STATEMENT OF
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BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Good morning Chairman Takano, Ranking Member Bost and distinguished Members of the Committee. My colleagues and I appreciate the opportunity to talk about the important work VA has done and will continue doing related to suicide prevention. I am accompanied today by Dr. Matthew Miller, Executive Director, Suicide Prevention, Office of Mental Health and Suicide Prevention, and Dr. Lisa Brenner, Director, Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC). I want to thank the House for passing a strong Military Construction, Veterans Affairs, and Related Agencies funding bill. Of note, the bill includes robust funding for mental health and includes the $598 million requested specifically for suicide prevention activities in FY 2022 ($286 million above fiscal year (FY 2021). This funding is critical to the continued focus on our suicide prevention efforts and the Veterans Crisis Line (VCL) implementation of the new 988 number.

In 2019, 45,861 adult Americans died by suicide. Of those, 6,261 were Veterans. These numbers are more than statistics. They reflect individual lives ended before their full stories were written. With each loss for each family, we continue to rededicate, with each of you, a commitment to the mission to address suicide as a national public health concern. Suicide has no single cause and there is no one set solution.

There are multiple individual and societal factors related to death by suicide, which reflect a complex interaction of stressors at several levels to include: international, national, community, familial and relational and individual. Economic disparities, unemployment, relationship problems health concerns including global pandemics, access to care, mental health concerns and more are interwoven, impacting each individual uniquely. This sociocultural context of suicide suggests that a national plan to end suicide is needed, and this plan should embrace a systematic, public health approach combining both community-based prevention strategies and clinically-based interventions. The Office of the U.S. Surgeon General collaborated with the National Action Alliance for Suicide Prevention to create the 2012 National Strategy for Suicide Prevention, which reflected this public health approach, and we built upon these efforts in expanding the comprehensive public health approach to suicide prevention for

Veterans with the development of the *National Strategy for Preventing Veteran Suicide* in 2018.[1]

Within this public health approach, we hold to the following three major tenets that drive our mission with all of you, our Government partners, our agency partners and our community partners: (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.

From our 2021 Annual Report, we highlight several anchors of hope, which remind us that amidst the challenges and ongoing work needed together with all of you, that our mission matters and our efforts must continue. Three-hundred and ninety-nine (399) fewer Veterans died from suicide in 2019 than in 2018, reflecting the lowest raw count of Veteran suicides since 2007. A reduction of 399 suicides within 1 year is unprecedented, dating back to 2001. The single year decrease in the adjusted suicide rate for Veterans from 2018 to 2019 was larger than any observed for Veterans from 2001 through 2018. Further, the Veteran rate of decrease in suicide (7.2%) exceeded by 4 times the non-Veteran population decrease (1.8%) from 2018 to 2019. There was an approximate 13% 1-year rate (unadjusted rate) decrease for women Veterans, which represents the largest rate decrease for women Veterans in 17 years. COVID-19-related data continues to emerge and be clarified; however, data thus far do not indicate an increase in Veteran suicide-related behaviors. Additionally, the level of differential mortality by mental health status has not increased since the COVID-19 pandemic began. Although VA is heartened by these anchors of hope, we are poignantly and painfully mindful that 6,261 Veterans died by suicide in 2019 and we must continue to review long term trends in Veteran suicide. Veteran suicide adjusted rates were 52.3% greater than those for non-Veteran adults in 2019 and we have further work to do with each of you.

Yet we highlight these data as a reminder that there is always hope, as we continue to move together in this daily mission to end Veteran suicide. Together we are making a difference by implementing a public health approach, which focuses 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.

Our work continues, and I would like to focus today on the cutting-edge innovations within VA's suicide prevention efforts, including the full operationalization of our National Strategy for Preventing Veteran Suicide (2018). This strategic plan is being actively implemented through deployment of the Suicide Prevention 2.0 initiative (SP 2.0); Suicide Prevention Now initiative (Now); the President's Roadmap to Empower

[1] 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.

Veterans and End a National Tragedy of Suicide (PREVENTS); 988 and VCL expansion; new authorities, including the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) (P.L. 116-171) and the Veterans Comprehensive Prevention, Access to Care and Treatment Act of 2020 (COMPACT Act) (P.L. 116-214); and ongoing research advancements and their translation into practice.

