STATEMENT OF
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Good afternoon Chairman Takano, Ranking Member Roe, and Members of the Committee. I appreciate the opportunity to discuss the critical work VA is undertaking to prevent suicide among our Nation's Veterans. I am pleased to be in attendance with Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, and Frederick Jackson, Deputy Assistant Secretary, Office of Security and Law Enforcement.

Introduction

Suicide is a complex issue with no single cause. It is a national public health issue that affects people from all walks of life, not just Veterans. Suicide is often the result of a multifaceted interaction of risk and protective factors at the individual, community, and societal levels. All of us at VA are saddened by suicide among Veterans, and we are committed to ensuring the safety of our Veterans, especially when they are in crisis. Losing one Veteran to suicide shatters his or her family, loved ones, and caregivers. Veterans who are at risk or reach out for help must receive assistance when and where they need it in terms they value.

Thus, VA has made suicide prevention our top clinical priority and is implementing a comprehensive public health approach to reach all Veterans—including those who do not receive VA benefits or health services.

These efforts are guided by the National Strategy for Preventing Veteran Suicide. This 10-year strategy, published in June 2018, provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans through a broad public health approach with an emphasis on comprehensive, community-based engagement. This approach is grounded in four key focus areas as follows:

- Primary prevention that focuses on preventing suicidal behavior before it occurs;
- Whole Health offerings that consider factors beyond mental health, such as physical health, social connectedness, and life events;

- Application of data and research that emphasizes evidence-based approaches that can be tailored to fit the needs of Veterans in local communities; and
- Collaboration that educates and empowers diverse communities to participate in suicide prevention efforts through coordination.

Through the National Strategy, we are implementing broad, community-based prevention initiatives and clinical intervention driven by data to connect Veterans in and outside our system with care and support at both the national and local facility levels.

Clinical Intervention Strategies: Care Coordination Across the Continuum of Services

VA provides a full continuum of care from crisis intervention services, screening, same day access to mental health care, outpatient, residential, and inpatient mental health services across the country. A 2019 RAND study[i] shows that VA is providing high-quality mental health care and that this care can improve recovery rates and is cost-effective. Points of access to care span VA Medical Centers (VAMC), community-based outpatient clinics (CBOC), Vet Centers, mobile Vet Centers, the Veterans Crisis Line (VCL), and through the network of Suicide Prevention Coordinators (SPC) and team members available at all VAMCs. Veterans and their family members can connect with support through in-person appointments at local VA facilities, telehealth sessions, and online resources.

VA-Department of Defense (DoD) Collaboration for Suicide Prevention Care Coordination Among Servicemembers in Transition

VA collaborates closely with DoD to provide a single system of lifetime services for the men and women who volunteer to serve in the Armed Forces. Our partnership with DoD and the Department of Homeland Security (DHS) is exemplified by the successful implementation of Executive Order (EO) 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*. EO 13822 was signed by President Trump on January 9, 2018, and focused on transitioning Servicemembers (TSM) and Veterans in the first 12 months after separation from service, a critical period marked by a high risk for suicide.

The EO mandated the creation of a Joint Action Plan by DoD, DHS, and VA that provides TSMs and Veterans with seamless access to mental health treatment and suicide prevention resources in the year following discharge, separation, or retirement. VA provides several outreach programs and services that facilitate enrollment of Veterans who may be at risk for mental health needs, to include VA Liaisons stationed at 21 military medical treatment facilities as well as multiple outreach programs to support engagment in mental health services at VA or in the community. Some of our early data collection efforts point towards an increase in TSM and Veteran awareness and knowledge about mental health resources, increased facilitated health care enrollment, and increased engagement with peers and community resources through

the Transition Assistance Program (TAP) and Whole Health offerings. TAP curriculum additions and facilitated enrollment have shown that in the third quarter of Fiscal Year (FY) 2019, 86 percent of 11,226 TSM respondents on the TAP exit survey reported being informed about mental health services.

