

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



VA



U.S. Department  
of Veterans Affairs

## Supplemental Materials for the PREVENTS Roadmap

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## Introduction

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On March 5, 2019, President Donald J. Trump signed Executive Order 13861: *President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)* with a call to action to amplify and accelerate progress in addressing the Veteran suicide crisis in our Nation. While there have been other efforts to address suicide prevention, this is a Cabinet-level, interagency effort charged with developing the first Federally coordinated national public health strategy to address Veteran suicide.

To reduce the suicide rate, the PREVENTS Office must work side by side with partners from state, local, territorial, and tribal governments — as well as private and nonprofit entities — to provide our Nation's Service members, Veterans, and all Americans with the resources they need. Veterans Service Organizations (VSOs) play a crucial role in preventing Veteran suicide, have long championed important changes in the way to engage and interact with Veterans, and provide a strong example of the collaborative work possible across sectors.

The work of the PREVENTS Office must also build on previous efforts to address suicide across the military life cycle. Research from the U.S. Department of Veterans Affairs (VA) shows that in the year following discharge from military service, Veterans may experience many transition-related challenges — such as homelessness, family reintegration, employment, posttraumatic stress disorder (PTSD), and substance misuse — that can increase the risk for suicide.<sup>1,2</sup> Through Executive Order 13822: *Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life*, VA and the Department of Defense (DoD) strengthened their partnership to work toward a seamless transition from active duty military service and to enhance protective factors for those who might be at highest risk during this challenging time.

Our work begins with the belief that suicide is preventable and prevention requires more than intervention at the point of crisis. The Federal government, state government, academic institutions, employers, members of the faith-based community, tribal communities, nongovernmental and nonprofit organizations, first responders, and the Service member and Veteran community must all work together to change the conversation about mental health, advance understanding of the underlying risks and protective factors associated with suicide, and foster a culture in which Veterans, their families, and our broader communities can thrive.

### What Causes Suicide?

Suicide is a complex interaction of risk and protective factors with no single cause. However, it is known that suicide is preceded by a level of suffering and hopelessness that can result from a wide range of biological, environmental, psychological, and social factors.<sup>3</sup>

Although suicide cannot be attributed to a single mental health diagnosis or crisis, certain mental health conditions, such as depression, PTSD, psychosis, and substance misuse, may be associated with increased risk for suicide. At any given time, 1 in 5 Americans have a diagnosable mental health condition and research has found that 46% of people who die by suicide had a known mental health condition.<sup>4</sup>

## Complexity of the Problem

Given that the factors that lead to suicide are complex and numerous, our efforts to prevent suicide must be multidimensional and varied as well. Indeed, if suicide rates could have been easily decreased among our Veterans — or any at-risk group — it most certainly would have already been done. Unfortunately, even the conversation concerning mental health issues in general and suicide in particular remains difficult for most people to have.

Research shows that attitudes and stigma related to help-seeking are as important as the accessibility and availability of mental health care services in helping individuals obtain help for mental health issues.<sup>5</sup> Sadly, due to a lack of awareness or misinformation, the majority of individuals with symptoms of mental health conditions remain without treatment, even in high-income economies;<sup>6</sup> yet research indicates that 46% of people who die by suicide had a known mental health condition.<sup>4</sup> When compared with how people talk about and seek care for physical health conditions, such as heart disease and cancer, these gaps in awareness and help-seeking behaviors become even more striking.

Fortunately, evidence suggests that national public health efforts can be effective with respect to attitudes about mental health challenges. Canada's Let's Talk initiative has addressed stigmatizing language and lack of interest in help-seeking behaviors for more than nine years, which has resulted in 86% of Canadians' reporting that they are more aware of mental health issues.<sup>7</sup> In addition, the effort has committed an impressive \$108,415,135 to mental health initiatives.<sup>7</sup>

Suicide happens at a crisis point when an individual may feel utterly and completely hopeless and/or intense and overwhelming psychological pain. Sometimes a suicide is contemplated for hours or days, or sometimes for minutes or only seconds. Research suggests that for someone to die by suicide, he or she must override the powerful human inclination toward self-preservation.<sup>8</sup> Suicide is not a single — or rational — action. When people are suffering and unable to hope for a better tomorrow, their desire to stop the unbearable pain overrides the fundamental instinct to survive.

While interventions aimed at saving people when they are in crisis are necessary, to successfully prevent suicide across all communities, people must be reached upstream — before they reach the point of desperation. To this end, interventions must reach people where they live, work, learn, play, and pray to provide the education, tools, resources, and hope that allows them to heal, withstand, and overcome.

The PREVENTS Roadmap outlines an integrated and coordinated public health approach that reflects what is known about prevention and intervention. It expands the existing research ecosystem to more effectively identify, integrate, share, and translate data and more quickly employ successful prevention approaches and interventions, where and when they are needed. While the report builds on previous efforts, it offers a unique perspective and a national platform that amplifies and elevates the good work that is underway, while supporting and encouraging community-based efforts to fill remaining gaps in care.

Beyond developing more-effective early intervention and prevention tools and techniques, cultural barriers must be removed when they inhibit conversations about and responses to suicide risk. Just as there are particular risk factors for heart disease, diabetes, and cancer, there are also identifiable risk factors for suicide. However, most people do not know how to identify their own risk factors and, therefore, cannot seek care when necessary or protect themselves from something that has the potential to harm them.

To further complicate matters, risk factors may change over an individual's life depending on a variety of conditions and circumstances, such as changes to physical or mental health, economic stress, or the experience of trauma. Sometimes, an individual's risk might be high; at other times, because of effective treatment or support, that same individual's risk might be lessened. It is critical that everyone has the knowledge and information necessary to recognize and respond in a healthy and productive way to mitigate the impact of their individual risk.

## Why Public Health?

Everyone has a role to play in suicide prevention. Our efforts must reach beyond the four walls of a health care facility to teachers, first responders, barbers, faith leaders, friends and neighbors, family members, and others. To effectively prevent suicide in our Nation, a comprehensive, data-driven public health approach is required. The public health model focuses on a range of evidence-informed approaches targeted for different specific purposes, from clinical interventions delivered at the individual level to broader policies and strategies that aim to promote prevention and the health and well-being of communities and societies.

The foundation for this type of comprehensive public health approach is found in R.S. Gordon's 1983 classification scheme of universal, selective, and indicated prevention strategies. Universal prevention strategies are used to reach all people; selective strategies target those at increased risk for suicide, such as people with substance use disorders; and indicated strategies address those who may already be experiencing suicidal ideation or attempts. However, even within these subpopulations, suicide does not have one cause. Preventing suicide requires implementing strategies that address the interrelated risk factors and protective factors that exist at the individual, relationship, community, and societal levels of the social ecological model.<sup>9</sup>



Figure 0-1

Indeed, a significant level of coordination and collaboration among the public and private sectors is needed to effectively prevent suicide using the public health approach. Together, our communities must change the conversation and embrace a total cultural shift in the way mental health and suicide are viewed, talked about, and treated. This country is no stranger to massive cultural shifts — such as tobacco control, seat belt use, and AIDS awareness — and it can shift again to prevent suicide.

This level of cultural change requires a powerful communications effort to drive messaging that will change hearts and minds across the Nation. Building on the president's mandate to prevent Veteran suicide, the PREVENTS Office is launching one of the key features of the Executive Order: a broad-scale public health campaign.

This campaign includes a robust and clear call to action that will drive Veterans — and all Americans — to reach out to those in need and to reach out when help is needed. Our goal is to ensure that every Veteran — and every American — knows when to reach out and what to do when they see someone who is struggling. We know that those who are struggling may feel hopeless and desperate. It is time to equip our citizens and our communities with the knowledge and tools that will prevent suicide and save lives.

## What Are Risk and Protective Factors?

Risk and protective factors (see table below) are characteristics that affect the likelihood that an individual will consider, attempt, or die by suicide. An individual's suicide risk changes as a result of the number and intensity of risk and protective factors experienced.<sup>3</sup> Risk and protective factors may be fixed or modifiable and are present at the individual, relationship, community, and society level.<sup>2,10,11,12,13</sup>

Level of Interaction	Example Protective Factors	Example Risk Factors
Individual Level	<ul style="list-style-type: none"> <li>• Positive coping skills</li> <li>• Positive problem-solving skills</li> <li>• Having reasons for living or a sense of purpose in life</li> <li>• Moral objection to suicide</li> </ul>	<ul style="list-style-type: none"> <li>• Impulsive or aggressive tendencies</li> <li>• Adverse childhood experiences</li> <li>• Feelings of hopelessness</li> <li>• Chronic pain</li> <li>• Mental illness</li> <li>• Sleep deprivation</li> <li>• Physical illness</li> <li>• Previous suicide attempt(s)</li> </ul>
Relationship Level	<ul style="list-style-type: none"> <li>• Feeling connected to other people</li> <li>• Strong sense of belonging to a unit</li> <li>• Supportive relationships with health care providers</li> </ul>	<ul style="list-style-type: none"> <li>• Relationship conflict, discord, or loss</li> <li>• Sense of isolation and lack of social support</li> </ul>
Community Level	<ul style="list-style-type: none"> <li>• Safe and supportive school and community environments</li> <li>• Sources of continued care after psychiatric hospitalization</li> </ul>	<ul style="list-style-type: none"> <li>• Employment in certain industries/professions</li> <li>• Disaster, war, and conflict</li> <li>• Stresses of acculturation and dislocation</li> <li>• Discrimination</li> <li>• Trauma or abuse</li> </ul>
Societal Level	<ul style="list-style-type: none"> <li>• Access to physical and mental health care</li> <li>• Safe storage techniques for lethal means</li> <li>• Safe media report practices</li> <li>• Cultural or religious beliefs</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced access to physical and mental health care</li> <li>• Poor social determinants of health</li> <li>• Lack of safe storage options for lethal means</li> <li>• Cultural or religious beliefs</li> <li>• Inappropriate media reporting</li> </ul>

## High Risk Groups and Subpopulations

To address Veteran suicide, the communities in which Veterans live and the groups to which Veterans belong must be identified. Although the Nation has seen an increase in suicide rates across groups during the last 25 years, some groups and individuals are at greater suicide risk and have unique risk factors. Groups that have unique risk factors require thoughtful and tailored efforts as suicide risk is addressed for our Veterans.

Understanding effective efforts to reduce the suicide rate for Veterans can also be helpful in our efforts to create and target interventions for others. Finally, sometimes participation in a group can serve as a protective factor against suicide.

Throughout the PREVENTS Roadmap, you will find brief descriptions explaining the risk and protective factors for these groups and the Veterans within them.

## Evaluation

While working toward broad-scale cultural change to reach every Service member and Veteran in need across the military life cycle, evaluation will play a vital role in ensuring adherence to advancing established goals while allowing for the PREVENTS Office to change course as necessary to reach target audiences.

Recognizing the importance of understanding the impact of these efforts, the PREVENTS Office will evaluate the reach, effectiveness, adoption, implementation, and maintenance of all PREVENTS Task Force recommendations, both individually and collectively. A team of experts in the fields of implementation science, evaluation, suicide prevention, Veteran health and wellness, public health, community-based research, and data science will ensure that the execution and impact of the PREVENTS effort are measured objectively and in accordance with best practices in the field.

## How Will Success Be Measured?

Preventing suicide on a large scale will not be easy, nor will it happen quickly. Indeed, a sense of urgency must drive this effort, but also needed are patience and mindfulness of the time needed to see the needed level of societal change. Sustainability must be built and thoughtful implementation encouraged across sectors and communities. Progress must be tracked at both the community and societal levels to allow for course correction as needed based on new knowledge and innovation.

The implementation of the PREVENTS Roadmap will seek to inspire cross-sector support and funding — from inside and outside of government — to support new developments.

Through coordinated, community-focused efforts, Service members and Veterans will be empowered and those who are hurting will receive the care and support they deserve. Workforce development efforts will focus on improving the mental health and well-being of the national workforce, as well as increasing training for professionals who potentially interact with those who are at risk for suicide. Through these public health efforts, cultural barriers and stigma that leave some people feeling guilty, ashamed, or embarrassed to ask for help will be removed.

As more resources are shifted toward prevention and early intervention, the focus will be on educating children, families, communities, and the Nation about suicide risk and protective factors, which will drive more conversation, more sharing, and more openness and support.

Through data-driven research efforts and the expansion of the research ecosystem, specific treatments aligned with specific populations at specific times will be developed — all with the goal of preventing that moment of despair. In tandem, new tools for peer-based and clinical interventions will be created.