Suicide Prevention 2.0 (SP 2.0)

SP 2.0 is a critical initiative moving forward the operationalization of VA's public health approach, including both a Community-Based Intervention for Suicide Prevention (CBI-SP) approach and a clinical approach focusing on broad dissemination of evidence-based psychotherapies outlined in the recently updated clinical practice guideline.[2] The SP 2.0 CBI-SP model expands VA's Office of Mental Health and Suicide Prevention's (OMHSP) current efforts by taking a comprehensive public health approach to suicide prevention that blends a focus on community-based prevention and clinically based interventions. CBI-SP reaches Veterans through facilitating community coalitions focused on ending Veteran suicide. The program merges State Governor's Challenge initiatives; the Together with Veterans rural peer-to-peer model; and VHA Community Engagement and Partnerships Coordinators (CEPC) to help local communities adapt an overarching model to local needs and resources. That evidence informed model has the following three focus areas:

- Identify Service Members, Veterans and their Families and Screen for Suicide Risk;
- Promote Connectedness and Improved Care Transitions; and
- Increase Lethal Means Safety (LMS) and Safety Planning.

Significant progress has been made since the launch of SP 2.0 CBI efforts. At the end of FY 2021, 35 States have joined the Governor's Challenge, and 9 of 18 Veterans Integrated Service Networks (VISN) have implemented CBI-SP and CEPC roles, with the remaining States to be invited for participation in 2022 along with the remaining VISNs. CEPCs serve as subject matter experts in public health approaches; coalition facilitation and management; and other community-based models for suicide prevention regarding Veterans. This program emphasizes public health planning; partnered and collaborative action; and effective community coalition building for suicide prevention. The CEPC role enhances and expands current VA suicide prevention efforts that are facilitated by over 450 suicide prevention team members nationwide. As of quarter 3, FY 2021, there have been 108 active coalitions developed, exceeding the goal for the quarter. By the end of FY 2021, we anticipate having more than 100 CEPCs hired in 9 VISNs and ultimately 200-250 by the end of FY 2022, helping us to move

[2] Department of Veterans Affairs and Department of Defense (2019). VA/DoD clinical practice guideline for the assessment and management of patients at risk for suicide. Accessed: https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

forward a goal of an additional 600-800 active coalitions to the CBI-SP program. These community-based programs are working to reach and engage the majority of Veterans who are not served by the VHA system.

In addition to these community efforts, significant innovation has occurred translating the work of the 2019 VA/DoD Clinical Practice Guideline (CPG) for The Assessment and Management of Patients at Risk for Suicide into reaching Veterans across the Nation. SP 2.0 Clinical Telehealth offers evidence-based psychotherapies and interventions to Veterans with recent suicidal self-directed harm, ensuring access to Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP); Problem Solving Therapy for Suicide Prevention (PST-SP); and the Safety Planning Intervention (SPI). The program is designed using a virtual care platform (video telehealth), obviating geographic and site specific staffing barriers, a particular strength as the Nation battles the spread of COVID-19. Partnering with the Clinical Resource Hub (CRH), OMHSP has allocated funds to hire more than 100 providers to reach all VA health care systems, setting up each VISN CRH to have a clinical team available to provide timely access to potentially life-saving treatments to Veterans at elevated risk of suicide, who have engaged in recent self-harm behavior. Through the end of July 2021, 52 therapists have onboarded across 12 VISNs. All 52 providers have been trained in 1 or more evidence-based interventions to prevent suicide, as outlined in the CPG. Throughout FY 2022, we will expand the hiring to more than 100 providers across all VISNs to ensure access to evidence-based psychotherapies for suicide prevention.

Suicide Prevention Now Initiative (Now)

The Now plan aims to develop and deploy interventions that are deemed to reach Veterans at high risk for suicide, within 1 year. Led by staff within VA's Suicide Prevention Program and key VA partners, 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) Lethal Means Safety (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 less than 10 minutes for approximately 47-50% of individuals

with a history of a suicide attempt.[3] VA has dedicated significant efforts to expand LMS related to firearms in order to provide more time and space between a person in a crisis moment 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, 2021, a total of 145,690 VHA employees have completed the course, with 95% completing it within 90 days of the course being assigned. Our Governor's Challenge Teams received training on how to implement the Suicide Prevention Is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community[4]. LMS is a priority for all Governor's Challenge Teams and is addressed within their State action plans.

Within Now, an interdisciplinary implementation plan was established to increase distribution of Naloxone (including patient education) to Veterans diagnosed with opioid use disorders (OUD) in calendar year (CY) 2021. In February 2021, VHA distributed a memo to the field aiming to increase Naloxone distribution to Veterans with OUD diagnoses. The intended goal of the effort is to increase facility-level Naloxone dispensing rates by 25% for Stratification Tool for Opioid Risk Mitigation (STORM) identified patients with OUD; this is attempting to reach 67,821 Veterans. By March 2021, we had a 25% increase in Naloxone prescribing compared to the period between October and December 2020; this will translate into lives saved.