VA and DoD are committed to delivering compassionate support and care, whenever and wherever a Servicemember or Veteran needs it. This includes collaborating to implement programs that facilitate enrollment and transition to VA health care; increasing availability and access to mental health resources; and decreasing negative perceptions of mental health problems and treatment for Servicemembers, Veterans, and providers. The most recent coordinated effort under EO 13822 began in December 2019, when VA launched the Solid Start call center, which proactively contacts all newly separated Servicemembers at least three times during their first year of transition from the military.

Although EO 13822 was established to assist in preventing suicide in the first-year post-transition, the completed and ongoing work of the EO effects suicide prevention efforts in the years following a Servicemember's transition. These efforts are demonstrated through increased coordinated outreach, improving monitoring, and increasing access to care beyond the first year. VA is working diligently to promote wellness, increase protection, reduce mental health risks, and promote effective treatment and recovery as part of a holistic approach to suicide prevention.

Care Coordination for Veterans at Risk of Suicide Across the Continuum of Care: The Role of Suicide Prevention Coordinators

Within the VA system, there is currently a network of over 400 SPCs. Overall, SPCs facilitate the implementation of suicide prevention strategies within their respective VAMCs and catchment areas to ensure that all appropriate measures are being taken to prevent suicide in the Veteran population, particularly Veterans identified to be at high risk for suicidal behavior. As an integral part of Veterans' care teams implementing VA suicide prevention programs, SPCs are experts on suicide prevention best practices. SPCs work closely with other providers to ensure that Veterans living with mental health conditions and experiencing difficult life events receive specialized care and support for their suicide risk.

SPCs also plan, develop, implement, and evaluate their facility's Suicide Prevention Program to ensure continual quality improvement and excellence in customer service. This work affects a wide range of agency activities and operations and directly affects the health and well-being of the Veterans served and relationships with community organizations and stakeholders.

An essential role of SPCs is to participate in outreach activities in local communities to increase awareness of suicide prevention and the resources available in the local community (a minimum of five events per month with increased efforts during September's Suicide Prevention month). These outreach activities include: (1)

community suicide prevention trainings and other educational programs; (2) exhibits and material distribution to a wide variety of organizations and populations; (3) meetings with state and local suicide prevention groups, collaborations with Vet Centers, local Veterans of Foreign Wars (VFW) and American Legion branches; and (4) suicide prevention work with Active Duty/Guard/Reserve units, college campuses, and American Indian/Alaska Native groups.

Suicide Prevention Crisis Services and Follow-up Care Coordination: VCL and Emergency Department

Established in 2007, VCL provides confidential support to Veterans in crisis. Veterans, as well as their family and friends, can call, text, or chat online with a caring, qualified responder, regardless of eligibility or enrollment for VA care. VA is dedicated to providing free and confidential crisis support to Veterans 24 hours a day, 7 days a week. VA has streamlined and standardized how crisis calls from other locations within VA reach VCL, including full implementation of the automatic transfer function that directly connects Veterans who call their local VAMC to VCL by pressing a single digit (7) during the initial automated phone greeting. SPCs also assist in coordination of follow-up referrals for Veterans after they call the VCL by assisting Veterans with accessing VHA care and assisting with evaluation, treatment, and or referrals to community-based care for those who decline VA services or are ineligible for services.

Veterans in crisis not only present to the VCL but also present in VA emergency departments (ED). Suicide Prevention in Emergency Departments (SPED) is an evidence-based strategy currently being deployed in VA. Veterans presenting to the ED, or for VA urgent care, who have been assessed as at risk of suicide, but are safe to be discharged home, receive suicide safety planning intervention prior to discharge and follow-up outreach to facilitate engagement in outpatient mental health care. Safety planning interventions (SPI) in EDs provide safety planning and lethal means counseling prior to discharge and follow-up contact after discharge with the Veteran to offer support until he/she has connected with outpatient mental health providers. Implementing an SPI and follow-up phone call for patients who visited participating VA EDs for suicide-related concerns reduces suicidal behaviors by almost half (45 percent) in the 6 months following the ED visit.[ii]