There is a great cost in the failure to address this public health issue. If nothing more is done than what has been done before, the number of suicide deaths and suicide attempts will continue to rise. The health and well-being of our Nation will suffer.

Further, how can military families be expected to continue sending their loved ones to protect and defend the Nation if these families come to fear the Service member's transition into civilian life more than any enemy combatant?

In addition to suicide's human toll, it is a costly issue for our society. In 2015, the Substance Abuse and Mental Health Services Administration estimated the average cost of one suicide at \$1.33 million, while the total cost of suicide and suicide attempts was \$93.5 billion.<sup>14</sup>

As with other public health issues and initiatives, a number of things will start shifting simultaneously as change begins. As people become more comfortable talking about and addressing mental health challenges in general, and suicide more specifically, and new interventions are developed and easily accessible, more people will seek and receive the care and support they need and deserve. As these changes occur in attitudes, behaviors, and practices, eventually suicide rates will drop.

## PREVENTS Roadmap and Supplemental Materials

The PREVENTS Roadmap was made possible by the tremendous amount of time and effort devoted by many individuals, agencies, and organizations. Over the course of the past nine months, well over 175 individuals from inside and outside of government contributed to this effort through the PREVENTS Task Force and work groups. Their work was organized in six areas, called lines of effort, to ensure a full review of the current state of suicide prevention and appropriate recommendations.

The 10 overarching recommendations that guide the PREVENTS Roadmap are the result of careful research, review, and exploration. While the collection of recommendations offered is impressive and comprehensive, they will be successful only if they are carried out, studied, and refined as this effort moves forward.

To provide additional context and research for the PREVENTS Roadmap, the PREVENTS Task Force and Office created Supplemental Materials for the PREVENTS Roadmap. The chapters that follow aim to empower states and communities with the background and detail necessary to coordinate efforts and integrate services by strengthening connections between the many sectors and stakeholders at the Federal, state, and local levels that play a role in suicide prevention. The supplemental materials will demonstrate how the PREVENTS Roadmap builds on the work of previous suicide prevention strategies while filling in gaps, creating synergies between their goals, and moving the Nation to action as it works to prevent suicide among Veterans.

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



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## Chapter 1 Communications

## Importance of Communication in Preventing Suicide

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*"Anything that's human is mentionable, and anything that is mentionable can be more manageable." — Fred Rogers*

Communication is an integral part of our lives, from informal, personal exchanges to interpersonal mass media and social media. While these forms of communication are at opposite ends of a spectrum, they both play a critical role in preventing suicide. Communication is an important force in driving culture change.

However, for communication to change culture, difficult conversations need to happen. Unfortunately, in our society — and around the world — conversations about emotional crises, mental illness, and suicide do not often happen because such conversations make people uncomfortable. In some communities, there are also cultural taboos about talking openly about these matters and many people worry about the possible ramifications of having these discussions. Indeed, many believe that asking someone who is struggling emotionally if they are thinking about hurting themselves will increase the likelihood that the person will make a suicide attempt.<sup>15</sup> However, the opposite is true. In fact, some people who have attempted suicide have reported that if someone had reached out while they were contemplating suicide, they would have been less likely to make the attempt.

Although mental health is as much a part of a person as physical health, people deal with these two aspects of themselves very differently. To prevent suicide among Veterans and all Americans, culture — and the conversation about mental health generally and suicide specifically — needs to change.

People are clearly comfortable sharing experiences about physical challenges and do so on a regular basis. Typically, one reaches out to friends when dealing with the misery of a cold or the flu. Those who have cancer often go through treatment with the love and support of their families as well as others who have had a similar experience.

This is not so when it comes to mental health, even though mental health challenges are quite common. For example, all people have experienced emotional pain and suffering, many have dealt with anxiety or depression, and some have felt hopeless and suicidal. Typically — and sadly — people go through these struggles alone, often feeling ashamed and embarrassed that they are unable to push through these experiences.

Discussions about emotional health, mental illness, and suicide should be as common as conversations about a bad cold, the flu, or cancer. All these ailments and experiences are part of the human condition. Learning to share challenges and supporting each other during difficult times help to heal, whether the struggle is physical or emotional.

At the heart of the PREVENTS effort is a coordinated and comprehensive national media and public health campaign. The goal is not only to highlight the importance of preventing suicide, but also to encourage everyone to reach out to those in need — and to reach out when they themselves need help.

To prevent suicide among Veterans and all Americans, people must overcome not only the discomfort often felt when one sees someone else who is in crisis, but also the shame or embarrassment felt when they need support themselves.



The following section of the PREVENTS Roadmap provides important information on a public health approach to suicide prevention, focusing particularly on the role of communications.

## A National Public Health Approach

Suicide is an issue that affects all of us. We all have risk factors — some of us have many. Also, it is rare to find someone whose life has not been directly touched by suicide. Research shows that for every suicide, 135 people are personally affected — families, friends, co-workers, and community members — which means that in any given year, up to 6.3 million people were directly affected by suicide.<sup>16</sup>

The PREVENTS Executive Order states that “our collective efforts must begin with the common understanding that suicide is preventable, and prevention requires more than intervention at the point of crisis.” In other words, preventing suicide among Veterans and all Americans must focus on efforts that reduce the likelihood of two situations: that those who are experiencing suicidal ideation will act on those thoughts; and of individuals’ becoming suicidal in the first place. This requires many different types of services and prevention activities in addition to crisis intervention.

According to the Centers for Disease Control and Prevention,<sup>17</sup> public health is “the science of protecting and improving the health of people and their communities,” which is done through the promotion of healthy lifestyles, research, and the prevention of disease and injury. “Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world.”<sup>17</sup>

### The Public Health Model



Figure 1-1

A public health campaign relies on data to define the problem it aims to address and encourages the use of evidence-informed strategies among its stakeholders to encourage widespread adoption. Data can answer questions about the size or scope of the suicide problem, who is most affected by it, and the trends in suicide over time. Data can also promote innovation that fosters interdisciplinary collaboration, contributes to leading-edge technological advancement, and reveals actionable insights. Harnessing the power of data is vital to the PREVENTS public health approach. For example, now that the challenge of preventing suicide has been defined, the next step is to engage in and coordinate research to help identify the factors that are associated with increases in the suicide rate (e.g., alcohol misuse) and decreases in the suicide rate (e.g., a sense of belonging). With this information, prevention strategies can be developed and tested to address these factors. Finally, evidence-informed strategies can be shared with the community for widespread adoption.

Effectively addressing suicide in the Veteran community will require a comprehensive public health campaign that shifts the culture around suicide for all Americans. This comprehensive suicide prevention approach refers to activities that:

- Aim to both support efforts for those — Veterans and all Americans — at high risk for suicide and prevent individuals from becoming suicidal in the first place.

- Include a multisector approach, acknowledging that no single sector alone can prevent suicide but that all of society and the whole of government must be engaged.
- Incorporate all parts of the communities where individuals live and work. Suicide prevention for Veterans cannot be accomplished separately from suicide prevention for all Americans. Strengthening America's communities to prevent suicide among all Americans will also help reduce Veteran suicide rates.
- Coordinate suicide prevention efforts and strengthen collaboration across the public and private sectors.

The need for communication is a critical feature of each of these elements. For success, all aspects of a public health campaign need to have common themes, use plain language, and tailor messages that are appropriate to different audiences and partners. As Patrick Remington noted in "Communicating Public Health Information Effectively," "Knowledge and implementation of health communication principles can greatly enhance the practice of public health."<sup>18</sup>

There are many health communications models available, but the principles included in each fall into similar categories:

- Identify the need for the campaign and conduct research to develop a campaign plan that includes themes, messages, strategies, and tactics.
- Research and understand the needs and cultural background of the campaign's audiences and learn how they find and use information.
- Develop clear messages and images that are tested with target audiences for ease of understanding and cultural competency.
- Create and test a wide range of materials, both digital and print, to spread the campaign messages.
- Engage partners and influencers to serve as intermediaries to spread campaign messages.
- Monitor and evaluate the campaign and make adjustments as needed.

### **Safe Language**

When implementing suicide prevention strategies, language must be taken into special consideration, as it has the potential both to promote healthy behaviors and to exacerbate risk factors. Research shows that media coverage that uses unsafe language about the occurrence of suicide can lead to copycat suicides or contagion. This phenomenon is observed particularly after a celebrity dies by suicide.<sup>19</sup> A number of sources provide information on safe language for use in public health campaigns as well as resources for journalists who cover suicide, including [reportingonsuicide.org](https://reportingonsuicide.org).

There are also excellent resources and guides for addressing the issue of suicide within the Veteran population, such as VA's Veteran-specific safe messaging guide.<sup>20</sup>

### **Cost and Return on Investment**

Creating cultural change on a large scale via a public health campaign requires a comprehensive, intensive, and focused approach using all available media. This type of effort requires significant resources, but the return on investment can be equally significant. For example, in February 2000, the American Legacy Foundation (now the Truth Initiative) launched the Truth campaign, which was supported by the 1998 Master Settlement Agreement between the major tobacco companies, 46 U.S. states, the District of Columbia, and five U.S. territories, which transformed tobacco control.

It represented the largest national youth smoking prevention campaign in history. From 2000 through 2002, expenditures for the campaign totaled just over \$324 million.<sup>21</sup>

The results were clear: An evaluation published in the American Journal of Public Health found that 22% of the overall decline in youth smoking between 1999 and 2002 could be directly attributed to the Truth campaign.<sup>22</sup> By 2002, smoking rates among youth had dropped 1.6% below the estimated rate without the campaign, equaling 300,000 fewer youth smokers in 2002.<sup>22</sup> A second study in the American Journal of Preventive Medicine estimated that “the campaign recouped its costs and that just under \$1.9 billion in medical costs were averted for society.”<sup>21</sup>

## **The PREVENTS Public Health Campaign**

A key feature of the PREVENTS Roadmap will be to launch a public health campaign that will inspire the American public to come together to end our national tragedy of suicide. The themes and messages for the campaign have been tested and materials have been developed that will be disseminated as part of the release and implementation of the PREVENTS Roadmap.

### **Social and Traditional Media**

The PREVENTS Public Health Campaign will use a wide range of strategies and tactics to share the messages of the campaign, including outreach to traditional media outlets; public service advertising through broadcast, digital, and print outlets; and the delivery of print and digital materials to organizations such as Veterans Service Organizations, Military Service Organizations, nongovernmental organizations, medical professional societies, and a wide range of community-based organizations.

The PREVENTS Public Health Campaign will use the following strategies and tactics in its promotion: traditional social media, digital and standard advertising, and custom activities and contents to promote suicide prevention to Veterans, the subpopulations highlighted in Chapter 2, and the rest of Americans.

Traditional media is no longer sufficient to spread the messages of a national public health campaign since 7 in 10 Americans<sup>23</sup> use social media to connect with one another, engage with news content, share information, and entertain themselves. According to the Pew Charitable Trusts, YouTube and Facebook are the most widely used online platforms; fewer Americans use Twitter, Pinterest, Instagram, and LinkedIn.

As a result, the PREVENTS Public Health Campaign will use social media platforms to share text and video posts that spread its messages. The key to an effective social media campaign is to do more than use these platforms just to spread information passively: The PREVENTS Public Health Campaign must also engage and entertain viewers to prompt them to act.

### **Partnerships**

While one effort can certainly spark a movement, as mentioned above, culture change cannot be accomplished by one organization or entity. The PREVENTS Office is working with a number of partners to help change the culture around mental health, encourage help-seeking behavior, and promote suicide prevention best practices.

For example, as described below in the Partnerships chapter, the PREVENTS Office and the Department of Veterans Affairs (VA) have established a strategic partnership with the U.S. Chamber of Commerce and its Hiring Our Heroes (HOH) initiative.

Americans spend a tremendous amount of time in the workplace, which makes this focus an important one for any effort to address a national public health crisis. As a result of this partnership, the HOH initiative worked with member companies to create the “Pledge to Prioritize Mental Health and Emotional Wellbeing in the Workplace,” which calls on companies to provide managers and employees with the services and resources needed to promote mental wellness.

On Nov. 13, 2019, nearly 30 companies signed the PREVENTS HOH Employer Challenge at an event in Washington, D.C. In addition to the workplace pledge, the U.S. Chamber of Commerce is committed to working with the PREVENTS effort more broadly to promote the messages of the PREVENTS Public Health Campaign.

### **Outreach by Intermediaries**

Using intermediaries to reach key audiences is critical to the success of the PREVENTS Public Health Campaign. To engage intermediaries, the PREVENTS Office is establishing and will leverage a community of PREVENTS Ambassadors — a diverse group of key influencers who will join Veterans as leaders in the challenge to change the culture around suicide nationally.

