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Last year, the Department of Veterans Affairs released the results of the most comprehensive analysis conducted to date focused on suicide among U.S. military Veterans.[1] Building on previous findings, these analyses highlighted the continued problem of increased suicide risk among veterans, and yielded the frequently-cited statistic of "20 Veterans per day." Since 2001, the suicide rate among all Veterans has increased faster than the suicide rate among civilians, such that Veterans are 20% more likely than civilians to die by suicide. Differences across several Veteran subgroups have also been identified. Of greatest relevance to the current hearing, from 2001 to 2014 the suicide rate among Veterans who do not use VA services increased by 39% from 2001 to 2014, whereas the suicide rate among VA users increased by only 9%. For comparison, the suicide rate among civilians increased by 23% during this same period of time.

Taken together, this suggests a relative benefit for Veterans who have accessed and used VA services, although this observation is tempered by the fact that the suicide rate has nonetheless increased, rather than decreased, among VA users. Further tempering enthusiasm is the fact that only 30% of all Veterans who died by suicide were VA users, which means the considerable majority of suicides are occurring among Veterans external to the VA. This brings to the forefront a critical point about Veteran suicide prevention: our efforts must extend beyond the walls of our VA facilities. If we confine our efforts solely to the VA, we will not have a significant impact on overall Veteran suicide rates. We must therefore seek to complement suicide prevention efforts in the VA with suicide prevention efforts in the community at large.

Simple Things Save Lives

Of all the many things we have learned about Veteran suicide over the past decade, the most important are the following: (1) some interventions work much, much better than others, and (2) simple things save lives. The past few years have been marked by dramatic gains in suicide prevention for military personnel and Veterans. In just the past two years, several treatments studies reporting suicide-related outcomes among military personnel and Veterans have been published,[2-8] proving us with critical information about how to most effectively save lives. Three of these studies tested treatments explicitly designed to reduce suicidal thoughts and behaviors, regardless of diagnosis, gender, age, or background.[2-4] Of these three, two proved to be especially potent: brief cognitive behavioral therapy,[2] a 12-session therapy that reduced suicide attempts by 60%, and crisis response planning,[3] a single-session, 30-minute intervention that reduced suicide attempters by 76% as compared to typical treatment methods. Three other studies entailed PTSD-focused treatments[5-7] and one study entailed insomnia-focused treatment.[8] All found significant reductions in suicidal thoughts among service members and veterans

diagnosed with PTSD and/or insomnia, suggesting that other treatments targeting key risk factors among military personnel and veterans may also reduce suicide risk.

These results have prompted a new wave of research studies designed to build on these initial gains. For example, we are currently conducting a new treatment study in the VA testing a 3-session treatment that shares many of the elements of brief cognitive behavioral therapy and crisis response planning. In light of our previous research findings, we are hopeful that this new study will point us to a brief and cost effective method for reducing Veteran suicides that can be easily implemented within the VA.

The findings of the crisis response planning study hold particular promise for suicide prevention among Veterans, as this procedure can be taught to peer mentors, family members, teachers, and other non-healthcare providers. Just as we teach cardiopulmonary resuscitation (CPR) to non-healthcare providers so they are prepared to save a life in the event of a heart attack or other cardiac emergency, so can we teach crisis response planning to individuals within our communities to intervene with Veterans (and non-Veterans) experiencing mental health emergencies. No longer does suicide prevention have to be confined to hospitals and mental health clinics; all of us can learn the simple procedures involved in saving a Veteran's life.

The science is now clear: certain treatments save lives. The question we now face is how to use this knowledge. Training curriculum and methods already exist. We are therefore well-positioned to start teaching mental health professionals in the VA and our local communities how to put these practices into action.

Access Without Quality Assurance: Making It Easy for Veterans to Obtain Services That Don't Work

In order to advance Veteran suicide prevention, we must ensure that VA personnel and other members of the community are ready and able to respond appropriately. Over the past decade, the VA has adopted and implemented an impressive array of measures intended to prevent suicide including the expansion of the Veteran Crisis Line, improved same-day access for Veterans with urgent mental health needs, expanded tele-mental healthcare services, hiring of new mental health professionals and crisis hotline staff, and the establishment of collaborative relationships with community service providers. These efforts have collectively focused on improving access to care for all Veterans, but especially those Veterans who are eligible for VA services. Unfortunately, many of these initiatives have been aimed at improving access to care (i.e., making it easier for Veterans to "get in the door") with little to no structure or guidance for maximizing the effectiveness of these services. As a result, we have made it easier for Veterans to access services that do not work.

A recent study by VA researchers highlights this issue.[9] In that study, VA records were reviewed to assess the quality of safety planning, an intervention that is based on crisis response planning and, as such, intended to prevent suicidal behavior among high-risk VA users. Although the safety plan's efficacy has not yet been tested, it has nonetheless been recommended for use with suicidal patients based on expert consensus, and was implemented by the VA several years ago as a required part of a Veteran's comprehensive suicide prevention plan.

Results of this study indicated that, on average, safety plans were of "moderate quality," showed considerable variability in quality, and lacked sufficient specificity to maximize its utility. For example, 23% of Veterans had "generic, copied and pasted statements" and only 29% showed evidence of ongoing review of the safety plan. In light of these findings, it is perhaps not surprising that safety plans did not correlate with the incidence of later suicide attempts. A second study conducted by an independent team of VA researchers has yielded similar findings.[10]

Researchers have concluded that high variability in the quality of safety plans are most likely attributable to insufficient training provided to VA healthcare professionals. In short, the VA mandated and implemented a suicide prevention strategy that was based on expert recommendations but no program was implemented to teach personnel how to effectively implement the strategy. Further compounding this issue was the adoption and implementation of standardized forms and templates, which fostered an understanding of safety planning as an administrative task rather than a suicide prevention intervention. As a result, a promising suicide prevention strategy was rendered inert. Simply put, creating forms and posting user manuals online are not enough to ensure that individuals know how to competently and effectively use the procedure. Reading books and filling out forms will not save lives; training matters.

