who are not being treated in VA settings.

3. Develop and disseminate suicide prevention apps that include safety planning that are available to all Veterans whether or not they are receiving VA healthcare.