PREVENTS Ambassadors are thought leaders who are passionate about suicide prevention — individuals who want to use their platforms to bring awareness to this critical issue. The PREVENTS Office is honored that one such thought leader, Second Lady of the United States Karen Pence, will serve as lead PREVENTS Ambassador and empower Veterans and change agents across the Nation to prevent suicide.

The PREVENTS Office is looking for a diverse group of people who can represent and drive the initiative — locally and nationally. Ambassadors can offer to serve or be nominated to serve.

For a list of all PREVENTS Ambassadors, please visit: [the PREVENTS "Get Involved" page](#).

### **What Role Will Ambassadors Play?**

Ambassadors will represent the spirit of the PREVENTS Public Health Campaign by talking openly about mental health, emotional well-being, and suicide. PREVENTS Ambassadors will be encouraged to share their own risk factors for suicide, as well as stories of resilience and recovery. They should inspire others to reach out to those in need to reach out when they need support.

Ambassadors will share the approved messaging of PREVENTS through personal channels and through their day-to-day activities in their communities. The PREVENTS Office will look to its ambassadors to leverage their personal networks to extend the reach of PREVENTS efforts to the media, the public, academia, employers, members of faith-based and other communities, nongovernmental and nonprofit organizations, and the Veteran and military communities.

All ambassadors may share PREVENTS-approved social media posts to promote PREVENTS messaging and initiatives. They will also have the option to choose from other engagement opportunities, including:

- Promoting community meetings and PREVENTS events on social media channels.
- Using the approved PREVENTS talking points to ensure consistent messaging.
- Inspiring individuals and organizations to become supporters to increase the impact of PREVENTS initiatives.

- Participating in community meetings or gatherings to share information about the PREVENTS Public Health Campaign.
- Promoting the PREVENTS Public Health Campaign through personal channels via public announcements, op-eds, news releases, media interviews, and other appearances or podcasts.
- Collaborating with PREVENTS partner organizations to further the reach of the PREVENTS Public Health Campaign and to promote best practices for mental health in general and suicide prevention in particular.

## How Will PREVENTS Office Support the Ambassadors?

The PREVENTS Office will support the ambassadors as they go into the community to inspire others with their stories and messages by regularly providing up-to-date content, tools, and resources. The PREVENTS Office also will feature the activities of the ambassadors on the PREVENTS website and will highlight them in social media.

### State Proclamations and Pledges

One key element to the implementation of the PREVENTS Roadmap and the communications strategy is the signing of PREVENTS Proclamations in all 50 states, the District of Columbia, and 14 U.S. territories and tribal nations.

The PREVENTS Proclamations will demonstrate that states and territories are engaged in a concerted effort to end suicide for both Veterans and all Americans. By proclaiming their support, leaders across the country will lead a growing movement to ensure that those in need are able to seek and receive the help they deserve, as our Nation moves toward a culture of acceptance and compassion for those who are facing emotional challenges.

Like the PREVENTS HOH Employer Challenge, a PREVENTS Community Pledge will also be offered to encourage community members who are inspired to change the conversation about suicide in their communities. Community pledges will encourage community and faith-based organizations to educate citizens about the importance of understanding suicide risk and protective factors. Finally, individuals will be able to take a personal pledge to help prevent suicide for themselves, their families, and in their community, as they encourage others to join our efforts.

### Connecting at the Local Level

A vital component of an effective public health campaign is to reach audiences where they live, work, play, worship, and learn — and to capitalize on a natural tendency to seek affirmation from people like ourselves. Indeed, people tend to connect with and often relate best to their peers. For example, Veterans often seek out the company of other Veterans, older adults with other older adults, and so on. Peer groups are useful not only as a way to share messaging; these connections with peers also help to reduce the suicide risk that social isolation creates for someone who is in crisis. Peer support and social engagement increases the likelihood that those who are hurting will be identified and supported is increased.

## Measuring the Effectiveness of Public Health Campaigns

It is critical to build a system for monitoring and measuring the effectiveness of the PREVENTS Public Health Campaign as it is being developed and launched. Establishing key milestones and metrics while planning the campaign will help sharpen the approach used to implement the national effort.

Monitoring the effectiveness of messages will make it easier to make data-based changes to ensure success. Metrics will include process measures to gauge the effectiveness of the campaign's implementation and outcome measures to show resulting changes in behavior. Logic models and implementation plans for the PREVENTS Public Health Campaign should ensure that the desired outcomes are matched to appropriate activities to achieve them. A public awareness campaign is designed to 1) raise awareness, 2) increase knowledge, and 3) cue people to action. Thus, the activities that are undertaken and the outcome measures that are selected should have the capacity to evaluate the effectiveness of all three stated objectives.

## Conclusion

Effective communication is key to changing behavior and, ultimately, changing culture. To prevent suicide, people need to feel comfortable and have the tools they need to have the difficult conversations about mental health and suicide. The PREVENTS Roadmap and Public Health Campaign are important steps in achieving that goal.

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs



## Chapter 2 Partnerships

## Background

The only way to reach every Veteran is to reach every community in every corner of the Nation. This type of effort requires a comprehensive, collaborative network using teamwork to achieve what no single individual or organization can do alone. That is why partnerships play a critical role in the plan to empower Veterans and end a national tragedy of suicide.

Effective partnerships bring together government, industry, nonprofit, and faith-based organizations to leverage strengths and create programs that achieve what individual efforts cannot do alone. When designed and executed effectively, programs created by strategic partners can solve even the most complex societal challenges.

As Secretary of Veterans Affairs (VA) Robert Wilkie stated, “The next 100 years will be the story of partnerships, of VA working outside its own walls with people and organizations who share our goal of helping those who have borne the battle.” Large-scale and bold partnerships have helped VA expand programs in critical areas such as launching targeted oncology centers of excellence, leading the Nation in virtual care, expanding health care access to Veterans in rural communities, and eliminating Veteran homelessness in many communities. Similarly, PREVENTS partnerships, such as the governors’ and mayors’ challenges partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), will galvanize the country to support efforts to prevent Veteran suicide and build a coalition of organizations committed to address this national tragedy.

A small sample of successful VA partnerships illustrates Secretary Wilkie’s point regarding the potential role that partnerships play for Veterans and their families and communities:

### Examples of Successful Partnerships

**T-Mobile, Verizon, and Sprint** eliminated data charges for Veterans and their caregivers using VA Video Connect to access VA health care.<sup>24</sup> In addition, T-Mobile aired a commercial that reached a potential audience of more than 800 million viewers, informing them of VA’s innovative telehealth services as well as the department’s elimination of data charges for Veterans using those services.<sup>25</sup>

**Philips** donated the construction and installation of remote telehealth exam rooms in 10 rural Veterans of Foreign Wars and American Legion posts for Veterans without home broadband who live far from a VA medical center.<sup>26</sup>

**VA’s Veterans Experience Office** has helped 160 communities nationwide to organize partners from across Federal, state, nonprofit, business, industry, health care, benefits, and community services sectors to form local Community Veterans Engagement Boards (CVEBs) that focus on collaborative efforts to improve communication and address local challenges. For example, VA and CVEBs partner to host sessions of the Community Clergy Training Program to inform clergy members about suicide prevention and intervention, empowering them to have necessary but difficult conversations about suicide.

**VA’s Health Care for Reentry Veterans** and **Veterans Justice Outreach programs** partner with local law enforcement, criminal courts, jails, and Federal and state prisons to help prepare the criminal justice system to address the unique needs of Veterans, emphasizing treatment and rehabilitative services when appropriate, rather than incarceration and punishment.



As these examples demonstrate, the value of effective partnerships is in the ability to build bridges between organizations, expanding resources and enabling services to flow seamlessly from one to another, benefiting both the partners and those they serve. Partnerships also provide a means to more effectively communicate a message, provide resources, and expand an audience. For this reason, they are critical to launching a successful campaign to change the culture around mental health and suicide.

A growing number of thought leaders in the private and public sectors are recognizing the significant impact that suicide has on individuals, families, and communities. These leaders are eager to leverage their influence — and that of their organizations — to end this national tragedy, thereby improving the lives of their employees, customers, and members. They are invested in addressing this challenge for the good of the greater community in which they are embedded.

The PREVENTS Office is engaging organizations across the country, encouraging them to develop partnerships that maximize the opportunity to reach every Veteran in need in the effort to prevent suicide among those who have served our country and all Americans. By building a network of strategic partnerships that have shared goals and broad reach, there is an increased likelihood of a cultural shift that takes mental health as seriously as physical health. As this shift occurs, there will be more support for those who are suffering emotionally, greater comfort in discussing topics like mental illness and suicide, and a higher priority placed on developing techniques and approaches that bring relief to those who feel despair.

## Goals and Approach

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*“The whole is greater than the sum of its parts.” – Aristotle*

### Goals

The overarching goal of partnerships that focus on suicide prevention is to advance knowledge and interventions — and foster a culture in which Veterans and others who need support are able to seek and receive the care they deserve so they never reach the point of crisis. To do this, suicide prevention partnerships should aim to achieve one or more of the following objectives:

- Maximize collective impact to solve this complex societal challenge.
- Improve navigation and access to resources.
- Enhance the customer experience and the results for those in care or seeking care.
- Eliminate barriers and bridge gaps.
- Explore future solutions.

### PREVENTS Partnerships Approach

Tackling a complex societal issue such as Veteran suicide is a monumental task that requires the establishment of multiple partnerships across numerous sectors. To create a network of effective and dedicated partnerships to advance the work of PREVENTS, the Partnerships effort looked first to capitalize on an existing partnership between VA and the U.S. Chamber of Commerce. Working with the Chamber’s Foundation Hiring Our Heroes (HOH) initiative, the PREVENTS Office joined VA as they brought together leaders from the corporate and nonprofit sectors to discuss best practices in the workplace. On Nov. 13, 2019, the U.S. Chamber of Commerce Foundation, in collaboration with the PREVENTS Executive Order Task Force and VA, launched Wellbeing in the Workplace, a collaborative effort to prioritize mental health and well-being in the workplace.

More than 30 large corporations, each a significant employer of Veterans, signed a pledge to strengthen employee mental wellness within their organizations. More about this coalition can be found in the Employer Challenge Case Study found later in this chapter.

Simultaneously, the PREVENTS Office began developing new partnerships with leaders and organizations throughout the country to create relationships that can build momentum and move the PREVENTS Roadmap from the planning phase to implementation. As potential partnerships were identified, they were formalized with written agreements, which included timelines and metrics for measuring success. A list of early partnerships and a template of the PREVENTS partnership agreements is included in the Learn More section.

## Findings

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Effective partnerships occur in a number of settings and can involve participants from a variety of sectors. The best results for addressing complex challenges often come from partnerships that focus on collective impact, which requires a group of important community actors from different sectors to commit to a common agenda to solve a complex societal problem. Collective impact revolves around a common agenda, a shared measurement system, mutually reinforcing activities, and continuous communication. It also requires an independent and centralized infrastructure with staff and processes to facilitate the initiative and measure its outcomes. Given the required commitment and support, collective impact coalitions have the capacity to address the complex, large-scale societal problems that individual organizations cannot.<sup>27</sup>

Evidence of the power of collective impact can be found by looking at communities before and after their organizations partnered in a widespread collective impact initiative. For example, in the early 2000s, a number of organizations throughout the country were dissatisfied with the quality of the public education system and were working toward improving it. Much like suicide, public education is a complex societal issue, affected by too many variables for one organization to address alone. In Cincinnati, over 300 community organizations agreed to participate in a collective impact initiative with StriveTogether as the backbone organization facilitating their coalition. Within four years of establishing the coalition, during a time of increasing budget cuts, StriveTogether found improvement in 34 of the 53 metrics they used to measure success, including an increase in graduation rates. This is an example of how collective impact can solve a complex issue.<sup>27</sup>

To emphasize the shift from crisis intervention to upstream suicide prevention, VA held a 2020 Community Partnership Challenge with a theme focused on six social determinants of health (SDoH). Each partnership will increase Veterans' access to:

- **Education** — Affordable, convenient, and safe education, training, or skill development opportunities.
- **Employment** — Opportunities for safe temporary or permanent employment.
- **Food Security** — Safe, accessible, and nutritious food sufficient to maintain a healthy and active life.
- **Housing** — Resources that aid in procuring permanent or temporary, affordable, and safe housing and/or shelter.
- **Spiritual Support** — Support from spiritual leaders, religious officials, healers, or faith-based organizations, as well as opportunities for participation in activities, observances, or communities related to spiritual health, beliefs, or religion.
- **Transportation** — Accessible, affordable, and safe transportation options for moving around within or traveling to and from their communities.