VA continues to advance the Recover Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program, which uses predictive (statistical) modeling to identify Veterans at risk for suicide and other adverse outcomes. Predictive factors in the algorithm include both medical and social determinants of health to identify those Veterans who may be at greatest risk for suicide or other significant adverse events. Improved tracking has been developed to identify those sites in need of technical assistance to improve efforts to meet the required targets. Nationally, VA is exceeding benchmarks for all five metrics. As the result of an ongoing effort to review comprehensively the care of Veterans identified by the REACH VET program, the percentage of higher risk individuals who had their care reviewed by a VHA provider rose from 91% in March 2020 to 99% in July 2021. Outreach attempts to Veterans identified by REACH VET rose from 89% in January 2020 to 99% in July 2021, with 89% of these attempted outreaches resulting in successful contact with the Veteran.

Safety Planning in the Emergency Department (SPED) is an evidence-based practice implemented across VHA in 2019. This initiative is based on initial research

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[3] 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

[4] Suicide Prevention is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community.

found to reduce suicidal behaviors by 45%,[5] and it is an excellent example of the translation of research to practice. Approximately 5,500 Veterans present to VHA EDs with suicidal ideation annually. Improved tracking and technical assistance have yielded significant increases in attempted safety planning with Veterans who present to the ED with suicidal ideation, up from 60% in January 2020 to 86% by July 2021.

Another Now initiative is focused on outreach to Veterans with suicide risk who screen or test positive for COVID-19. VA quickly modified the Suicide Prevention Population Risk Identification and Tracking for Exigencies (SPPRITE) Dashboard, a tool to assist providers in tracking Veterans identified at high-risk for suicide, to include COVID-19 screening and test results. On April 13, 2020, VHA released a memo requiring outreach to Veterans with COVID-19 who also are at high risk for suicide. In June 2021, outreach was attempted to 90% of identified Veterans, with 82% of those Veterans receiving successful and timely outreach. We know this program is particularly critical, as a recent study found that Veterans who were infected with COVID-19 were more than twice as likely to report suicidal ideation.[6]

Finally, the Now plan focuses on implementing paid media targeted to include COVID-19-specific messaging such as targeting methods to encourage connection during times of social isolation and addressing increasing sales of firearms. Beginning in February 2020, VA implemented national paid media across the following three campaigns: (1) Be There; (2) Firearm Suicide Prevention and LMS; and (3) the VCL. Through the end of April 2021, advertisements have generated:

- Over 1.16 billion impressions, a 12% increase from the prior month;
- Over 3.3 million website visits, a 26% increase from the prior month;
- Over 404.2 million completed video views, a 27% increase from the prior month; and
- Over 94,000 resource engagements (number of user interactions garnered by VA resources).

PREVENTS

On March 5, 2019, Executive Order (EO) 13861[7] was signed, establishing a 3-year effort known as the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). PREVENTS created an interagency Task

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[5] Stanley, B., Brown, G.K., Brenner, L.A., Galfaly, 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. 2018 Sep 1;75(9):894–900. doi: 10.1001/jamapsychiatry.2018.1776.

[6] Nichter B, Hill ML, Na PJ, et al. Prevalence and Trends in Suicidal Behavior Among US Military Veterans During the COVID-19 Pandemic. *JAMA Psychiatry.* Published online August 25, 2021. doi:10.1001/jamapsychiatry.2021.233.

[7] https://trumpwhitehouse.archives.gov/presidential-actions/executive-order-national-roadmap-empower-veterans-end-suicide/.

Force to lead the development and implementation of a national, comprehensive roadmap to change how our Nation addresses suicide prevention. As part of our efforts for Suicide Prevention month (September), VA launched an LMS Reach Out campaign. The LMS campaign advances PREVENTS Recommendations related to a public health campaign and methods for addressing LMS as part of suicide prevention. The goal of the overall LMS campaign is to raise awareness that increasing the time and distance between someone in a suicidal crisis and a firearm (lethal means) can reduce the risk of suicide and save lives. The LMS campaign and commercials focus on awareness tactics designed to reach as many Veterans and their supporters as possible. All channels and tactics focus on Veterans and leverage the "Understanding" and "Pivot Point" messages in 15, 30 and 60-second videos, with variations to include a male, female and older Veteran for this campaign. Each variation concludes with a clear call to action, to *"Learn how securing your guns can help prevent suicide."*

988 and the Veterans Crisis Line (VCL)

