Prepared Testimony of

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Chairman Takano, Ranking Member Roe, and Distinguished Members of the Committee:

Thank you for this privilege to testify as you redouble your commitment to preventing veterans' suicide and improving their mental health. I speak on behalf of the Veterans Healthcare Policy Institute, a non-profit think-tank whose mission is to furnish analyses about optimal healthcare for our veterans. I am also a clinical psychologist who spent my four-decade Department of Veterans Affairs (VA) career as a mental health clinician and administrator, and was a contributor to the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) lethal means line of effort.

This is a pivotal moment in the care of our nation's veterans.

Over 6,000 veterans die by suicide every year.[1] That's almost as many each year as the total number of service members who were killed in action during the Iraq and Afghanistan operations.[2] Every suicide is heartbreaking, not only for the individual whose life is lost, or the scores of family and friends directly affected, but for how it pierces the common humanity that binds us all. Preventing suicide among our veterans is a sacred responsibility.

Congress has provided VA with substantive resources and guidance to address the challenges of veteran suicide, and there are tangible successes to show for it. Between 2005-2017, while suicide rates among US adults continued to escalate, the advancing rate for veterans who use VA for their healthcare was dramatically slowed[1] Still, the tide has yet to turn.

One reason is that the resources remain short of what's needed to keep up with the demand for mental health services. In spite of large increases in the number of providers hired and visits furnished, the workforce remains markedly understaffed. The majority of facilities fail to meet the VA-required mental health staffing ratio of 7.72 clinical FTE per 1000 MH patients, a ratio that when attained, has been shown to prevent suicide.[3] And the shortage could soon get worse, as Executive Order 13822[4] will bring 32,000 more transitioning service members yearly into the VA for mental health care at the juncture in their lives when they have the highest vulnerability to suicide.[5]

A more basic reason has been hesitancy to capitalize on the known impact of access to firearms on suicide. Firearms are the means used in 7 out of every 10 veteran suicide deaths,[1] yet safe storage counseling strategies that could save lives are underutilized.

Proposed legislation under discussion include the mechanisms to correct these deficiencies, as well as much else.

Foremost, House bills embrace approaches that increase the time and distance it would take a veteran with suicidal impulses to access lethal means. Counseling voluntary safe storage oughtn't be a divisive issue. There is common agreement that this kind of policy is needed.

For starters, the White House is firmly in this camp. Their recent President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) report proclaims, "The science supporting lethal means safety (LMS) is robust and compelling: enhancing safety measures specific to the availability and accessibility of potential lethal means saves lives. A key component of effective suicide prevention is voluntary reduction in the ability to access lethal means with respect to time, distance, and convenience, particularly during acute suicidal crises."[6]

It further states, "Moving firearms out of the home is generally cited as the safest, most desirable option; this can include storage with another person or at a location like a firearm range, armory, pawn shop, self-storage unit, or law enforcement agency." One of its ten top recommendations was to "provide and promote comprehensive suicide prevention training across professions." Another was to "increase implementation of programs focused on lethal means safety (e.g., voluntary reduction of access to lethal means by individuals in crisis, free/inexpensive and easy/safe storage options)."

Many firearms community stakeholders subscribe to the utility of counseling safe storage as a prevention strategy.

The National Shooting Sports Foundation (NSSF), the firearm industry's trade association, has spent the last three years partnering with the VA and the American Foundation for Suicide Prevention (AFSP) to create community educational, training and resource toolkits that foster safe firearm storage practices for veterans in crisis. In their suicide prevention program material[7], NSSF supports temporary restricting access to firearms for those at-risk of suicide and provides numerous examples of safe storage options that gun owners and their families can utilize to accomplish this, as well as other options such as disassembly of the firearm, having friends hold keys to a safe or, when appropriate, temporary offsite storage.

The U.S. Concealed Carry Association (USCCA) co-sponsored a recent firearm suicide prevention video webinar on protecting mental health and preventing suicide during COVID-19.[8]

The Second Amendment Organization (2AO) educates shooters, firearms owners and pro-Second Amendment businesses to protect the Second Amendment. They state the right to bear arms comes with a matching responsibility to reduce negative outcomes, including firearm suicides. They espouse the development of lethal means safety training courses that convey

respect for responsible firearms ownership and are created with input from firearms responsibility advocates.