Such partnerships move the focus upstream by addressing potential issues before they reach a boiling point and become a crisis. They not only improve overall health and well-being by improving SDoH, but also extend needed services to Veterans who are not connected to VA services. To support its mission to serve all Veterans, including those who do not use VA services, VA has formed key partnerships with for-profit, nonprofit, faith-based, and philanthropic organizations; traditional and new Veterans Service Organizations (VSOs); and government and tribal agencies. A list of VA's national partners who support an explicit goal to end Veteran suicide can be found at [Secretary's Center for Strategic Partnerships \(SCSP\)](#).

The workplace is an ideal environment for partnerships focused on addressing Veterans' needs because it touches a broad audience and offers a structure for measuring outcomes. About half of all Veterans are employed in the civilian workforce,<sup>28</sup> and even those who are unemployed are likely to be employed at some point or have family members and friends who are. Therefore, changing the workplace culture is a promising strategy to reach Veterans who are not being reached through other means. Further, with Veterans sprinkled throughout the civilian workforce, the workplace is an ideal environment for mobilizing Veterans to lead efforts to change the culture.

### Case Study: Employer Challenge

Although no amount of money can account for the loss of a human life, suicide and suicide attempts are estimated to cost the American economy \$93.5 billion annually.<sup>14</sup> With this in mind, VA sought to build an employer coalition to strengthen mental health and encourage suicide prevention in companies with large Veteran populations.

Through VA's existing strategic partnership with the U.S. Chamber of Commerce Foundation's Hiring our Heroes (HOH) initiative, the PREVENTS Office developed a plan to invite U.S. companies to improve mental health through programs in the workplace. The goal of this expansion was to build a coalition of employers united in their commitment to prevent suicide by focusing on:

- Strengthening the well-being of all employees.
- Developing and sharing best practices.

- Learning from VA's experiences in addressing mental well-being and suicide prevention.
- Providing support services to help prevent employees from reaching the point of despair and hopelessness.

This partnership with the Chamber's Foundation HOH initiative has been a particularly powerful effort, as it engaged a group of companies that had already demonstrated their investment in hiring and empowering Veterans, making this partnership a perfect fit for the PREVENTS effort. The participating employers recognize the value that Veterans bring to companies. They also recognize that to reach those Veterans who need support, they must create a culture where Veterans are able to easily seek and receive care. In addition, these employers understand that mental health challenges affect many of their employees — and suicide affects many families. By engaging Veterans in this effort, the employers will help lead the way to build healthier companies and healthier communities.

In August 2019, HOH and VA Secretary's Center for Strategic Partnerships convened a small work group that began crafting what would become the cornerstone of this shared mission: a pledge that could drive engagement and action among companies across the country. By the end of this process, the work group created the HOH Employer Challenge.

On Nov. 13, 2019, a coalition of more than 30 corporations accepted the Employer Challenge and signed a pledge to support employee wellness within their organizations. The employers pledged to:

- **Overcome stigma** by encouraging their senior leaders, as well as business and community leaders, to serve as role models in the fight to normalize mental health challenges and treatment and to encourage mental and emotional wellness.
- **Adopt a comprehensive, proactive education approach** by making resources, training, and other educational opportunities available to employees to help them recognize the signs of possible mental health challenges or suicide risk in themselves and their colleagues, and to address mental health and well-being issues when they arise.
- **Provide access to assistance and services** by making behavioral health services, such as employee assistance programs and mental health benefits, available and encouraging employees to use them, creating a culture of health to promote self-care with multiple pathways to access behavioral health support and treatment.
- **Assess and measure progress** by using qualitative information related to efforts to reduce discrimination, promote awareness, and provide access to services, to inform future interventions and services on a continuous basis.
- **Build a culture of inclusion** by promoting a safe, inclusive work environment and leveraging employee resource groups to build awareness of mental health and emotional well-being topics, creating communities of support.
- **Evaluate and collaborate continually** as community leaders to share best practices and lessons learned, working to provide greater understanding within the business community.

Employers can sign up to take the Employer Challenge pledge at [www.hiringourheroes.org](http://www.hiringourheroes.org). See the end of the chapter for a list of employers who signed the pledge at the November 2019 meeting. Following the meeting, the coalition members continued to work together under the leadership of HOH and are now focused on phase two of their work.

In addition to implementing the pledge within its members' own companies, the coalition developed a second set of goals that includes:

- Create an employer best practices guide for improving mental health in the workplace.
- Expand the coalition to include a range of companies with respect to size, sector, and geographic footprint.
- Identify sources and methods for data collection to support program evaluation.
- Plan upcoming pledge-signing events.

The coalition also envisions a third phase that will focus on accomplishing the following:

- Host a national conference with thought leaders to identify additional best practices and desired areas for further research.
- Expand the coalition by recruiting additional business partners of participating companies.
- Implement projects to engage local chambers of commerce.

Employee mental health is a critical priority for forward-looking employers, and the U.S. Chamber of Commerce Foundation is an ideal partner to mobilize the corporate sector. The coalition that has formed because of the partnership between the U.S. Chamber of Commerce Foundation and VA aims to implement best practices in the workplace to strengthen employee well-being, providing critical support to the PREVENTS efforts. Employers may benefit from increased employee productivity and engagement, while wellness can enrich the lives of employees, their families, and the broader community — including Veterans and their families.

## Barriers and Limitations

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To achieve the aspirational goals set forth by Executive Order 13861, the PREVENTS Office needs to develop a coordinated and comprehensive network of organizations and initiatives at the national, state, and local levels that delivers effective messaging and education to increase awareness about suicide risk and protective factors, provides programs focused on prevention and early intervention, allows individuals and their families to easily access support resources, and provides evidence-based interventions when needed.

The steps outlined above will help facilitate the kinds of partnerships necessary to achieve these outcomes, but it is important to recognize possible roadblocks that may exist or develop over time, such as:

- **Lack of trust and communication between partners** — A partnership relies on trust. Part of building trust is open, honest, and consistent communication. A lack of communication can result in a failed partnership. If one partner communicates poorly — or if there is a significant misunderstanding — a potentially effective relationship can collapse. Many partnerships are not bound by legal contracts and, therefore, either side can terminate the agreement for any reason. Under these circumstances, it is critical to foster an open and honest working relationship among partners.
- **Conflicting strategies and/or goals across public, nonprofit, and for-profit organizations** — The goals and motivating factors within the public and private sectors are very different. A for-profit company, while interested in social responsibility, must answer to shareholders and is likely to be more focused on profit, whereas a nonprofit organization needs to identify funding sources but is focused primarily on a social mission.

In many cases, this distinction can be a benefit, as the partners can leverage their unique strengths. However, if the parties bound to an agreement are not fully aware of how these differences affect decision-making, problems can develop within the partnership.

- **Imbalance of power when one company is larger or more visible in the partnership** — Many organizations want to partner with highly visible initiatives, organizations, and agencies to increase their visibility and audience reach. Indeed, this may be a prime motivator for some potential partners. However, organizations should recognize that this may create an imbalance of power — and that one or more of the partnering organizations may feel disappointed or frustrated if they do not feel that they are getting what they expected from the partnership. Communicating clearly about expectations, responsibilities, and decision-making power is key to avoid difficulties that arise within a partnership, especially if there is a significant power differential.
- **Difficulties in addressing challenges around data rights, sharing, and ownership** — Many partnerships require the sharing of data between organizations. However, organizations have different security mechanisms in place to protect data, and various levels of approval are required before information can be shared outside the organization. To further complicate matters, there are no comprehensive standards across industries regarding when and how data can be shared and for what purposes, as well as how privacy rights can be waived or protected. Even where rules exist, they vary by industry. For example, the demographic data gathered by internet cookies is easier to share than the demographic data gathered by a medical facility. When creating a partnership agreement, it can be difficult to clearly address challenges concerning data rights and ownership, as well as licensing and ownership rights concerning a shared data product. Technology changes so rapidly that even when these topics are addressed, an agreement could quickly become outdated if no one is actively monitoring it.
- **Having enough resources, time, and staff to manage the partnership** — A partnership requires commitment. Each partnership requires people to negotiate an agreement, resources to implement the actions agreed upon, and time to measure the outcomes. Many partnership opportunities do not come to fruition because organizations do not invest enough time, resources, or staff to pursue and manage them.

For complex societal issues like suicide, a partnership is an opportunity to make a long-term investment in improving the community. Potential opportunities should be weighed carefully against potential barriers. To avoid potential barriers and pitfalls, realistic expectations should be agreed upon in advance and issues should be addressed as they arise.

## Recommendations

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### What are future priority areas for partnerships?

As detailed above, partnerships are critical to Executive Order 13861's goals of empowering Veterans and preventing suicide. In developing recommendations, the PREVENTS Office recognizes the importance of partnerships that change the culture around suicide broadly and extend the reach of government agencies to engage Veterans who are not currently connected to VA services. The goals formulated as a result of the Partnerships effort are to:

- Facilitate the development of codified partnerships across government agencies and between government and nongovernment entities and public and private organizations, including faith-based organizations, while increasing the capacity and reach of programs and research efforts.

- Build a “no-wrong-door” approach by leveraging relationships with community-based organizations, tribal communities, faith-based organizations, nonprofits, and Veterans and Military Service Organizations.

Recommendations for advancing progress toward these overarching goals include:

Recommendations
Expand and support the U.S. Chamber of Commerce Foundation/Hiring Our Heroes' Employers Challenge to develop and implement best practices in the workplace for strengthening mental wellness and preventing suicide.
Develop partnerships and coalitions at the local level designed for Veterans, including those who are unemployed, retirees, students, homeless, incarcerated, disabled, or in residential settings.
Encourage and support partnerships with and among community organizations, VSOs, faith-based and academic institutions, government, aging and disability service organizations, tribal communities, and others to implement best practices. Facilitate collaboration among these partners to address the social determinants of health identified as risk factors for suicide, such as financial stress, food insecurity, and social isolation.
Build partnerships among health systems, employers, universities, and professional associations to incentivize young people to pursue careers in the mental health field.
Share VA best practices on suicide prevention and intervention including screening protocols, testing, interventions, data, and surveillance programs with other health care systems.
Ensure state resources are integrated with national suicide prevention strategies and are disseminated and implemented through local organizations and communities.
Create a PREVENTS partnership database that would house best practices for building business partnerships and share opportunities for companies to find and create partnerships based on their needs and desired outcomes. The database also could collect valuable mental health resources and suicide prevention training for employers and employees.
Develop a community partnership that develops best practice guidelines for building peer support networks for Veterans, first responders, or other professions and populations at high risk.
Establish local Veterans treatment courts, supported by VA and law enforcement, to provide services including mentoring, and mental health and/or substance use treatment for Veterans involved in the criminal justice system.
Provide wellness and suicide prevention resources — including information on Veterans’ benefits for Veterans during typical business and community engagements such as the closing of a mortgage or the signing of a rental agreement.
Create partnerships that bring basic mental health literacy to the general population to ensure that individuals have the skills to identify signs of emotional pain and distress and know when and how to refer a person to helpful resources.

## Learn More

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### *Employer Challenge Participant List*

- Amazon
- Bank of America
- Boeing
- Booz Allen Hamilton
- Capital One
- Cisco
- Comcast NBCUniversal
- Cushman & Wakefield
- Deloitte
- Department of Defense
- Department of Veterans Affairs
- EasterSeals
- Edelman
- General Electric Co.
- George W. Bush Institute
- Grant Thornton
- HCA Healthcare
- Hilton Worldwide
- IBM
- JPMorgan Chase
- Lockheed Martin
- Microsoft
- National Council for Behavioral Health
- Nestle
- Pentagon Federal Credit Union
- Philips North America
- Prudential Financial
- Sprint Business
- Starbucks
- T-Mobile
- U.S. Chamber of Commerce Foundation
- USAA
- Walmart
- Wounded Warrior Project



## ***Hiring Our Heroes Employer Challenge Pledge***

### **Pledge to Prioritize Mental Health and Emotional Well-being in the Workplace:**

*Building a public/private partnership to strengthen emotional well-being in the workplace*

Mental health and wellness are strategic imperatives for American business. Depression, anxiety and feelings of isolation and hopelessness not only plague productivity and work quality, they have a real impact on employee morale and our sense of shared purpose. Some of our most vulnerable employees are at greater risk of long-term health challenges, self-harm, and suicide. By addressing problems and providing support early on, employers have the opportunity to prevent much more serious outcomes in their employees' lives.