Established in 2007, VCL is the world's largest crisis line, providing confidential support to Veterans and Service members in crisis. Veterans, as well as their family and friends, can call, text or chat online with a caring, qualified responder, regardless of VHA eligibility or enrollment. VA is committed to providing free and confidential crisis support to Veterans and Service members 24 hours a day, 7 days a week, 365 days a year. VCL seamlessly converted to remote operations during the COVID-19 pandemic. VCL is a critical component of the Nation's largest Integrated Suicide Prevention Network. VCL links to more than 450 Suicide Prevention Coordinators at every VA medical center for local follow-up within 1 business day. VCL maintains comprehensive training and quality assurance programs across VCL services. The VCL Employee Wellness Program (WellVCL) is modeled on the Substance Abuse and Mental Health Services Administration's (SAMHSA) 8 Dimensions of Wellness to support the readiness and resiliency of VCL staff. VCL is accredited by several national organizations, including the American Association of Suicidology (AAS), Commission on Accreditation of Rehabilitation Facilities (CARF) and International Customer Management Institute (ICMI). Since its 2007 launch, VCL has:

- Answered more than 5.6 million calls;
- Responded to more than 218,000 texts;
- Engaged in more than 660,000 online chats; and
- Initiated the dispatch of emergency services to callers in crisis more than 204,000 times.

VCL has over 600 Social Science Specialist Phone Responders. From the start of FY 2021 through July 31, 2021, VCL has exceeded its key performance indicators (KPI) with 97.04% of calls handled, an average speed of answer less than 10 seconds and a rollover rate of 0.072%. Over the past year, VCL has also expanded its services "beyond the call." In June 2020, the 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 beyond the call. In just under 12 months, VCL will have mailed over 531,000 caring letters to approximately 100,000 Veterans; approximately 36,000 of those letters were mailed to Veterans for Veterans Day.

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.

Upon becoming aware of the recent events in Kabul, Afghanistan, VCL developed a response plan to ensure that callers, chatters and texters who reach out are able to receive support and resources. VCL took several steps to respond to these current events, including the following:

- **Partner engagement to define resources available.** Leadership team members contacted several agencies to obtain resource information to support responders in assisting callers; these included the American Red Cross, the Department of State, SAMHSA, the Defense Health Agency (DHA), the Defense Suicide Prevention Office (DSPO) and VA's National Center for PTSD (NCPTSD)
- **Dissemination of resources.** VCL staff were notified via email, SharePoint communication boards and their supervisory chains of command of resources. VCL also shared identified resources with other VA call centers.
- **Identifying support for VCL staff.** WellVCL is encouraging use of the Employee Assistance Program and wellness coordinators are offering supportive contacts within the last 15 minutes of employee shifts. Supervisors and Workflow Coordinators remained available within clinical operations for support.
- **Preparation for anticipated increased volume.** VCL's backup center, was notified by VCL's contracting officer representative to prepare for a possible increase in VCL volume. VCL staff have been offered overtime/compensatory time earned for increased call, chat and text coverage.
- **Enhanced Data monitoring.** VCL established a tracking mechanism for all calls related to current events in Afghanistan and initiated daily reporting for VA leadership.

VCL has seen an increase in call, chat and text volume. Between August 13 and September 14, 2021, we have seen an increase in the following compared with the prior year:

- 5.54% in the number of calls;

- 73.05% in the number of texts; and
- 32.50% in the number of chats.

Several factors may contribute to these increases in VCL volume, including the time of year, as August and September are typically busier months, increased media coverage of VCL information during the past month, mentions by elected officials of VCL, the 20th anniversary of 9/11, and several weather related events (e.g., Hurricane Ida)

We know VCL care matters for the population at highest risk or suicide. Data indicate that VHA-using Veteran VCL callers are at increased risk of death by suicide, with a suicide rate several times higher than the general Veteran population. VCL has expanded a full program evaluation of its efforts. VCL has been found to be effective in helping Veterans decrease their distress and suicidality over the course of the call. Veterans report feeling better following their call to VCL. Research has also shown that Veterans are inclined to use VCL as a resource. Veterans who called VCL were more likely to make contact or engage in any health care (including mental health care) in the month following the call than in the month preceding the call. The majority of Veteran callers who are suicidal at the time of the call report that VCL helped them not act on their suicidal thoughts.

VCL is preparing for full implementation of 988, the new national 3-digit crisis intervention emergency telephone number for the National Suicide Prevention Lifeline and VCL. Telecommunications providers must activate 988 services by July 16, 2022 (See 85 FR 57767). All major wireless carriers, including T-Mobile, Verizon, AT&T and UScellular, have already activated the 988 number. VCL is planning for a significant increase in volume after 988 messaging to Veterans, Service members and their families regarding activation. Currently, 460 new full-time employee equivalents have been approved to expand VCL to prepare for the 122-154% increase in demand anticipated after marketing of 988 is initiated. Additional staff are projected to be necessary.