Suicide Risk Identification Process: Screening to Enhance Access to Treatment and Care Coordination

In addition to providing suicide prevention services during the time of crisis, VA provides proactive methods for identifying individuals at high risk for suicide. VA has implemented a standardized suicide risk screening and assessment process, providing Veterans with a high standard in preventive care. This process, known as the Suicide Risk Identification Strategy (Suicide Risk ID), was introduced in May 2018. The Suicide Risk ID is for all Veterans receiving VA care. The strategy is comprised of three components and implements population-based mental health screening for those with unrecognized risk (universal screening), for those who may be at risk (selected

screening), and for those at elevated risk (indicated screening). The components include standardized primary and secondary screens specific to risk of suicide and a comprehensive suicide risk evaluation for Veterans with a positive secondary screen. Screenings occur at every ED and urgent care visit across VA. For Veterans presenting for other VHA services, VA has setting-specific guidance for screening and assessment.

The Suicide Risk ID integrates the recently-published (2019) VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (CPG). CPG is an update to the 2013 guideline and outlines five recommendations on screening and evaluation; the Suicide Risk ID uses part of the CPG's recommendations, including comprehensive screening, specifically:

- The use of a validated screening tool for universal screening to identify individuals at risk for suicide-related behavior;
- The use of the Patient Health Questionnaire- item 9, and
- An assessment of risk factors as part of a comprehensive evaluation of suicide risk.

From October 1, 2018, through December 4, 2019, more than 4.1 million Veterans have received a standardized risk screening.

Same Day Access: Getting to Care when Care is Needed

A critical part of suicide prevention is ensuring same day access to mental health services. VA launched the My VA Access Initiative in 2016. This initiative provides same day access to primary care and mental health services. In mental health care clinics, the number of same-day scheduled appointments increased from 796,242 in FY 2017 to 824,276 in FY 2018. The percentage of new patients with same-day appointments increased from 29.5 percent (FY 2017) to 33.2 percent (FY 2018).

Suicide Prevention in Primary Care: Reaching Veterans through Early Identification

VA's Primary Care Mental Health Integration (PCMHI) is an initiative that provides collaborative care with embedded mental health providers within primary care clinics and collaborative care management. Through PCMHI, primary care providers are critical partners in VA suicide prevention strategies. The PCMHI model provides open access to Veterans, as well as mental health consultative advice to Primary Care staff, assessment, and brief interventions in a stepped approach within the Veteran's local health care clinic. Early identification, accurate diagnosis, and effective treatment of mental health conditions improves the chances for recovery.

As a result, VA primary care providers screen Veterans for depression, posttraumatic stress disorder (PTSD), problematic alcohol use, and difficulties related to military sexual trauma. It also provides an opportunity to deliver mental health services to those who may otherwise not seek them and identify, prevent, and treat mental

health conditions at the earliest opportunity. Making mental health care a routine part of primary care helps reduce stigma and provides the right intensity of care to the Veteran as quickly as possible.

Suicide Prevention and Care Coordination through Outpatient Mental Health Services

Each Veteran receiving ongoing VA specialty mental health care is assigned a Mental Health Treatment Coordinator (MHTC) who ensures continuity of care and provides the Veteran with a consistent and reliable point of contact, especially during times of care transitions. The MHTC serves as a clinical resource for the Veteran and staff, generally as part of the Veteran's assigned mental health care team.