Our Nation has learned a great deal about mental health through our Veteran community. Veterans have shown great strength and resiliency as many have addressed and overcome challenges associated with mental health problems. They have worked to address stigma by openly discussing their challenges, creating support networks, and looking for community-based solutions.

As part of the President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS) task force, the American business community is working with the U.S. Chamber of Commerce Foundation and the Department of Veterans Affairs to help identify and develop best practices around mental health and well-being in the workplace. Businesses are in the unique position to leverage the learnings from our employees, including Veterans, encourage a national discussion on mental health in the workplace, and collaborate on meaningful solutions.

Together, we pledge to prioritize mental health in the workplace and undertake the following core actions to affect change:

- 1. Overcome Stigma.** We will work to reduce stigma related to mental health issues by encouraging open and healthy conversations by and between all employees and their leaders. Our senior executives and front-line managers are key to our efforts. We will leverage them as well as our business and community leaders to serve as role models in the fight to normalize mental health problems and encourage mental and emotional wellness.
- 2. Educate Employees and Promote Awareness.** We will provide broad training to all employees that will help to identify the signs that colleagues may be struggling, as well as available tools and resources. We will emphasize the important role of front-line managers in our effort to prioritize the mental well-being of all employees.
- 3. Provide Access to Assistance and Services.** We will make behavioral health services such as employee assistance programs (EAPs) and/or mental health benefits available to support employees in need and to create a culture of health and well-being. We will encourage employees to use these services without repercussions, creating a culture of health that promotes self-care along with multiple pathways to access behavioral health support and treatment.
- 4. Assess and Measure.** We will use available aggregate data and qualitative information to increase our collective understanding of employee populations, as well as risk factors such as financial stress; emotional stress; substance use and abuse; and use insights on best practices to inform future interventions and services on a continuous basis.

**5. Build a Culture of Inclusion.** We will promote a safe, inclusive work environment and leverage employee resource groups to drive awareness around mental health topics, creating communities of support.

**6. Continuous Evaluation and Ongoing Collaboration.** We will commit to ongoing efforts to review the effectiveness of our mental health programs and make necessary adjustments based on the needs of our employees and available data from private and public partners. We will collaborate as community leaders to share best practices and lessons learned, working to provide greater understanding among the business community.

Overall employee mental health and well-being is a critical priority for forward-looking employers, such as our organization. The workplace will benefit from improved productivity and employee engagement to drive better business performance and outcomes for those we serve. Together, we are committed to implementing proven best practices to enhance productivity and engagement, and enrich the lives of our employees, their families, our business partners, and the broader community we are dedicated to supporting.

Sincerely,

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Name and Title

---

Company

---

Date

## PREVENTS Agreement Template

### PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



VA



U.S. Department  
of Veterans Affairs

### Memorandum of Agreement

Between

The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide  
Task Force Office

And

[NGO Name]

#### I. PURPOSE:

This Memorandum of Agreement (MoA) is entered between the U.S. Department of Veterans Affairs (VA or Department), through the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide Task Force Office (PREVENTS Office), 810 Vermont Ave NW, Washington DC 20420, and [insert NGO name], [insert address], individually referred to as a "Party" and collectively referred to as the "Parties." This MoA sets forth a structure in which both entities will work in a mutually beneficial manner to advance and improve national mental health and suicide prevention efforts, benefiting not only our Nation's Veterans, but also our Nation as a whole.

Authorities (choose those applicable):

- (1) The Secretary or his delegatee has the authority to accept gifts, bequests, or devises of all kinds that would benefit Veterans, agency medical/domiciliary facilities, the Secretary's authority to administer the laws under his jurisdiction, or that would enhance his ability to provide services or benefits, codified under 38 U.S.C. § 8301.
- (2) The Secretary or his delegatee has the authority to accept gifts or donations of all kinds for the alteration, acquisition, expansion, or construction of medical facilities, codified under 38 U.S.C. §§ 8103, 8104.
- (3) The Secretary can and has delegated that authority to subordinate agency officials and employees under 38 U.S.C. § 512.
- (4) The Secretary may coordinate programs and efforts to provide and to enhance benefits with state, local, and private entities, codified under 38 U.S.C. § 523.
- (5) The Department has statutory charges to conduct outreach regarding Veterans and eligible beneficiaries under 38 U.S.C. § 6301 et seq et inter alia.

#### II. BACKGROUND:

Department of Veterans Affairs

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# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



VA



U.S. Department  
of Veterans Affairs

VA's mission is to fulfill President Lincoln's promise, "[t]o care for him who shall have borne the battle and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans in accordance with Federal law.

On March 5, 2019, President Trump signed Executive Order 13861 President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS) to empower Veterans and lower the suicide rate through the development and implementation of a national public health Roadmap. In order to support this effort, VA established the PREVENTS Office within the Office of the Secretary. PREVENTS is a three-year effort. The Roadmap is to be submitted by March 5, 2020.

The PREVENTS Roadmap is an all-hands-on-deck approach to integrate public and private entities across the nation to work together to:

- Empower Veterans to pursue an improved quality of life
- Prioritize related research activities
- Prompt collaboration across the public and private sectors

## PREVENTS Office

On March 5, 2019, President Trump signed Executive Order 13861 PREVENTS to empower Veterans and lower the suicide rate through the development and implementation of a national public health Roadmap. The PREVENTS Executive Order covers a three-year effort. The Roadmap is to be submitted at the end of the first year, and then implementation and evaluation of the ensuing efforts will occur for the remaining two years.

The PREVENTS Roadmap is an all-hands-on-deck approach to integrate public and private entities across the nation to work together to:

- Empower Veterans to pursue an improved quality of life
- Prioritize related research activities
- Prompt collaboration across the public and private sectors

[NGO Name]

[NGO Name is insert boilerplate text that describes the NGO.]

## III. OBJECTIVES:

The PREVENTS Office and [NGO Name] have a shared goal to empower Veterans' health and well-being and disseminate strategies and educational materials needed to effectively lower the rate of suicide (insert a simplified version of purpose/goal from above. This partnership will be mutually beneficial as the Parties work together through a set of objectives to achieve this goal.

This MoA sets forth a framework of intent and cooperation between the Parties to achieve the following objective(s):

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



VA



U.S. Department  
of Veterans Affairs

- (1) [Insert objective #1 of this partnership that supports VA's mission, goals, priorities, objectives, and/or strategies.] *consider the number of objectives, drafting accordingly*

## IV. RESPONSIBILITIES:

The PREVENTS Office will:

- (1) [Insert what you are committing VA to do in this partnership.]  
*include other ancillary VA responsibilities in the subject area*

[NGO Name] will:

- (1) [Insert what the NGO is committing to do in this partnership.]

## V. PERFORMANCE MEASURES:

The PREVENTS Office and [NGO Name] seek to increase access to and enhance services to Veterans and their families through this partnership. The ability to quantitatively and qualitatively capture objective performance through metrics that demonstrate the impact of this partnership is critical. Therefore, the Parties agree to use the following metrics to capture and record objective performance through related outcomes, outputs, measurables, and/or impacts, as appropriate:

- (2) [Insert metric #1 of this partnership that captures and records appropriate quantitative or qualitative outcomes, outputs, measurables, and/or impacts.] *Expected ROI or Result?*

## VI. POINTS OF CONTACT:

DEPARTMENT OF VETERANS AFFAIRS

[NGO NAME]

Business Unit or Office

NGO POC Name

VA POC Name

Title

Title

Department of Veterans Affairs

NGO Name

Address 1

Address 1

Address 2

Address 2

City, State Zip Code

City, State Zip Code

Phone Number

Phone Number

Email Address

Email Address

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# PREVENTS

The President's Roadmap to Empower Veterans  
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VA



U.S. Department  
of Veterans Affairs

## VII. LIMITATIONS:

- a) For the purposes of this MoA, a partnership is a voluntary, collaborative, working relationship between VA and NGO Name. The term partnership does not imply that VA and NGO Name are jointly liable for either Party's obligations. Neither party is responsible for debts, contractual obligations, or conduct, tortious or otherwise, of the other Party. This MOA shall not be construed to create a joint venture, agency, employment, or any other relationship between the PREVENTS Office and NGO Name. This MoA does not authorize the expenditure or reimbursement of any funds. This MoA does not create a binding contractual obligation, obligate either Party to expend appropriations or other monies or enter into any contract or other obligation, or create any rights between the Parties. Should any exchange of funds or resources be necessary, the Parties will first enter into a supplemental binding instrument.
- b) NGO Name will not use this MoA to sell or promote any products or services.
- c) NGO Name will not use the name of the VA or any of its components, except in factual publicity and with prior written approval of VA. Factual publicity includes announcements of dates, times, locations, purposes, agendas, speakers, and fees, if any, involved with activities or events. Such factual publicity shall not imply that the involvement of VA serves as an endorsement of the general policies, activities, or products of NGO Name. Where the publicity references the VA or the PREVENTS Office, publicity will be accompanied by a disclaimer to the effect that no VA endorsement is intended. NGO Name may use the PREVENTS Office or VA logo, seals, flags, and other symbols only pursuant to a written determination by VA that the proposed use by NGO Name advances the aims, purposes, and mission of the Department. VA approval is not guaranteed.
- d) VA will not use, and has obtained no ownership interests in NGO Name's names, logos, and/or trademarks (the Marks). VA will obtain NGO Name's prior written approval to use the Marks.
- e) This Agreement is not intended to be an exclusive arrangement. The relationship established in this Agreement in no way limits VA or NGO Name from establishing similar relationships with any other entity.
- f) This Agreement does not represent any endorsement by VA or the PREVENTS Office of the general policies, activities, or products of NGO Name.
- g) Any publicity released by either Party concerning this MoA, the services or supports provided within, or any resulting outcomes, will be subject to prior approval of the other Party.
- h) Each party shall bear its own costs, risks, and liabilities incurred by it arising out of its obligations and efforts under this MoA. One Party cannot commit the other to any cost, expense, or obligation without the prior written consent of that Party.
- i) This MoA may not be assigned or otherwise transferred by any Party, in whole or in part, without the expressed prior written consent of the other Party, which shall not be unreasonably withheld.
- j) VA and NGO Name will only disclose data to one another as permitted under applicable federal law.



## PREVENTS

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VA



U.S. Department  
of Veterans Affairs

*Note: The liability, if any, of the United States for injury or loss of property, or personal injury or death shall be governed exclusively by the provisions of the Federal Tort Claims Act. This agreement is subject only to Federal law.*

### VIII. DURATION, AMENDMENT, REVIEW, TERMINATION, DISPUTES:

- a) This MOA will have a Period of Performance of one (1) year, followed by X consecutive option years, subject to the availability of appropriated funds. [adapt POP as needed]
- b) Amendments must be bilaterally executed in writing, signed by authorized representatives of both Parties. No oral or unilateral amendments will be effective. Only terminations done in accordance with the terms of this agreement may be done unilaterally.
- c) Should disagreement arise as to the interpretation of the provisions of this agreement that cannot be resolved between the Parties' POCs, the area(s) of disagreement will be reduced to writing by each Party and presented to the authorized officials on both sides for resolution. If settlement cannot be reached at this level, the disagreement will be raised to the next level in accordance with the Parties' procedures for final resolution.
- d) This agreement may only be terminated in writing with XX days' notice sent from the authorized representative of the terminating Party to the authorized representative of the other Party. In no case will any oral termination be effective nor will any termination attempted outside these stated requirements.

### IX. APPROVALS:

Department of Veterans Affairs  
Business Unit or Office

By: \_\_\_\_\_

NAME  
POSITION

Date: \_\_\_\_\_

NGO Name

By: \_\_\_\_\_

NAME  
POSITION

Date: \_\_\_\_\_

*Attachments/Appendices [If exhibits or attachments are needed—to be incorporated by reference as though fully set forth in the main document]*

## Supplemental Information

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### Building a Partnership

Every partnership will look slightly different, but they all include a set of common components. A partnership is formed when two or more organizations join in a voluntary, collaborative working relationship to achieve shared objectives. Partnerships can exist between organizations of any size or type, including Federal, state, or local governments; corporations; academic institutions; and local, nonprofit, industry, and service providers. A partnership can also include individuals who are dedicated to supporting the cause by using their personal resources, such as philanthropists who provide funds, entertainers who lend their cultural influence, and community leaders who advocate for policy advancement.

Strategic partnerships can be categorized based on the type of product or service an organization receives from the partnership. For this reason, the same partnership may fall into multiple categories, depending on which organization defines it. For example, consider a for-profit pharmaceutical company that partners with a government agency to spread awareness of safe prescribing practices in an effort to reduce prescription opioid misuse and suicide. In this case, the for-profit organization would consider it a sustainability partnership, while the government agency would consider it a marketing partnership. What is most important is not the label itself, but rather the value that each member of the partnership brings to the relationship.