There are others across the spectrum. The Department of Defense (DoD) has policies[9] in place for health professionals and commanders who have reasonable grounds to believe a service member is at risk for suicide to inquire about privately owned firearms and ask if they will voluntarily store their private firearms for temporary safekeeping.

The Disabled American Veterans strongly endorses the implementation of programs that address firearms safety and voluntary reduction of access to lethal means. Henry Ford Health System, National Action Alliance for Suicide Prevention and the trailblazing American Foundation for Suicide Prevention do too.

Thus, there is broad accord to expand lethal means safety initiatives, and the White House PREVENTS report gave clear direction. To foster acceptability, policies needs to underscore the voluntary and temporary nature of safe storage during crises, while conveying respect for responsible firearm ownership. It's exactly like the "friends don't let friends drive drunk" campaign. Under regular circumstances, friends let sober friends drive at liberty, but when there's intoxication, friends and others step up. That strategy has reduced deaths from alcohol-impaired crashes by two-thirds in the last 40 years.[10] [11]

Indeed, that's been the VA's thoughtful approach for the last five years, contributing to its status as the recognized leader in training and implementing lethal means safety concepts. VA has honed a course in how to work with at-risk veterans to make mutually-agreeable, culturally respectful plans to voluntarily, temporarily reduce access to firearms. 20,000 of its providers have taken the training. The Lethal Means Safety Training Act (H.R. 8084, Underwood) and Veterans COMPACT Act of 2020 (Discussion Draft, Takano) direct VA to upgrade, expand and necessitate dissemination of this course.

Means safety is only one of many issues being considered today that aim to prevent veterans dying by suicide and help them achieve fulfilling lives. The range of House bills corresponds to S.785 "Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2020." However, they go much further in seven critical ways. They assure that:

1. VA adopt the White House PREVENTS recommendations that professionals be trained in lethal means safety counseling for preventing suicide;
2. Community Care Network (CCN) providers have competence to treat veterans' mental health conditions;
3. CCN providers have training in suicide prevention;
4. VA furnishes its expert mental health care, and that its purpose as a provider of care isn't lessened;
5. Veterans receive health care during their first year after leaving military service when they are the most vulnerable;
6. Veterans obtain stabilization care during a suicidal emergency; and
7. Providers utilize the best predictors for assessing suicide risk.

Following is the more detailed analysis of how House legislation more comprehensively and effectively address these seven prevention and care matters.

1. Adopting the PREVENTS recommendations that professionals be trained in lethal means safety counseling for preventing suicide

House Legislation	How House Legislation Would Improve Prevention and Care
Veterans COMPACT Sec. 202	House legislation requires the VA to provide training to grant entities in lethal means counseling. S.785 has no such provision.
Veterans COMPACT Sec. 201	House legislation requires that all VA and CCN primary care practitioners receive bi-yearly suicide prevention training that includes lethal means counseling. S.785 has no such provision.
H.R.8084	House legislation upgrades VA suicide prevention and lethal means safety training. It requires VA and CCN mental health providers, and many others with frequent contact with veterans, to receive this training. S.785 has no such provision.

As mentioned earlier, the White House PREVENTS report recommended promoting comprehensive suicide prevention training with professionals who regularly engage with veterans, and increasing implementation of programs focused on voluntarily and temporarily limiting access to lethal means during times of heightened vulnerability. House bills adhere to those recommendations. They solicit firearms community input for cultural and clinical competency components. They train non-mental health personnel as well, important given that the majority of older adults who die by firearm suicide have no known mental illness and are not receiving mental health services. S.785 has no such provision.

2. Assuring that VCCP providers have basic competence to treat veterans' mental health conditions

House Legislation	How House Legislation Would Improve Prevention and Care
H.R.7504 (Blunt Rochester)	House legislation requires that standards and requirements for CCN mental health providers be raised to equal those applicable to VA mental health providers. It requires that CCN mental health providers complete a four-module course about military culture and core competencies for treating veterans with Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Military Sexual Trauma (MST). S.785 has no such provision.