New Statutory Authorities

Signed into law by the President on October 17, 2020, the Hannon Act will provide critical mental health care resources and evaluate alternative and supportive treatments to clinical care for Veteran populations through VA. Section 201 of the Hannon Act requires VA to provide financial assistance to eligible entities, through the award of grants to such entities, to provide or support the provision of suicide prevention services to eligible individuals and their families to reduce the risk of suicide. This authority, also known as the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, honors Veteran Parker Gordon Fox who joined the Army in 2014 and died by suicide on July 21, 2020. VA may award grants to eligible entities for a period of 3 years after the date on which the first grant is awarded. VA is working diligently towards next steps in implementation of the grant program and we look forward to advancing this work with all of you.

Signed into law on December 5, 2020, the COMPACT Act authorizes 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 requires VA to furnish emergent suicide care to an eligible individual at a medical facility of the Department, pay for emergent suicide care provided to an eligible individual at a non-Department facility and reimburse an eligible individual for emergent suicide care provided to the eligible individual at a non-Department facility. Section 201 of the COMPACT Act defines eligible individuals to include any Veteran (as defined in 38 U.S.C. § 101), and certain former members of the Armed Forces. VA is working rapidly to develop a process to ensure the Office of Community Care is notified whenever an emergency dispatch or Facility Transport Plan (FTP) results in a Veteran receiving care at a community facility. VA already notifies facility-based Suicide Prevention Coordinators through a triple redundant system whenever an Emergency Dispatch or FTP is facilitated by VCL.

Suicide Prevention Work Across the Veterans Benefits Administration

The Veterans Benefits Administration provides a variety of benefits and services upstream which can help reduce or eliminate risk factors associated with suicide and promote protective factors for some Veterans. Programs such as Solid Start, Disability Compensation, Pension, Veteran Readiness and Employment and Education/GI Bill assist Veterans with transitioning to civilian life, connecting with benefits, establishing, and achieving educational, vocational and career goals and supporting financial well-being.

The VA Solid Start Program provides early and consistent caring contact to newly separated Veterans at least three times during their critical first year of transition from the military. Specially trained VA representatives address issues or challenges identified by the Veteran during the call and assist with accessing benefits and services, health care, mental health care, education and employment opportunities. From December 2019 through August 2021, the VA Solid Start Program made over 148,000 successful connections with Veterans throughout their first year following military separation. VA Solid Start also provides priority contact to those individuals who had a mental health care appointment during the last year of active duty, to support a successful transition to VA mental health care treatment. Since inception of the program through August 2021, VA Solid Start has connected with over 24,000 such Veterans.

Research

VA is committed to Suicide Prevention research to inform and advance our knowledge base in this top VA clinical priority area. VA's Office of Research and Development (ORD) and OMHSP work together to ensure that research inquiries and funding are synchronized with operational priorities aligned with the National Strategy for Preventing Veteran Suicide. Annual review of the suicide prevention research

portfolio is conducted to inform strategic planning and priority setting. Research efforts are focused to better understand specific Veteran populations, including Women Veterans, elderly Veterans and those transitioning from active duty, as well as to test the efficacy of innovative and targeted interventions. In FY 2021, there were 126 funded suicide research studies.

Because the majority of Veterans who die by suicide are not receiving VHA care at the time of their death, it is vital to build and investigate community-based interventions. The number of studies focused on population-level prevention has increased from 18 to 29 in FY 2021, and studies aimed at suicide risk among population subgroups increased from 34 to 69 in FY 2021. This increased research attention expands our knowledge base beyond individual risk factors to the population level risk and protective factors advocated by the public health approach to suicide prevention. In addition to research on community-based innovations, other areas of high research priority include messaging to Veterans in areas of lethal means and seeking help, gender-based differences in suicidal behavior and intervention, peer delivered interventions, the application of telehealth and technology and the impact of social determinants of health on suicide risk. Development of innovative research designs is underway to study multi-level and multi-component interventions and to encourage collaboration across disciplines and investigators. Finally, in partnership with our research centers and centers of excellence, VA is translating research findings to practice, using implementation science principles to guide our roll out process (*e.g.,* suicide risk screening, safety planning in the emergency department).

Conclusion

Anchored in hope, we hold to our core tenets: (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. Suicide prevention will take all of us, including all of you and all of our communities across the Nation. We appreciate the Committee's continued support and encouragement as we identify challenges and find new ways to care for Veterans.

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