Regardless of the type of strategic partnership being formed, an organization should expect to go through four basic phases when developing a partnership.



*Figure 2-1*

#### Discovery

During this phase, an organization will assess its market, determine gaps in service or product delivery, and identify and research potential partners with strengths in needed areas. Once an organization identifies a potential partner, it will reach out and begin developing a relationship.

#### Development

An agreement can be flexible to fit the needs of the partners. It may be formal or informal, written or oral, spanning one day or multiple years, and project-based or ongoing.

Some partnerships are informal and require little in terms of contractual agreements. Organizations in these partnerships generally collaborate and support the work of the other but are not explicitly endorsing each other or creating a shared work product.



For example, a VA medical center may hold an outreach event where community organizations are provided with a space to set up an information table and educate Veterans about the services they offer. In this example, neither the participating community programs nor VA expects to be promoted or endorsed, but all feel the arrangement is beneficial and is in the best interest of the Veterans they serve.

To create a more formal partnership with explicit expectations for each party, it is advisable to negotiate a written partnership agreement (also called a memorandum of understanding or letter of agreement). This agreement should establish and outline goals, obligations, limitations, and liabilities, including resource commitments. Such an agreement should be based on shared strategic goals and objectives, outlining what the partnership will accomplish and how the collaboration will benefit each organization and the population it serves. To assess the value of a formal partnership, actions and outcomes should be projected and then measured against predetermined metrics. Therefore, the agreement should include metrics and milestones required to achieve successful results and a timeline for measurement.

### **Implementation/Measurement**

Implementation and measurement are often described as two separate phases, but they should be considered together, as they occur in tandem. Organizations that form a partnership take the actions outlined in the agreement to achieve desired milestones and measure progress using the agreed-upon metrics and timeline outlined in the agreement. Periodically the organizations should review progress, discuss lessons learned, and determine whether they are achieving the desired outcomes. If not, they should take immediate action to get back on track.

At the conclusion of the agreement, a final review should be completed to determine whether the original need still exists, and the agreement should be continued, revised, or concluded. Regardless of whether the organizations choose to continue the partnership, they may choose to continue measuring outcomes and, if their work together was successful, disseminating information about the partnership as a source of best practices or lessons learned to other organizations.

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs



## Chapter 3 National Research Strategy

## Introduction

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The PREVENTS National Research Strategy (NRS), a component of the PREVENTS Roadmap, was developed with broad insight from leaders in Federal government, research institutions, nonprofit organizations, Veterans' groups, health care professionals, as well as experts in the research and scientific community, and other stakeholders. The NRS takes a broad public health approach to investigate and understand the dynamic nature and inherent complexity of factors associated with enhanced suicide risk, the onset of suicidal behaviors, and opportunities for intervention long before the individual is at greatest risk for self-harm. Additionally, a public health approach allows for positive impacts to reach all Veterans, not just those receiving care within the Veterans Health Administration, and focuses on strategies to enhance the communities and systems in which Veterans live, work, and spend their free time — an approach that ultimately transcends Veterans, to positively impact the health and well-being of all Americans<sup>12,29</sup> and Veteran suicide prevention clinical practice guidelines.<sup>30</sup>

The research ecosystem is the interrelationship of researchers, funders, policy, and structures that generate collaborative, reproducible, innovative, and cost-effective solutions from conception through implementation. The PREVENTS NRS recommends two overarching goals: promote tailored approaches to suicide prevention and enhance the research ecosystem with associated objectives for developing a strong research framework that will lead to a reduction in suicides in the Veteran population and beyond.

Executive Order 13861, PREVENTS, challenges the Federal government to develop an innovative approach to conducting suicide research that prioritizes innovative processes, promotes individualized risk identification, encourages data sharing, and translates research into actionable next steps to reduce suicide risk and prevent suicide. According to the Department of Veterans Affairs (VA), of the approximately 20 million Veterans in the United States, fewer than half use one or more VA service and only 3 in 10 Veterans receive their health care from VA.<sup>2</sup> It is clear that VA alone cannot solve this challenge. To inform prevention efforts, the PREVENTS NRS takes into consideration individual and population-based risk factors that change over time. One such change that contributes to risk occurs as individuals transition, this may occur between military service and Veteran status, or during transitions throughout the military life cycle. The PREVENTS NRS also requires a broader public health approach to understand factors, particularly population health and social determinants of health that could prevent the onset of suicidal thoughts and/or mitigate related symptoms early. These factors are characterized as being “upstream” from the time of a crisis and include socioeconomic, health and health care, physical environment, and educational influence. This broader approach moves beyond Veterans to affect the systems in which they live, work, and spend their time, an approach that ultimately affects all people.

The PREVENTS NRS is focused on addressing the following seven elements described in the Executive Order by setting two overarching goals (stated above) and associated recommendations:

- Improve the ability to identify individual Veterans and groups of Veterans who are at greater risk for suicide.
- Develop and improve individual interventions that increase overall Veteran quality of life and decrease the Veteran suicide rate.
- Develop strategies to better ensure that the latest research discoveries are translated into practical applications and implemented quickly.
- Establish relevant data sharing protocols across Federal partners that also align with the community collaboration outlined in the Executive Order.
- Draw upon technology to capture and use health data from nonclinical settings to advance behavioral and mental health research to the extent practicable.
- Improve coordination among research efforts, prevent unnecessarily duplicative efforts, identify barriers to or gaps in research, and facilitate opportunities for improved consolidation, integration, and alignment.
- Develop a public-private partnership model to foster collaborative, innovative, and effective research that accelerates these efforts.

## A Public Health Approach

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The National Academy of Medicine (NAM) characterized public health as what “we as, a society, do collectively to assure the conditions in which people can be healthy.” In support of this concept, the PREVENTS NRS proposes a strategy for how research can provide the scientific underpinnings for impact on a collective societal effort. The PREVENTS NRS focuses on scientific inquiry that informs public health interventions that can be applied at the population level and functions as a foundation for developing interagency efforts to coordinate public health solutions to reduce Veteran suicide. Specifically, the PREVENTS NRS expands upon the linkage of suicide research to public health practices by focusing on social determinants of health as targets of opportunity to prevent suicide. The PREVENTS NRS also proposes aligning research and recommendations with public health models and prioritizing population-based research about suicide interventions.

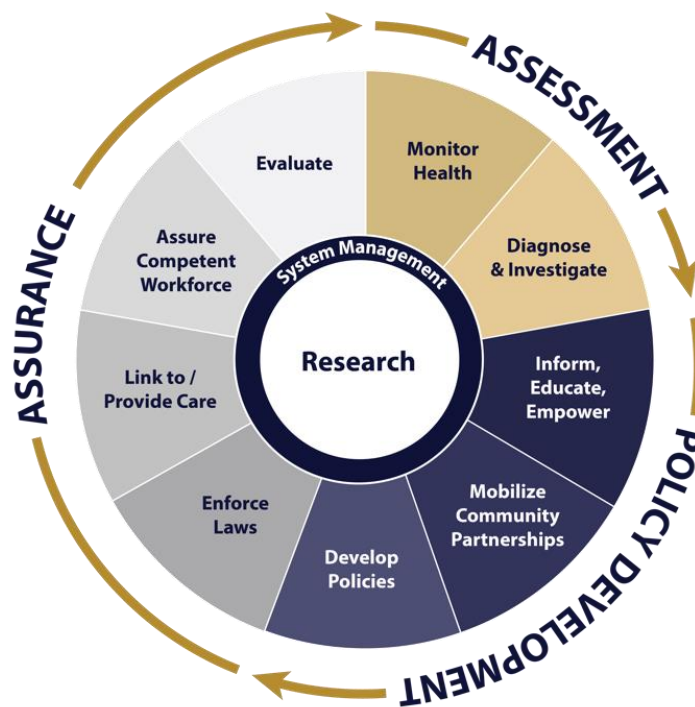


Figure 3-1

The PREVENTS NRS casts a wider net to learn from scientific investigations, research studies, and clinical trials with findings that may be applicable to the Veteran population but were conducted in non-Veteran populations. Similarly, it includes consideration of other public health solutions that have demonstrated effectiveness even if not originally conceptualized as a suicide-specific solution, such as organized efforts to coordinate resources through state public health offices and novel data integration techniques and technologies. While robust reviews of suicide research and the role of the research ecosystem are included, the PREVENTS NRS does not offer a comprehensive review of the science of public health methods, such as implementation science or program evaluation. It is, however, acknowledged that evaluations of the implementation science and public health methods will be necessary to ensure effective delivery and use of an intervention scientifically shown to be effective in preventing suicide. Successful public health programs require continual monitoring and adjustments over time. While the PREVENTS NRS includes an initial assessment, ongoing coordination will be needed to support a successful public health program that reduces suicide.

## PREVENTS NRS Mission, Vision, and Goals

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The vision of the PREVENTS NRS is to position the Federal research portfolio to accelerate the development and implementation of effective solutions to help prevent Veteran suicide.

The mission of the PREVENTS NRS is to enhance and expand a suicide research portfolio by coordinating processes and systems-level changes to the research ecosystem. By enhancing the speed, quality, and reproducibility of scientific findings, innovative solutions to suicide will be developed to enable matching of risk profiles to data-driven treatments, and leverage implementation science to assess and refine the portfolio.

Two overarching strategic goals, along with associated strategic objectives and recommendations, are presented as a framework to strengthen and guide research activities that may reduce suicides in the Veteran population and beyond. This PREVENTS NRS is intentionally aspirational and broad in nature, including many possible recommendations to address the complex nature of suicide, as well as the role of research funding agencies, investigators, and policymakers in generating new prevention solutions and optimized interventions. Based on the two strategic goals below, 10 overarching strategic objectives were aligned in this framework.

**Goal 1:** Promote Individualized Approaches to Suicide Prevention and Treatment – Identify and prioritize suicide surveillance and research that focuses on a Veteran’s unique combination of individual, social, and societal factors to deliver the most effective intervention(s) tailored to meet their needs and circumstances.

**Goal 2:** Enhance the Research Ecosystem — Accelerate development and implementation of scientific discovery through shared data sets, innovative policy, novel funding mechanisms, and structural changes, supporting team science and reproducibility.

These goals, in combination, will exponentially enhance research solutions to prevent Veteran suicide by empowering researchers to deliver fast, high-quality research (see [Figure 3-2](#)).

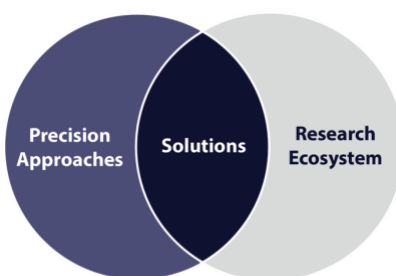


Figure 3-2

## Goal 1: Promote individualized Approaches to Suicide Prevention and Intervention

Effective suicide prevention approaches exist — some at the population level promoted by public health approaches (e.g., lethal means safety), and some tested via clinical trials. Few public health approaches have been able to track individual exposure to interventions and response to said interventions (e.g., reduced alcohol access), and few randomized clinical trials have been large enough to allow for subgroup analyses capable of detecting variation in individual risk and treatment response.

There are not many efforts to tailor proven interventions to various subgroups where risk factors may vary. For example, suicidal behavior varies within cultures and also by sex and age, and these variables are typically left out of risk assessment screening tools. Accounting for cultural characteristics in suicide risk assessments can better identify suicide risk factors. Additionally, motivational interviewing techniques can be added to effective psychotherapy approaches to further engage subgroups who often have low engagement with health care (e.g., males with substance use disorders). Continuing and future studies will seek to determine the difference in risk among population subgroups including minorities, adolescents, Veterans, etc. The current state of suicide intervention research could benefit from matching the effectiveness of treatments to individual and group-based risk factors.

Limited public health infrastructure overall has precluded analyses of public health interventions that identify subgroups, individual risk, and/or responses to interventions. The next stages of clinical trial efforts, such as comparative effectiveness, can reveal directions for targeted interventions that consider individuals' risk and treatment response profiles.

Specifically, this goal promotes suicide prevention research that enables targeted interventions for an individual's unique combination of individual, social, and environmental risk factors to deliver effective and timely targeted interventions. The following strategic objectives support this goal and, as described above, encompass the larger set of detailed recommendations necessary to generate targeted treatment options.

