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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
U.S. HOUSE OF REPRESENTATIVES
ON
"ANSWERING THE CALL: EXAMINING VA'S MENTAL HEALTH POLICIES"

APRIL 30, 2025

Chairwoman Kiggans, Ranking Member Ramirez, and distinguished Members of the Subcommittee. Joining me today is Dr. Anthony Stazzone, Chief Medical Officer of the VA MidSouth Healthcare Network. It is an honor to be here on behalf of VA to discuss the critical work we are doing to ensure our Veterans receive the high-quality mental health care they deserve.

Introduction

Veterans face unique mental health challenges. While many Veterans are very successful and fully integrated back into society, some invisible wounds of war have manifested in conditions like posttraumatic stress disorder (PTSD), depression, and substance use disorders (SUD). These issues, combined with life transitions after military service, contribute to an elevated risk of suicide. In response, VA has developed a broad continuum of mental health services intended to ensure Veterans receive the help they need. This continuum ranges from crisis intervention and screening to same-day access for urgent mental health needs, as well as outpatient, residential, and inpatient care across the country. VA medical centers, community-based outpatient clinics, Vet Centers, the 24/7 Veterans Crisis Line, and a Nationwide network of Suicide Prevention Coordinators (SPC) all serve as points of access.

VA's mental health services are designed to be accessible, evidence-based, and recovery-oriented, ensuring that all Veterans receive the mental health support they need, regardless of where they access care. By emphasizing early intervention,

continuous support, and the seamless integration of mental health into overall health care, VA is committed to enhancing the well-being and resilience of Veterans Nationwide.

Most Veterans who utilize VA health care services report positive experiences and satisfaction with VA mental health care, including the availability of essential services, the strong emphasis on the privacy and confidentiality of medical records, the ease of accessing VA mental health services, the expertise and professionalism of the mental health care staff, and the courtesy and respect demonstrated by the staff toward patients.

In 2018, VA published the National Strategy for Preventing Veteran Suicide[1] which emphasized the need to develop and implement of a public health approach to suicide prevention. The public health approach combines both community prevention and clinical intervention actions that directly serve Veterans. The National Strategy focuses on preventing suicide for all Veterans, as well as selective and indicated strategies for reaching Veterans at higher risk for suicide. VA Suicide Prevention has fueled ongoing work with our partners in the Department of Defense (DoD) to support transitioning Service members. VA's commitment to preventing Veteran suicide is also interwoven throughout all mental health treatment programs and bolstered by enhanced staff educational requirements in suicide prevention.[2]

Let me be clear: the Secretary has made preventing Veteran suicide a top priority for VA. We face a sobering reality that demands acknowledgement: Since 2008, the number of Veterans who died by suicide each year has remained essentially unchanged at roughly 6,500 per year. Yet over that same period, VA spending on suicide prevention has increased by more than 11,000%, from $4.4 million per year in 2008 to $522 million per year in 2022. In other words, VA spending on suicide prevention is now more than 100 times what it was in 2008, but we're getting the exact same results. This status quo is unacceptable.

[1] https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf
[2] VHA Directive 1071, Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

This new Administration and VA leadership are committed to challenging the status quo in order to find new and better ways of helping Veterans. We cannot continue approaches that have failed to produce meaningful improvements despite substantial resource investments.

Recent reports by the Office of Inspector General (OIG) have highlighted deficiencies in VA's mental health care intake process and adherence to suicide risk identification screening guidance, among other issues. These findings underscore the urgent need for concerted efforts to address policy adherence and to strengthen our initiatives to provide high-quality health care to our Veterans. Despite these challenges, VA is committed to our mission: promoting, preserving, and restoring Veterans' health and well-being; empowering them to achieve their life goals; and to provide state-of-the-art mental health treatments. We are accelerating efforts to enhance access to care, whether delivered in VA facilities or through VA community care when eligible.

This is not simply an organizational priority; it is VA's sacred obligation to those who served. The Secretary has established this as the standard by which the Department's effectiveness will be measured, and VA leadership will accept nothing less than transformative improvement in suicide prevention and mental health care.

Suicide Risk Identification Strategy (Risk ID)

VA staff play an important role in supporting the Department's top clinical priority to prevent Veteran suicide. VA has implemented a standardized suicide risk screening and assessment process, providing Veterans with a high standard of preventive care. This process, known as the Suicide Risk Identification Strategy, was introduced in May 2018. As a population health effort, Risk ID is completed annually for all Veterans receiving VA care. Risk ID is also completed for Veterans receiving care in a VA emergency department and for Veterans seeking mental health services. Additional suicide screening occurs in certain health care settings, such as during intake at an outpatient mental health visit. Risk ID processes ensure that all VA health care systems are equipped to identify Veterans at risk for suicide and connect them to life-saving resources and interventions. Risk ID consists of a primary screen (using a standardized questionnaire such as the Columbia Suicide Severity Rating Scale), followed by a

Comprehensive Suicide Risk Evaluation, a templated clinical assessment, for any patient who screens positive. The goal of the evaluation is to determine the Veteran's severity of suicide risk and collaboratively develop a plan for risk mitigation.

VA is the largest health care system in the United States to implement universal screening for suicide risk, highlighting the Department's commitment to comprehensive suicide prevention. To ensure adherence to the Risk ID screening process, VHA issued a memorandum requiring all Veterans Integrated Service Networks (VISN) to confirm that facilities within each network have established procedures for implementing Risk ID requirements across clinical services. This attestation must align with each facility's standard operating procedures and conform to national policy and guidelines by April 7, 2025.[3] In fiscal year (FY) 2024, VA completed over 2.6 million suicide risk screenings.