Teaching Bad Medicine: Deficits in U.S. Mental Health Professional Training

The aforementioned training deficits associated with VA suicide prevention efforts are not entirely the VA's fault. A recent report from the American Association of Suicidology (AAS)[11] brings into focus the stunning inadequacies of our nation's mental health professional training programs. As noted in this report, research studies have found that only half of psychology training programs, less than 25% of social work programs, 6% of marriage and family therapy programs, and 2% of counselor education programs provide any amount of education or training focused on suicide as a part of their curriculum. Relatedly, only 28% of psychiatry program training directors report the provision of skills-based suicide-focused to psychiatry residents. When such education is available, it is often very limited (i.e., less than a few hours over multiple years of training) and does not always include applied skills training. The AAS report further notes that state licensing boards for most mental health professions—the bodies charged with protecting the public's health and safety from unqualified professionals—do not require any exams or demonstration of competency in suicide risk assessment or intervention.

The AAS report highlights an urgent and shocking reality: the vast majority of our nation's mental health professionals are stunningly unprepared to effectively intervene with suicidal individuals. In short, the mental health professionals and trainees hired by the VA are unlikely to have any exposure to contemporary, state-of-the-art practices in suicide prevention like brief cognitive behavioral therapy or crisis response planning, the only interventions to date that are proven to reduce suicidal behavior among military personnel and veterans.

Because most of the VA's mental health professionals were trained in U.S. programs, the near-complete absence of training and education in scientifically-supported methods for suicide risk, PTSD, and other such conditions means an unsettling number of VA employees have little

to no education or practical experience using the most effective methods for suicide prevention. As a result, the VA must expend an inordinate amount of time, resources, and taxpayer dollars to provide training aimed at teaching its personnel the basic principles and concepts that should have been provided during graduate or medical school.

Next Steps in Veteran Suicide Prevention

If Veterans are to benefit from the most recent advances in suicide prevention research, implementation of newer, more effective strategies like brief cognitive behavioral therapy and crisis response planning must be accompanied by comprehensive and robust training programs. Luckily, the past few years have also led to considerable advances in our understanding of the most effective ways for teaching these methods. Much of this knowledge has been obtained by VA researchers and staff as part of its various training programs and initiatives. These results and lessons learned can provide critical clues and guidance for effectively implementing new strategies and treatments.

Reversing the trend of Veteran suicide will require bold and innovative thinking that will undoubtedly shake up and disrupt the status quo. This may require changes to existing policies and procedures, and the development and creation of new initiatives. The next steps in Veteran suicide prevention will therefore require a combination of strategies that might include the following:

1. The adoption of new strategies that have garnered strong scientific support (e.g., brief cognitive behavioral therapy, crisis response planning), even though these strategies may depart from existing procedures;

2. Investment in mental health professional training to ensure competent and effective implementation of these procedures;

3. Creation of incentive programs that reward mental health clinicians for completing training and demonstrating competency in effective suicide prevention strategies;

4. Requiring mental health training programs to provide training in scientifically-supported suicide prevention methods;

5. Encouraging accrediting bodies of graduate and medical training programs across mental health disciplines to include requirements for the training of suicide risk assessment and intervention to students; and

6. Encouraging state licensing boards to require demonstrations of competency specific to suicide risk assessment and intervention.

Interventions that Reduce Suicidal Thoughts & Prevent Suicidal Behaviors Among Military Personnel & Veterans

Brief Cognitive Behavioral Therapy (BCBT)[2]
BCBT is a 12-session therapy for preventing suicidal behavior. BCBT reduces suicidal thoughts and reduces suicidal behavior by 60% among military personnel as compared to standard mental health treatment.

Cognitive Behavioral Therapy for Insomnia (CBT-I)[8]
CBT-I is a 6-seesession outpatient therapy designed to reduce sleep disturbance. CBT-I reduces suicidal thoughts among Veterans. Effects on suicidal behavior are unknown.

Cognitive Processing Therapy (CPT)[6,7]
CPT is a 12-session outpatient therapy designed to reduce PTSD. CPT reduces suicidal thoughts among military personnel. Effects on suicidal behavior are unknown.

Crisis Response Planning (CRP)[3]
CRP is a 30-minute procedure for preventing suicidal behavior. CRP reduces suicidal thoughts and reduces suicidal behavior by 76% among military personnel as compared to standard mental health treatment.

Prolonged Exposure (PE)[5]
PE is a 10-session outpatient therapy designed to reduce PTSD symptom severity. PE reduces suicidal thoughts among military personnel. Effects on suicidal behavior is unknown.

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as compared to standard mental health treatment

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Deficient Suicide Risk Assessment & Intervention Training Among U.S. Mental Health Professionals

An American Association of Suicidology report[11] indicates **less than half of U.S. mental health professionals** receive adequate training in suicide risk assessment or intervention during graduate or medical school

- 50% of **psychologists** received suicide-focused didactics
- 25% of **social workers** received suicide-focused training
- 2-6% of **marriage & family therapists** and **professional counselors** had suicide-specific courses
- 28% of **psychiatrists** received suicide-focused skills training

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