### GOAL 1

#### Approaches to Suicide Prevention

“Existing suicide prevention algorithms have shown success in identifying high-risk individuals, however even with artificial intelligence, **current methods often fail to detect certain subgroups of the population, like low risk groups.**”  
— Organization

“A Veteran unable to concentrate on work because of even minor depression **will end up with several other issues:** income, housing, family, then legal, as a minimum, yet none of those is on the list past the mental health component.”  
— Individual

“A newly transitioned service-member with chronic PTSD, several adverse childhood traumas, a mild TBI and little or no family or social support structure will **likely have a lower threshold** for distress facing any future employment disruptions, loss of housing or loss of transportation.”  
— Individual

“First, **few systems are collecting the data necessary** to create targeted interventions for very sick patients or those with high risk scores.”  
— Organization

Figure 3-3 Responses from Research Request for Information

### Strategic Objectives Supporting Goal 1:

- **Risk Identification:** Expand risk identification techniques to include approaches to evaluate both clinical populations and public health perspective, stratifying risk across subpopulations by moving from a descriptive, to predictive, to mechanistic understanding of suicidal trajectories, improving prediction accuracy, and broadening opportunities for risk mitigation, earlier intervention, and when most needed enhanced (timely) response.
- **Prevention and Intervention:** Prioritize prevention and intervention research representing the dynamic and inherent complexity of suicide (e.g., the social-ecological model), encompassing research for risk and protective factors, prevention and intervention strategies, given system dynamics at the individual, familial/relational, community/social, society, and environmental-level.
- **Research Translation:** Develop an interagency process for effective research translation into policy solutions, health care delivery practices, technology transfer, or further refined investigation.
- **Data Sharing and Integration:** Establish a scalable, interoperable data infrastructure to securely aggregate, integrate, and analyze multimodal data, with controlled access, and secure data-transfer technologies to facilitate effective data-sharing across sources, coupled with clear data-sharing policy, in support of novel research in risk identification, prevention, and intervention.
- **Research Ecosystem Enhancement:** Correct longstanding administrative barriers that affect the communication of Veterans' status across Federal, state, and local systems of records, to enhance the availability of accurate and robust research and surveillance data.

### Goal 2: Enhance the Research Ecosystem

A research ecosystem includes the interrelationships of researchers, funders, policies, and structures as well as the ability of these entities to generate collaborative, reproducible, innovative, and cost-effective solutions from conception through implementation of findings. Despite a recent increase in suicide prevention and intervention research, funding levels have not been comparable to other areas of research and processes within the current research ecosystem; furthermore, the increase in investment has not resulted in novel solutions for sustained decreases in Veteran suicides. To accelerate the impact of Veteran suicide research, changes to the research ecosystem are needed to enhance interagency collaboration, evaluate the role of open science practices, and leverage interdisciplinary and cross-sector approaches and resources.





Figure 3-4 Responses from Research Request for Information

### Strategic Objectives Supporting Goal 2

- Risk Identification: Develop systems to stratify risk and prevention opportunities among Veterans within VA health care and outside of VA health care to identify evidence-informed approaches specific to each subpopulation.
- Prevention and Intervention: Conduct rigorous prevention and intervention studies within and beyond health care delivery settings, including those at the community and societal level.
- Research Translation: Identify an interagency research coordination process to enable gap-driven analysis across Federal agency suicide research portfolios.
- Data Sharing and Integration: Develop and implement standardized data management practices, including use of common data elements and data structures, data labeling and annotation, standardized data sharing and data-use agreements, data provenance methods to promote timely data sharing and enhanced data integration in support of research on Veteran suicide.
- Research Ecosystem Enhancement: Develop processes to promote collaborative interdisciplinary research, public-private partnerships, shared resources, and frequent engagement with government funders and regulators.

## National Research Strategy: Sources of Information

The PREVENTS NRS collected and analyzed information through an environmental scan, focused on external influences contributing to suicide morbidity and mortality, as well as organizational capacity, with the intent of informing optimization of research and structures around the research environment. Wide input was solicited on the Executive Order’s elements, with specific focus on how early interventions for suicide may require public health approaches that are complementary to ongoing health care delivery efforts, as well as actions the Federal government can take to increase speed, quality, and efficiencies within the Federally funded research environment.

Outreach efforts were developed to engage subject matter experts and stakeholders outside the Federal government. In particular, four major initiatives informed the development of the PREVENTS NRS:

- A preliminary policy landscape analysis completed during development of the Executive Order.
- The PREVENTS NRS request for information (RFI), to collect broad input from the public.
- The White House Summit on Veteran Suicide: Translating Research into Public Health Solutions, to gather Federal and non-Federal input.
- A Federal team of subject matter experts that developed summaries of the current state of the science, gaps, and recommendations.

Figure 3-5 depicts the relationship between these initiatives.



Figure 3-5

### Request for Information (RFI)

An RFI was published in the Federal Register on July 3, 2019<sup>31</sup> to solicit broad input on the seven elements described by the Executive Order. The RFI received over 700 responses. The organizational responses informed the development of questions for The White House Summit described below and shaped information developed by the writing teams. All responses were analyzed with natural language processing and with an expert review of the themes of the responses. This combination of qualitative and quantitative analyses provided a rich set of data that not only contributed to the development of the PREVENTS NRS but also will continue to inform this effort through the implementation phase.

The analysis also revealed a key distinction. While respondents were united in expressing the need for better assessment, prevention, and treatment, individual and organizational perspectives were divided on what is most important priority, and how to accomplish it.

From the analysis of organizational responses, two themes emerged:

- Improving clinical approaches to suicide prevention. For example, organizations highlighted the need to train clinicians to recognize warning signs of suicide and follow best practices.
- Addressing structural issues like funding, research, and access to clinical programs.

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*“Many have realized the mental health benefits of other services such as those that provide **social connection opportunities, physical health and wellness coaching, and economic empowerment strategies.**”*

*— An individual’s RFI response*

*“Combined with gatekeeper training, **access to analytic tools** in clinical settings provides extra opportunities to address suicide risk even when mental health concerns or suicide is not the issue bringing a Veteran to the clinic.”*

*— An organization’s RFI response*

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From the analysis of the responses of individuals, two themes emerged:

- A concern that calls for help are not always recognized, captured, communicated, or appropriately acted upon by health care personnel and other institutional representatives.
- A need for greater connection with the broader community, including connections to peers and caregivers, not simply clinical relationships with health care providers.

Several components of RFI submissions from both individuals and organizations that relate to the goals are highlighted in the boxes above.

## White House Summit

The White House Summit on Veteran Suicide: Translating Research Innovation into Public Health Solutions was held on Sept. 23, 2019. The Summit brought together over 125 researchers, clinicians, innovators, and decision-makers from inside and outside of government, to discuss existing barriers, suggest novel policy and research opportunities, share prior findings, and other mechanistic approaches carrying the potential to generate public health solutions. The Summit incorporated sessions reflecting the themes and gaps identified from the RFI, particularly those focused on mitigating Veteran suicide risk, the research ecosystem, and the need for innovative approaches.

### Summit attendees included:

Department of Veterans Affairs (VA)  
Department of Defense (DoD)  
Centers for Disease Control and Prevention (CDC)  
Department of Energy (DOE)  
National Institutes of Health (NIH)  
Department of Health and Human Services (HHS)  
Department of Labor

Office of Management and Budget (OMB)  
Office of Science and Technology Policy  
Nonprofit organizations  
Academic institutions  
State and local government  
Private industry

### Key Themes

- **Increasing Veteran identification to benefit research.** The inability to identify Veterans quickly and consistently, particularly those who do not receive care through VA, was identified by attendees as a major hurdle that must be overcome to develop effective prevention strategies. Enabling individuals to self-identify as Veterans on health insurance cards and driver's licenses, verified by records from DoD or VA, was recommended as a possible path to increase Veteran identification. Research recommendations specific to improving risk identification, prevention, and intervention rely on the ability to identify Veterans accurately and reliably at risk.
- **Integrating social determinants of health data.** Discussants noted the need to integrate data about the social determinants of health related to individual, interpersonal, community, and societal influences including physical environment, socio-cultural environment, and clinical/health care system factors that impact mental health outcomes. In addition, research is needed on how social determinants of health, including those related to adverse childhood events and military service, may act as risk or protective factors in suicide.
- **Leveraging technology to both facilitate research discoveries and ground-truth outreach techniques.** Participants identified areas of research that could benefit from incorporating cutting-edge technologies and data expertise to obtain new insights. While the importance of technology in research is undeniable, discussants also focused on the importance of identifying and promoting data-driven technological solutions while ensuring that outreach strategies do not discriminate against those with limited access to technology. Notably, data-driven solutions can miss those with low frequency events and magnify disparities.
- **Making relevant data available, accessible, and high quality.** Attendees discussed the fact that data cannot be treated as an afterthought. Data must be handled properly and securely, and the appropriate infrastructure needs to be in place to ensure data curation is funded adequately and that data access is controlled. A data enclave, a data-sharing system that includes tiered access, is also essential.

#### Discussion sessions included:

- Leveraging big data effectively to develop tools and technologies (e.g., machine learning, artificial intelligence, and others) for individualized precision medicine applications, public health approaches, and other applicable applications.
- Developing clear, implementable data-sharing policies and procedures of trust-building transparency and empowering data keepers to contribute to an enhanced research ecosystem for all, with language limiting differing interpretation and implementation.

- Leveraging secure, scalable data infrastructure, advanced analytics and artificial intelligence capabilities, multimodal data integration technologies, and deep expertise, particularly the world-leading capabilities of the U.S.
- Prioritizing research translation into practice and policy by leveraging implementation science, including living systematic reviews.
- Promoting and prioritizing interdisciplinary team science, possibly through the modification of funding mechanisms and requirements.
- Leveraging social media, nontraditional, and other outreach models to provide friends, families, and colleagues with information on how and when to support Veterans.
- Evaluating the potential for holistic care models that extend beyond traditional medical care to include health and social care of an individual.

### Reducing Negative Perceptions

Most of the breakout sessions noted that negative perceptions about help seeking related to mental health and suicide appears to reduce the willingness of affected individuals to seek assistance, and how thoughtful and sustained action is needed to eliminate this negative association. Suggestions included the use of military and civilian leaders to model positive attitudes and opinions about help seeking behavior.

### Subject Matter Experts and Writing the National Research Strategy

With the comprehensive input received from the RFI and White House Summit as described, 45 Federal subject matter experts were assembled in writing teams to draft the PREVENTS NRS. The expert writing teams also used information from the [National Strategy for Suicide Prevention](#) developed by the National Action Alliance, and [CDC's Technical Package for Preventing Suicide](#), to evaluate the current state of the science and research evidence as it relates to the Executive Order elements: risk identification, prevention intervention, research translation, and data sharing and integration.

## Current State of Science and Additional Findings

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### Risk Identification

Understanding the quantitative and qualitative nature of risk is necessary to appreciate how suicidal ideation develops and progresses, and to develop effective interventions for those who are struggling and feeling hopeless, and risk prediction models for application to various clinical populations and risk subgroups. This involves identifying unique risk factors for the groups at various times of risk across the lifespan. In addition to an individual's personal risk factors (e.g., genetics, adverse childhood events, etc.), a life course approach that includes critical transitions and times of risk as they vary for different populations (e.g., active duty, Veterans; men, women; across ethnic groups; rural versus urban; chronic pain versus lack of same; under- or unemployed; homeless; socially isolated; officer versus enlisted, etc.) is necessary for understanding the transitions involved in the process from suicidal ideation to suicide plan to suicide attempt and completed suicide.

Although a general body of knowledge exists that highlights many risk factors for suicide in the Veteran population, understanding the risk factor identifications that lead to the transition from suicidal ideation to suicide attempt or death by suicide remains a challenge. Furthermore, the ways in which risk factors operate with one another (e.g., additive risk) are not well understood. For example, the risk factors and interventions for a 22-year-old Veteran who is a parent of three children are likely to be different from those of a 75-year-old Veteran with a terminal medical diagnosis. Less intuitive may be that a 25-year-old Veteran with a history of adverse childhood experiences may have a distinctly different risk profile than a 25-year-old peer without a history of adverse childhood experiences. There is no national surveillance system for suicide or Veteran-specific data. Thus, priorities to enhance risk identification include individually tailored interventions and the application of a risk factor algorithm for providers and patients to use as decision-making tools.<sup>32</sup> One focal area is the use of predictive analytics, which allows for a clinical strategy that includes understanding risk factors and pathologic processes, applying tools for risk factor group classification (type I predictive analytics), and then matching the Veteran-at-risk to an efficacious treatment (type II predictive analytics). The definitions for types I and II predictive analytics are identified in Table 3-1.