While private sector psychotherapists who treat veterans are capable professionals, research has shown that they are less likely than VA psychotherapists to have the requisite skills to deliver high-quality mental health care.[12,13] CCN providers who treat the common psychological conditions of veterans have no minimum competency standards. A license is all they need. MISSION Act Sec. 133 meant to fix this clinical deficit by directing competency standards to be set for CCN providers who treat veterans for PTSD, TBI, and MST, but no requirements have ensued. H.R.7504 would ensure that CCN mental health providers must have basic instruction in those mental health conditions. S. 785 has no provisions to require competencies of CCN providers.

3. Assuring VCCP providers have basic training in suicide prevention

House Legislation	How House Legislation Would Improve Prevention and Care
Veterans COMPACT Sec.202	House legislation requires that VA provide training to grant entities in suicide risk assessment and management. S.785 has no such provision.
Veterans COMPACT Sec. 201	House legislation requires that all VA primary care practitioners and CCN primary care practitioners receive suicide prevention, suicide risk assessment and safety planning training every two years. S.785 has no such provision.
H.R.8084	House legislation requires CCN providers to have suicide prevention training. S.785 has no such provision.
H.R.7504	House legislation requires CCN providers to complete a VA-developed course in suicide evaluation and management.

As just noted, a license is all that is currently required of CCN providers to evaluate and treat veterans. Basic training in suicide prevention that is mandated for VA providers is voluntary for CCN providers. These House bills would require it.

4. Assuring that VA furnishes its expert mental health care, and that its purpose as a provider of care isn't lessened

House Legislation	How House Legislation Would Improve Prevention and Care
Veterans COMPACT Sec.202	Senate legislation prospectively funds entities to provide mental health services for eligible veterans and their families that includes outpatient, non-emergency individual and group counseling. The House bill does not allow individual and group counseling.

H.R.8144, (Hayes)	The House legislation calls for a plan to address the gap in VA mental health providers needed to meet demand, and a subsequent report on the number of providers that were hired to address the gap.

When treatment of veterans cannot be provided at a VA facility in a timely and convenient manner, the MISSION Act directed that the CCN should be the alternative option. S.785 creates yet a third mental health care option outside of VA/ CCN networks and allows these services to be furnished in the same locales as VA Medical Centers, VA Community Based Outpatient Clinics, Vet Centers and CCN offices. Individual and group therapies delivered by grant entities duplicate the care at which VA excels, and are held to no competency standards. Furthermore, these prefunded treatments escalate VA becoming a *payor* of clinical services rather than a *provider* of services. The House bill aligns with VA's core purpose as a provider of care.

The VA Mental Health Staffing Improvement Act (H.R.8144, Hayes) would identify the number of providers needed to adequately deliver mental health care. VA's mental health staffing gap urgently needs attention. VHA Directive 1161 (April 28, 2020) requires facility outpatient mental health staffing ratio to be a minimum 7.72 outpatient clinical mental health FTEs per 1,000 mental health patients. As of the first quarter of fiscal year (FY) 2020, only 42% of health care systems met the minimum outpatient mental health staffing level. That's an alarming problem given the reported connection between staffing shortages and suicide: "Mental health staffing enhancements have been associated with decreases in suicide rates among VA patients in regions where mental health outpatient staffing increases were greatest."[3]

5. Assuring that veterans receive care during their transitional first year when they are the most vulnerable to suicide

House Legislation	How House Legislation Would Improve Prevention and Care
Veterans COMPACT Sec.101	COMPACT legislation directs VA to provide health care to veterans for one year after they transition from military service. This strengthens Executive Order 13822 that provides veterans access to mental health care for that first year. S.785 called only for a "strategic plan" for how health benefits for transitioning veterans might be offered at some point in the future.
Ensuring Veterans' Smooth Transition Act, (EVEST) Discussion Draft	House legislation provides for automatic enrollment of eligible veterans in patient enrollment system of VA, with an easy alternative to "opt out." S.785 has no such provision.