In addition to broad screening efforts, VA also wants all Veterans and former Service members to know that they can access emergent suicide care, no matter where they are. Under 38 U.S.C. § 1720J, as added by section 201 of the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020 (P.L. 116-214), any Veteran – whether enrolled in VA or not – and certain former Service members can go to a VA or non-VA facility to access emergent suicide care If you're a Veteran in crisis or concerned about one, contact the Veterans Crisis Line to receive, confidential support 24 hours a day, 7 days a week. You don't have to be enrolled in VA benefits or health care to connect. To reach responders, Dial 988 then Press 1, chat online at VeteransCrisisLine.net/Chat, or text 838255.

Enhanced Training and Clinical Guidance

To stay at the forefront of suicide prevention, VA continually updates its clinical guidelines and training programs to support best practices. In 2024, VA and DoD released a new joint Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide, which compiles evidence-based strategies for evaluation, safety planning, and treatment of suicidal individuals. VA providers are encouraged to familiarize themselves with this critical guidance. Additionally, all VHA

[3] For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update (VIEWS 12521544)

health care staff must complete suicide prevention training. In recent years, VA has updated these trainings by, for example, creating improved education for all staff related to the steps to take to save Veterans lives, formerly known as "Operation S.A.V.E." VA tracks and monitors these courses to ensure training compliance.

Additionally, VA has implemented specialty training for SPCs and mental health clinicians on topics like lethal means safety counseling – such as how to talk with Veterans (and their families) about safely securing firearms or medications during a suicidal crisis. By institutionalizing such training and guidance, VA has worked to standardize the quality of care delivered to at-risk Veterans, no matter which facility they visit.

Another enhancement to our suicide prevention infrastructure is assigning dedicated SPCs across all VA medical facilities. SPCs actively monitor Veterans flagged as high-risk, coordinate follow-up care, facilitate safety planning, and ensure compliance with suicide prevention protocols. Regular contacts from a dedicated suicide prevention team during a high-risk period may reduce the risk of new suicidal behavior over time. During times of personal or community crisis, the SPC program provides a model for addressing risks related to mental health and for recovery enhancement. A 2021 study showed that additional SPC contact reduced the odds, between 4-5%, of suicide attempt, suicidal behavior, and reactivation of high-risk status within the next year.[4] Our enhanced safety planning practices now involve comprehensive, individualized safety plans collaboratively developed and documented clearly in electronic health records.

VA and DoD also have written CPGs for Bipolar Disorder, Management of First Episode Psychosis and Schizophrenia, Major Depressive Disorder, PTSD, and SUD. VA encourages mental health care providers to familiarize themselves with these guidelines.

With regard to training staff in recommended therapy dissemination, VHA is a recognized leader in ensuring that staff are trained in VA/DoD CPG-recommended therapies. VHA has done this through the National Evidence-Based Psychotherapy and Psychosocial Interventions (EBP) Provider Training Program, which advances access to

[4] Doran et al. (2021). Associations between veteran encounters with suicide prevention team and suicide-related outcomes. Suicide & Life-threatening Behavior.

VA evidence-based mental health through the provision of high-quality, competency-based provider training in VA/DoD CPG-recommended evidence-based psychotherapies and psychosocial interventions. In FY 2024,[5] the National EBP Provider Training Program included 14 training initiatives for depression, PTSD, SUD, insomnia, chronic pain, severe mental illness, and suicide risk management treatments. The program trained 2,781 VA mental health providers in 128 workshops and consultation trainings across the full range of mental health discipline professions and mental health work settings in FY 2024. The current VHA workforce has nearly 9,000 providers trained to competency, through the program.

All VHA mental health care staff are also mandated to complete training about Military Sexual Trauma and Prevention and Management of Disruptive Behavior. In recent years, the Office of Mental Health has provided staff with numerous additional trainings, for example, trainings on military cultural competence and trainings on how to treat Veterans with comorbid PTSD and SUD. In FY 2024, the Office of Mental Health and Mental Illness Research Education and Clinical Centers provided over 1,000 training sessions to VA staff.

Mental Health Policy and Governance

As a program office, the Office of Mental Health provides policy and operational guidance for delivering mental health services across the continuum of care. The Office of Mental Health also provides ongoing monitoring and makes data available to aid VISNs and facilities in implementing mental health programming in accordance with policy and developing action plans to address non-compliance. VISNs are responsible for ensuring the implementation of such action plans, resolving implementation and compliance challenges in the VA medical facilities within the VISN and providing oversight of VISNs to ensure compliance with mental health directives and their effectiveness. The Office of Mental Health works closely to support such operational implementation efforts and develops and maintains dashboards that provide facilities and VISNs with easily accessible and regularly updated program performance

[5] https://www.healthquality.va.gov/guidelines/MH/srb/VADoD-CPG-Suicide-Risk-Full-CPG-2024_Final_508.pdf

information. Weekly forums between Office of Mental Health leaders and VISN Chief Mental Health Officers offer opportunities for compliance-related discussion and planning, as needed. To further support VISNs and facilities with their implementation efforts, the Office of Mental Health has National Mental Health Quality Improvement and Implementation Consultants, assigned to specific VISNs and facilities, who complete scheduled and for-cause site visits and are available to work closely with sites in developing action plans to address non-compliance and ensure those plans are informed by best practices and implementation science.

Conclusion

VA is taking decisive action to transform the department's mental health care system for Veterans. The path forward requires VA to embrace innovation, accountability, and proven practices across every facet of its operations.

Meaningful change requires collaboration, within VA and with partners across government, private healthcare, and Veteran organizations. This whole-of-society approach is essential to reach Veterans wherever they may be. The oversight from the Committee strengthens VA's work and helps ensure our focus remains on what matters most: providing Veterans with the exceptional care they have earned. VA looks forward to continuing to work with this Committee and we look forward to answering any questions you may have.