In addition, VA facilities throughout the country are utilizing teams to promote Veteran-centered, coordinated care to support recovery. One model for this team-based care is the Behavioral Health Interdisciplinary Program (BHIP), which coordinates collaborative, evidence-based, Veteran-centered care by an interdisciplinary team of providers and clerical staff in outpatient mental health clinics at all VAMCs. BHIP is guided by the evidence-based Collaborative Care Model, which focuses on six core elements: providing organizational and leadership support, anticipating care needs through process redesign, enhancing Veteran self-management skills, offering decision support for providers, managing clinical information about Veterans, and accessing support for Veterans in the community. Through its emphasis on team building, communication, and coordination, BHIP is demonstrating a meaningful, positive impact on patient care and teamwork—including improved staff relationships, job satisfaction, and Veteran access to care. Early data show that, compared to non-BHIP patients, patients who had depression, PTSD, and serious mental illness, who were seen by BHIP teams, were more likely to engage in three treatments over 6 weeks.

Suicide Prevention and Care Coordination Related to Inpatient and Residential Services

VA's most intensive services for mental health and suicide prevention are delivered through residential treatment and inpatient mental health programs, either the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) or the Domiciliary Care Program, which is VA's oldest program—established in 1865, at the National Home for Disabled Volunteer Soldiers. Today, MH RRTPs provide intensive specialty treatment for mental health and Substance Use Disorders, as well as for co-occurring medical needs, homelessness, and unemployment. MH RRTPs are staffed 24 hours a day, 7 days per week, and provide access to both professional and peer support services. MH RRTPs identify and address Veterans' goals for rehabilitation, recovery, health maintenance, quality of life, and community integration. VA provides inpatient mental health care for Veterans at risk of harming themselves or others, or who require hospitalization to stabilize their condition and to facilitate recovery. Nationwide, 113 VA facilities offer acute inpatient psychiatry programs, and in FY 2018, those programs served approximately 57,000 Veterans.

VA has several policies and guidance that require care coordination, and a clinical care team member follows up or provides *caring* communications across all VA medical facilities for Veterans after an inpatient mental health stay or hospitalization for suicide related concerns. According to VHA policies for post-discharge follow-up and enhanced care for patients at high risk of suicide, the type and frequency of the contact varies depending on inpatient stay setting (residential vs. inpatient mental health), type of discharge (regular or against medical advice), and the severity of suicide risk presentation. Follow-up contact may include phone calls, letters, and clinical visits and can be as soon as 24 hours or 7 days post-discharge, with potential subsequent clinical contacts weekly for the next 30 days or longer.

Mental Health Safety and Environment of Care on VA Campuses

Providing a safe environment of care is a critical part of suicide prevention. In a 2018 study, Williams and Schmaltz completed a study of Joint Commission Accredited Hospitals who voluntarily reported 505 suicide deaths to The Joint Commission between 2010 and 2016, including VHA. The data in The Joint Commission's possession may not reflect the actual occurrence of suicides in all U.S. hospitals; however, data collected included inpatient suicides, suicides in emergency departments, suicides that occurred post-discharge, and suicides in which the victim may not have been directly receiving treatment at the hospital. Based on this report, VA has been able to reduce the number of in-hospital suicides from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions on mental health units, an 82.4-percent reduction, suggesting that well-designed quality improvement and safety initiatives can lead to a reduction in the occurrence of these tragic events.[iii]

One example of VA's safety initiatives is the requirement that each VAMC review its inpatient mental health units' environment every 6 months by using the Mental Health Environment of Care Checklist. To perform this task, facilities are expected to create Interdisciplinary Safety Inspection Teams (ISIT). ISITs are expected to provide their subject matter expertise on the environmental risks that facilities may face regarding suicide. ISITs use a risk assessment matrix to help determine the actions that need to be taken to improve facilities' mental health environments in accordance with Joint Commission Standards. In May 2019, VHA mandated that all VAMCs with an acute mental health unit install door top alarms. Door top alarms installed on swinging corridor doors of patient rooms in VA mental health inpatient units have proven to be effective in providing timely notification to staff and preventing completion of suicide attempts. As of August 2019, approximately 50 percent of VHA inpatient mental health facilities reported having door top alarms installed. Projects are underway to install door top alarms on the remainder of the inpatient mental health units, with a targeted completion date of March 1, 2020.