A disproportionate number of veterans' suicide attempts occur during the period following separation from military service. That fact was the impetus underlying Executive Order 13822 granting VA mental health care for veterans during the transitional first year. Veterans are more likely to utilize these life-saving mental health services if all their care is in one place. They'd also benefit from treatment of interrelated conditions, such as pain. The COMPACT Act facilitates that care. The EVEST Act in turn would foster quicker access of VA health care that is critical in an acute crisis.

6. Facilitating veterans obtain stabilization care during a suicidal emergency

House Legislation	How House Legislation Would Improve Prevention and Care
ANS for ACCESS Act, Discussion Draft (Takano)	House legislation facilitates and incentivizes access to needed emergency care for veterans in an acute suicidal crisis. It expands eligibility for this care to all veterans regardless of their eligibility for or use of other VA health care benefits, enrollment status, service-connection, or discharge status. It removes any out of pocket cost for this care. S.785 has no such provision.

Emergency mental health services mitigate immediate risk of suicide. COMPACT Act Sec. 201 ensures all veterans can receive this essential critical care during a mental health crisis, with guarantees there will be no charges.

7. Assuring that providers utilize best predictors for assessing suicide risk

House Legislation	How House Legislation Would Improve Prevention and Care
Veterans COMPACT Sec.202	House legislation lists access to lethal means as one of the environmental risk factors to be considered when assessing for suicide risk and providing services. Access to lethal means is not included in S.785.
Veterans COMPACT Sec.201	House legislation indicates that when elevated suicide risk is detected during a veteran's annual VA primary care provider appointment, access to lethal means should be assessed. S.785 has no such provision.

The 2019 VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide[14] affirms the strong evidence that "availability of firearms" is a factor that should be ascertained as part of a comprehensive assessment of suicide risk. Omission of this risk factor reduces the ability to predict the degree of risk and to counsel appropriately.

Beyond those seven critical areas, there are two bills of note:

COMPACT Act Sec. 605 Anti-harassment and Anti-Sexual Assault Policy

This section requires a comprehensive VA anti-harassment and anti-sexual assault policy. Such policy enhancement not only would elevate the fundamental right to be treated with respect, it could help reduce suicide death among women veterans, which occurs at a rate 2.2 times that of non-veteran women.[1] Many women veterans avoid the VA because of anticipated sexual harassment/assault. The bill would address inappropriate actions not just by staff and contractors but fellow patients and visitors as well. That would lead to VA facility environments becoming more psychologically safe for women, increasing their seeking life-saving suicide prevention and mental health services.

VA Complementary and Integrative Health Act (Discussion Draft) (Lamb)

VA Complementary and Integrative Health (CIH) Act Sec. 3 provides grants to non-VA entities to facilitate equine assisted therapy, other animal therapy, agri-therapy, and adaptive sports, recreation, and outdoor adventure to treat veterans' posttraumatic stress disorder, depression and anxiety.

It is important that novel, effective interventions continue to be developed for our nation's veterans with mental health conditions. However, VA already offers yoga, meditation, acupuncture, chiropractic care, agri-therapy, recreation therapy and outdoor sports. Hence, it is not immediately apparent what the entities would provide that supplement rather than duplicate VA activities that are currently available.

Furthermore, the COVER Commission[15] exhaustive review of research on standalone CIH activities found low strength of evidence with respect to outcomes for PTSD, depression and anxiety. Going forward, the COVER Commission recommended that VA should "Fund and conduct studies of CIH modalities used as an *adjunct* (italics added) treatment to evidence-based psychotherapies and medications to mirror how treatment is generally provided in clinics… Fund and conduct implementation science studies that focus on how to best integrate CIH modalities in current standard practice in mental health and primary care using multisite trials when possible." This legislation doesn't follow those recommendations to study the adjunctive benefits. Even if it hoped to determine whether the therapeutic benefits of CIH activities are equal or superior to evidence-based treatments, as drafted, it won't resolve that question. The accepted way to reach valid conclusions about treatment effectiveness is with randomly assigned control groups. The legislation circumvents that.

We thank you for the opportunity to provide our perspective on these vital matters.

Footnotes

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