As part of its efforts to ensure all facilities are safe for both Veterans and employees, VA also requires all MH RRTPs to "stand down" or suspend clinical operations for 1 day each year to focus on safety, security, and quality of care. MH

RRTP clinicians are required to undergo documented annual competency reviews for assessing risk for suicide. MH RRTPs are required to complete Annual Safety and Security Assessments of their environments before each Stand Down. SPCs are required to participate in both the Stand Down and the pre-Stand Down assessment of facility environments to assist with addressing suicide prevention content.

Responding to On-Campus Suicidal Behavior

VHA policy requires that all VHA employees must complete their required suicide risk and intervention training module (either Suicide Risk Management Training for Clinicians or Signs, Ask, Validate, and Encourage and Expedite (S.A.V.E.) training for non-clinicians) and, for providers/clinicians, pass the post-module test within 90 days of entering their position. VHA has also developed a Suicide Risk Management Training for registered nurses that may be assigned annually as an alternative training option to Suicide Risk Management Training for Clinicians, understanding that the roles may be different in some cases. Local facilities may assign training to appropriate staff and track this training through the Talent Management System. VA supports employees as well as external community providers by providing the VA Suicide Risk Management Consultation Program to consult on a specific case or talk about suicide risk management strategies more generally.

VA Police Officers receive specialized training at the VA Law Enforcement Training Center (LETC). LETC is accredited by the Federal Law Enforcement Training Accreditation Board, which emphasizes the use of non-physical techniques and is recognized as meeting the highest standards in Federal law enforcement training. All VA Police Officers go through a 10-week basic course at LETC. They receive 30 hours of training specific to de-escalation and conflict management, with a special focus on suicide awareness and prevention. Officers also complete nearly 24 hours of de-escalation training in which they learn skills to affect positive outcomes in real-life scenarios.

Collaboration between law enforcement and health care professionals is crucial when responding to violent incidents, police calls for service in the field, or Veterans in suicidal crisis. VA Police and all VA employees work every day to recognize Veterans who may be in crisis and expedite getting them the help they need. Their diligence and specialized training have saved lives across the country on VA campuses when they have interrupted or responded quickly to Veterans in suicidal crisis. VA began tracking on-campus suicidal behavior in October 2017; as of January 2020, there have been a total of 566 incidents of suicidal attempts, of which 49 were suicide deaths.

Community Prevention Strategies

Communication Strategies

Preventing suicide among all of the Nation’s 20 million Veterans cannot be the sole responsibility of VA; it requires a nation-wide effort. Suicide prevention requires a

combination of programming and the implementation of strategies and initiatives at the universal, selective, and indicated levels. This "All-Some-Few" strategic framework allows VA to design effective programs and interventions appropriate for each group's level of risk. Not all Veterans at risk for suicide will present with a mental health

diagnosis, and the strategies below employ a variety of tactics to reach all Veterans, which may include:

- Universal strategies that aim to reach all Veterans in the United States. These include public awareness and education campaigns about the availability of mental health and suicide prevention resources for Veterans, promoting responsible coverage of suicide by the news media, and creating barriers or limiting access to hotspots for suicide, such as bridges and train tracks;
- Selective strategies are intended for some Veterans who fall into subgroups that may be at increased risk for suicidal behaviors. These include outreach targeted to women Veterans or Veterans with substance use disorders, gatekeeper training for intermediaries who may be able to identify Veterans at high-risk, and programs for Veterans who have recently transitioned from military service; and
- Indicated strategies designed for the relatively few individual Veterans identified as having a high risk for suicidal behaviors, including some who have made a suicide attempt.

Guided by this framework and the National Strategy, VA is creating and executing a targeted communications strategy to reach a wide variety of audiences. VA uses an integrated mix of outreach and communications strategies to reach audiences. VA relies on proven tactics to achieve broad exposure and outreach while also connecting with hard-to-reach targeted populations. Our target audiences include, but are not limited to, women Veterans; male Veterans age 18-34; former Servicemembers; men age 55 and older; Veterans' loved ones, friends, and family; organizations that regularly interact with Veterans where they live and thrive; and the media and entertainment industry, who have the ability to shape the public's understanding of suicide, promote help-seeking behaviors, and reduce suicide contagion among vulnerable individuals.

VA proactively engages others to help share our messages and content, including Public Service Announcements (PSA) and educational videos. For example, in collaboration with Johnson & Johnson, VA released through social media a PSA titled "No Veteran Left Behind," featuring Tom Hanks. VA continues to use the #BeThere Campaign to raise awareness about mental health and suicide prevention and educate Veterans, their families, and communities about the suicide prevention resources available to them. During Suicide Prevention Month 2019, VA's #BeThere campaign reminded audiences that everyone has a role to play in preventing Veteran suicide. It also emphasized that even small actions of support can make a big difference for someone going through a challenging time and can ultimately help save a life. Through

shareable content and graphics, VA reached over 200 entities through a news bulletin and quarterly newsletter emails. In collaboration with Twitter, a custom icon—an orange awareness ribbon—was linked to the #BeThere hashtag in tweets. This positioned Veterans as part of the global Twitter conversation about Suicide Prevention Month. Veteran-specific posts that used the #BeThere hashtag had almost 84 million potential impressions.

We are leveraging new technologies and working with others on social media events while continuing our digital outreach through online advertising. VA also utilizes its Make the Connection resource (www.MakeTheConnection.net) to highlight Veterans' true and inspiring stories of mental health recovery, connecting Veterans and their family members with local VA and community mental health resources. Over 600 videos from Veterans of all eras, genders, and backgrounds are at the heart of the Make the Connection campaign. The resource was founded to encourage Veterans and their families to seek mental health services (if necessary), educate Veterans and their families about the signs and symptoms of mental health issues, and promote help-seeking behavior in Veterans and the general public. Finally, VA continues to rely on Veterans Service Organizations, non-profit organizations, and private companies to help us spread the word through their person-to-person and online networks.

Working with Communities

VA is working with Federal partners, as well as State and local governments, to implement the National Strategy to reach all Veterans through community prevention. Community Prevention focuses on "upstream strategies" to address social determinants of health outside the VHA health care system to promote early awareness and prevention prior to times of crisis, while also expanding collaboration and coordination of services across all Veterans, families, non-VHA health care systems, other community partners, and VA. In March 2018, VA, in collaboration with the Department of Health and Human Services, introduced the Mayor's Challenge with a community-level focus, and in 2019, debuted the Governor's Challenge to take those efforts in Veteran suicide prevention to the state level. The Mayor's and Governor's Challenges promote VA's suicide prevention efforts by working with 7 governors (from Arizona, Colorado, Kansas, Montana, New Hampshire, Texas, and Virginia) and 24 local governments; locations were chosen based on Veteran population data, suicide prevalence rates, and capacity of the city or state to develop plans to prevent Veteran suicide, again with a focus on all Veterans at risk of suicide, not just those who engage with VA. We will be expanding to 28 additional states in FY 2020 with a goal of engaging all 50 states and the territories by the end of FY 2022.

In addition to the Challenges, VA is developing models of community-based approaches for suicide prevention, including a pilot in Veterans Integrated Service Network 23, focused on community coalition-building and "Together with Veterans," a VA program focused on community coalition-building specifically in rural settings. The goal of "Together with Veterans" is to build and sustain local capacity to implement multiple coordinated suicide prevention strategies, following a science-based implementation toolkit. As part of these strategies, technical assistance is available to

provide data reporting, evaluation, and consultation in support of local communities implementation of strategic plans to address Veteran suicide.

In addition to the proactive work by VA Police on campus, VA Police are actively involved in training other first responders in the community in life saving strategies. The VA National First Responder Outreach and Training Program is an innovative, common-sense, and cost-effective public health approach that addresses the Veteran community, spefically prioritizing Veteran suicide. At its foundation, the program utilizes community outreach engagements to facilitate collaboration with emergency first responders at the local, state, and Federal levels. To date, this program has trained over 3,500 community emergency first responders across the country. The feedback from the first responder community has been resoundingly positive, noting that the information is relevant and presented in a way that has direct practical application.

Partnerships with Organizations for Suicide Prevention

The National Strategy is a call to action to every community, organization, and system interested in preventing Veteran suicide to help do this work where we cannot. For this reason, VA is leveraging a network of more than 60 partners in the public, private, and non-profit sectors to help us reach Veterans, and our network is growing weekly. For example, VA and PsychArmor Institute have a non-monetary partnership focused on creating online educational content that advances health initiatives to better serve Veterans. Our partnership with PsychArmor Institute resulted in the development of the free, online S.A.V.E. training course that enables those who interact with Veterans to identify signs that might indicate a Veteran is in crisis and how to safely respond to and support a Veteran to facilitate care and intervention. Since its launch in May 2018, S.A.V.E. training has been viewed more than 18,000 times through PsychArmor's internal and social media system and 385 times on PsychArmor's YouTube channel.

VA and DoD Veteran Suicide Data Tracking and Reporting

While implementing both clinical and community strategies for suicide prevention, VA aims to provide the most accurate report on the status of Veteran suicide in the Nation. Each year, VA and DoD produce separate annual reports on Veteran and current Servicemember suicide mortality, respectively. VA and DoD partner in preventing suicide for all current and former Servicemembers, but do not use the same data sources for suicide surveillance reporting, with VA reporting on Veterans and former Servicemembers, and DoD reporting on current Servicemembers. This allows VA's report to focus on former Servicemembers who most closely meet the official definition of Veteran status that is used by VA and other Federal agencies. For this report, a Veteran is defined as someone who had been activated for Federal military service and was not currently serving. In addition, the report includes information in a separate section on suicide among former National Guard or Reserve members who were never Federally activated.

For VA suicide surveillance reporting, VA and DoD partner to submit a search list of all identified current and former Servicemembers to the Centers for Disease Control and Prevention's (CDC) National Death Index (NDI) each fall. After processing, which can take several months, NDI returns all potentially matching mortality information. Additionally, internal processing and coordination occurs between VA and DoD to identify Veteran and Servicemember deaths, finalize mortality information, conduct statistical analyses, and interpret results.

Due to the different data sources, DoD data on mortality among current Servicemembers are available in a timelier fashion. DoD uses the Armed Forces Medical Examiner System (AFMES) as its data source for current active duty Servicemember suicide mortality information. A data source similar to AFMES is not available to VA. VA relies on national reporting to identify dates and causes of death per state death certificates, through NDI, which are reported up through local medical examiners and coroners to respective states and territories.

VA 2019 National Veteran Suicide Prevention Annual Report

The 2019 National Veteran Suicide Prevention Annual Report is VA's most recent analysis of Veteran suicide data from 2005 to 2017. It reflects the most current national data available through CDC's 2017 NDI.

One of the key ways in which this year's report is different is that it sets Veteran suicide in the broader context of suicide deaths in America and the complex cultural context of suicide. From the report, we know the average number of suicides per day among U.S. adults rose from 86.6 in 2005 to 124.4 in 2017. These numbers included 15.9 Veteran suicides per day in 2005 and 16.8 in 2017. The report highlights suicide as a national problem affecting Veterans and non-Veterans, and VA calls upon all Americans to come together to take actions to prevent suicide.

The data presented in the report are an integral part of VA's comprehensive public health strategy and enables VA to use tailored suicide prevention initiatives to reach various Veteran populations. The report includes a section on key initiatives that have been developed since 2017 to reach all Veterans. The report is designed for action based upon a stratification with the public health classification of universal (all), selective (some), and indicated (few) population framework as noted in the National Strategy.

When we look at our data, there are indicators that trends among Veterans in VA care that offer anchors of hope upon which we can continue to build. For example, suicide rates among Veterans in recent VHA care (Veterans who had a VHA health encounter in the calendar year of interest or in the prior calendar year) with a diagnosis of depression have decreased from 70.2 per 100,000 in 2005 to 63.4 per 100,000 in 2017. After adjusting for age and sex, between 2016 and 2017, the suicide rate among Veterans in recent VHA care increased by 1.3 percent while increasing by 11.8 percent among Veterans who did not use VHA care. We have seen a notable increase in

women Veterans coming to us for care. Women are the fastest-growing Veteran group, comprising about 9 percent of the U.S. Veteran population, and that number is expected to rise to 15 percent by 2035. Although women Veteran suicide counts and rates decreased from 2015 to 2016 and did not increase for women Veterans in VHA care between 2016 and 2017, women Veterans are still more likely to die by suicide than non-Veteran women. These data underscore the importance of our programs for this population. VA is working to tailor services to meet their unique needs and has put a national network of Women's Mental Health Champions in place to share information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care. Efforts are already underway to better understand this population and other groups that are at elevated risk, such as never federally-activated Guard and Reserve members, recently separated Veterans, and former Servicemembers with Other Than Honorable (OTH) discharges.

We need to consider the social determinants of health, defined broadly as well-being (economic disparities, homelessness, and social isolation), and how these issues, may create a context that markedly increases someone's risk of suicide. Veterans who are employed, have a stable place to live, and are affiliated with a community of Veterans and others for support are more likely to be optimistic about their future. While there is still much to learn, there are some things that we know for sure: suicide is preventable, treatment works, and there is hope.

Update Progress and Challenges Toward Addressing VA OIG Recommendations

In collaboration with the Office of Security and Law Enforcement, a staffing model was developed. The new staffing model is currently under review. In addition, VHA has modernized the position descriptions for all of the Police Chiefs in the field. This is part of a larger workforce modernization effort underway for the VA Police force. This was a major accomplishment as it helps ensure our Police Chiefs are paid equitably. VA is in the process of continuing to develop modernized positions for all of our law enforcement professionals. The intent of the modernized positions is to create uniformity in the way work is distributed and carried out, thereby raising the technical standard of each position to ensure the best services are provided to our Veterans.

Conclusion

On March 5, 2019, EO 13861, *National Roadmap to Empower Veterans and End Suicide*, was signed to improve the quality of life of our Nation's Veterans and develop a national public health roadmap to lower the Veteran suicide rate. EO 13861 mandated the establishment of the Veteran Wellness, Empowerment, and Suicide Prevention Task Force to develop the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide and the development of a legislative proposal to establish a program for making grants to local communities to enable them to increase their capacity to collaborate with each other to integrate service delivery to Veterans and to coordinate resources for Veterans. The focus of these efforts is to provide Veterans at risk of suicide support services, such as employment, health, housing, education, social

connection, and to develop a national research strategy for the prevention of Veteran suicide.

This EO implementation will further VA's efforts to collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they are engaging with VA. This EO, in addition to VA's National Strategy, further advances the public health approach to suicide prevention by leveraging synergies and clearly identifying best practices across the Federal Government that can be used to save Veterans' lives.

VA's goal is to meet Veterans where they live, work, and thrive to ensure they can achieve their goals, teaching them skills, connecting them to resources, and providing the care they need along the way. Through open access, community-based and mobile Vet Centers, app-based care, tele-mental health, more than 400 Suicide Prevention Coordinators, and more, VA is providing care to Veterans when and how they need it. We want to empower and energize communities to do the same for Veterans who do not use VA services. We are committed to advancing our outreach, prevention, empowerment, and treatment efforts, to further restore the trust of our Veterans every day and continue to improve access to care. Our objective is to give our Nation's Veterans the top-quality experience and care they have earned and deserve. We appreciate this Committee's continued support and encouragement as we identify challenges and create innovative solutions to address the needs of Veterans.

This concludes my testimony. I am prepared to answer any questions you may have.

Thank you.

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