Table 3-1

Linking Risk Identification to Prevention and Interventions	
<b>Type I Predictive Analytics</b>	Includes understanding risk factors and pathologic processes, applying tools for risk group classification.
<b>Type II Predictive Analytics</b>	Matching the individual at risk to an efficacious treatment based on risk group classification.

#### Type I Predictive Analytics — Select Risk Factors

Veterans represent a diverse group of individuals who will need increasingly robust stratification (type I predictive analytics) to determine the most effective prevention plan (type II predictive analytics). The classification “Veteran” currently applies to approximately 20 million individuals in the United States, of whom 10% are women. For example, in 2017, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for population differences in age and sex.<sup>33</sup>

Table 3-2

Group	2017 Rate of Suicide
<b>All Veteran adults</b>	27.7 per 100,000
<b>Non-Veteran adults</b>	18.5 per 100,000
<b>Male Veterans</b>	39.1 per 100,000

<b>Male non-Veterans</b>	30.1 per 100,000
<b>Female Veterans</b>	16.8 per 100,000
<b>Female non-Veterans</b>	7.6 per 100,000
<b>Veterans ages 18 to 34</b>	44.5 per 100,000
<b>*Note: Rates adjusted for sex and age</b>	

When reviewing variation by sex, the rate of suicide among female Veterans was 2.2 times that of female non-Veterans).<sup>33</sup> Similarly, the 2017 rate of suicide among male Veterans was 1.3 times higher than the age-adjusted rate for male non-Veterans.<sup>33</sup> However, subpopulations of Veterans have substantially different risk categories compared with non-Veterans that require identification as part of type I predictive analytics. Veterans ages 18 to 34 had the highest suicide rate in 2017.<sup>33</sup> The suicide rate for Veterans ages 18 to 34 increased by 76% from 2005 to 2017.<sup>33</sup> The absolute number of suicides was highest among Veterans 55 to 74 years old.<sup>30</sup> This group accounted for 38% of all Veteran deaths by suicide in 2017.<sup>33</sup>

### Common Risk Factors

In general, mental health disorders and substance use disorders are common risk factors cited in suicide risk factor research. History of child abuse and physical health conditions also contribute to risk and are risk factors themselves. However, most individuals with these disorders and experiences do not attempt or die by suicide. Suicide rates have been found to be highest among those who were divorced, widowed, or never married, and lowest among those who were married.<sup>34</sup> Suicide rates were also elevated in individuals residing in rural areas.<sup>35</sup> Additionally, Veterans who died by suicide were reportedly more likely to have sleep disorders, traumatic brain injury (TBI), or a pain diagnosis.<sup>34</sup> Conditions that are potentially devastating include depression, anxiety, substance misuse, and other mental health-related conditions, inpatient mental health care, prior suicide attempts, prior calls to the Veterans Crisis Line/Military Crisis Line, and prior mental health treatment were also associated with greater likelihood of suicide for Veterans and Service members.<sup>34</sup> Distinguishing risk factors that predict imminent risk for suicide and risk factors of those with suicidal ideation are important areas of focus with few well-established findings.

Another subcategory of Veterans is those who are experiencing homelessness, which appears to play a role in suicide for VHA patients — meaning those patients who access health care services at VA. VHA patients who experienced homelessness or received homelessness-related services had higher rates of suicide than other VHA patients.<sup>34</sup> VA's Rapid Resolution Program was established to prevent homelessness while additional evidence is collected on this risk factor.

Additional underlying factors play a pivotal role in who dies by suicide. For example, one risk is cultural context. Other precipitating factors include a wide range of stressful life events. A person's life course includes critical transitions and associated suicide risk that may vary based on a person's risk profile and circumstances.

How a person's risk profile affects critical transitions is necessary to better understand how a person may move from suicidal ideation to suicide plan to suicide attempt and death by suicide, as well as how to intervene at all these stages. As such, individuals with different risk profiles may respond differently to different prevention and intervention approaches. Disruption in connections (e.g., intimate relationship disruption) and interpersonal conflict are some of the most common precipitants. Hopelessness and impulsivity, measured in various ways, are also identified risk factors. It is important to note that connectedness, optimism, and hope are potentially modifiable protective factors, as evidenced by a wide range of measures and studies. Therefore, it is vital to understand the process and timing of the transitions from event to ideation to completion.

### **Specific Risk Factors Associated With Military Experience**

Among active duty military personnel and Veterans, TBI and posttraumatic stress disorder (PTSD) are considered "signature injuries" in the more recent Operation Enduring Freedom and Operation Iraqi Freedom engagements.<sup>36</sup> These signature injuries have consistently been identified as factors that increase risk of suicidal ideation and suicide attempts. Studies using VA electronic health record (EHR) data indicate that both TBI and PTSD independently increase risk for suicide; concurrent TBI and PTSD diagnoses indicate further increased risk.<sup>37</sup> Further complicating TBI and PTSD as risk factors is the high incidence of common comorbidities of each of these disorders with chronic pain, substance misuse, chronic neurodegeneration, and cognitive decline, many of which also have been shown to increase risk for suicidal behaviors.

Several disorder-related factors complicate interpretation of these TBI- and PTSD-related risk factors and their incorporation into suicide risk identification models. Challenges include time since injury or event, injury severity, and the complexity and variability of TBI and PTSD symptom clusters. Many of these complicating factors are difficult to derive from EHRs, as they require additional data collection and patient interviewing. Several natural history studies of both TBI and PTSD are being funded with the goal of developing novel patient stratification models that connect patient outcome trajectories with symptom clusters.<sup>36</sup> If successful, these patient stratification models may provide a more concise and accurate framework to incorporate the contribution of TBI, PTSD, and comorbid TBI and PTSD into suicide risk identification models.

In addition, the risk associated with suicidality (suicide, suicide attempts, suicide ideation) varies by:

- Veteran cohort (e.g., WWII, Vietnam, Desert Storm, Iraq/Afghanistan).
- Life course and associated events (e.g., age, transition out of service, divorce, unemployment, financial distress, family conflict, retirement, illness/pain).
- Locations where Veterans access services and spend time (e.g., social media, mental health settings, primary care, outpatient care, clinics for substance use disorders, college/university, workplace).

### **Risk Factors Related to Access to Care**

Some Veterans access VHA care and others have never or only temporarily accessed it. There is a significant gap in understanding suicide risk among Veterans who do not, either by choice or lack of eligibility, receive VHA health care. Only about 30% of Veterans receive VHA care and less than 50% use any VA services or benefits.<sup>33</sup>



Most Veterans do not use any VA services, including health care from VHA, and the majority of Veteran suicides occur among Veterans who have not received VA services during the past year.<sup>33</sup> It is important to note that in 2017, among Veterans who died by suicide, 38% had a VHA encounter in 2016 or 2017 (6.3 suicide deaths per day), while 62% had not (10.5 per day).<sup>33</sup>

Type I predictive analytics show that VHA patients with military service-connected disability status may have lower risk for suicide than other VHA patients. However, it is necessary to learn whether those rates vary due to disability status, VHA access to health care, or some other combination of factors.

At the individual level, suicide risk varies with the degree and type of stressful events experienced, as well as an individual's belief that behaviors involving suicide are acceptable.<sup>38,39</sup> An individual's willingness to seek help for suicide is often associated with their understanding of accessible, effective treatments and their views of the risks and benefits of engaging in treatment.<sup>40,41</sup> At the population level, exposure to stressful life events and understanding of suicide risk and treatment can vary across demographic factors (e.g., education, health care access, and ethnic and racial factors), and these contexts need to be considered in suicide prevention approaches with implications for reaching Veteran populations. Protective factors are skills, strengths, or resources that help people deal more effectively with stressful events; the identification and strengthening of these factors is critical to preventing suicide.

### **Prevention and Intervention**

Suicide prevention includes preventing suicide deaths, nonfatal attempts, and ideation. Most of the evidence for effective suicide prevention and interventions is characterized as "indicated prevention" (e.g., approaches that clinicians use to treat individuals with severe ideation and/or recent suicidal behavior). There are fewer studies that examine the benefits of mitigating symptoms of conditions that are associated with suicide, or that focus on "universal" approaches to prevention (e.g., enhancing mental health and suicide risk literacy). Suicide risk varies with degree and type of stressful events; context and culture can also affect acceptability and effectiveness of suicide prevention approaches, thus demonstrating how gap-driven research investments can specifically add to the knowledge base about Veteran suicide. Much remains to be determined in the identification of the processes through which risk evolves. As type I predictive analytics increase our ability to identify subpopulations, matching the Veteran first to a risk profile classification then to a corresponding effective intervention can occur through type II predictive analytics.

A range of prevention and intervention approaches have been shown to be effective, including clinical patient-level interventions and evidence-informed strategies in community settings. However, it should be noted that most of the research supporting the evidence base for suicide prevention and intervention has been conducted in civilian populations, without distinguishing Veterans and non-Veterans. The degree to which Veterans' suicide risk and response to intervention may differ from the civilian population has not been fully researched, and the strength of evidence for these interventions varies.

## Patient-Level Interventions

### *Psychotherapies*

Research supports the efficacy of a range of psychotherapies for individuals experiencing suicidal ideation, behavior related to suicide, or conditions such as depression that are associated with increased suicide risk. These include but are not limited to cognitive behavioral therapy (CBT), dialectical behavioral therapy, and interpersonal psychotherapy. However, research on effectiveness and implementation when applied to specific subpopulations is limited, especially for technology-enhanced administration of these interventions.<sup>42</sup> Coached online CBT has been shown to be equivalent to in-person interventions for mental health disorders<sup>43</sup> suggesting a potential for the efficacy of e-health approaches for suicide prevention.<sup>44</sup> While less is known about the effectiveness of psychotherapies for postvention for those affected by a suicide death, research suggests that those who have experienced a suicide by someone close to them are at increased risk for suicide themselves.<sup>16</sup> Additionally, individuals bereaved by a suicide death have an increased risk of developing complicated grief.<sup>45</sup> Those meeting criteria for complicated grief, who are often immediate family members, may benefit from medication and psychotherapy.<sup>45</sup>

### *Pharmacologic Interventions*

While there is no medication to prevent suicide, there are several pharmacologic interventions that are effective in treating depression, a critical risk factor for suicide. For example, ketamine infusions have shown positive efficacy in the rapid reduction of suicidal ideation among those with treatment-resistant depression.<sup>46</sup> However, traditional antidepressant medications that can take weeks or months to improve depressive symptoms may increase thoughts of suicide in some patients. Because of this, there is a great need for additional studies on the effects of antidepressants relating to increased thoughts of suicide. Esketamine nasal spray for rapid resolution of treatment-resistant depression has recently been approved by the Food and Drug Administration (FDA). However, the benefits of ketamine/esketamine are typically short-lived (several days to a few weeks), and preliminary evidence suggests that these infusions are best combined with cognitive, behavioral, and other pharmacological interventions for long-term maintenance.

### *Device-Based Interventions*

In addition to these psychotherapeutic and pharmacologic interventions, electroconvulsive therapy has shown efficacy in reducing suicidal ideation,<sup>47</sup> and other device modalities, such as high-frequency repetitive transcranial magnetic stimulation<sup>48</sup> and magnetic seizure therapy, are showing promise.<sup>49</sup>

### *Caring Communications*

“Caring communications” is another type of patient-level intervention that has been tested in several studies. This is a nondemanding, cost-effective approach involving periodic contact with individuals who have received treatment for suicide risk. Some trials found reduced reattempt rates with this intervention, other studies (some that are underpowered) have had mixed results.<sup>50,51,52</sup> Because caring communications may effectively decrease risk, efforts are underway to evaluate the benefit in combination with more active follow-up contacts.<sup>53</sup>

### *Models of Care*

Specific models of combined interventions have also been tested in health care settings, where changes are made at the level of a clinic or across a health care system. For example, in addition to a single suicide prevention intervention such as CBT alone, several health care settings are testing specific models of care that combine practical and evidence-informed practices. The collaborative care model is one approach to integrating behavioral health with primary care and has been shown effective in more than 80 clinical trials.<sup>54</sup> Collaborative care enhances the usual primary care by adding two key services: care management support for patients receiving mental health treatment and regular consultation with a mental health specialty clinician who advises the primary care team. Research suggests that patients receiving collaborative care have lower suicide risk, better mental and physical health outcomes, and better overall functioning. Collaborative care was also found to reduce the risk of suicidal ideation and later mortality in geriatric patients.<sup>55,56</sup> Beyond collaborative care there are broader models of integrated care such as primary care behavioral health, known within VA as co-located collaborative care. These models highlight the need to improve access as they emphasize a warm handoff and same-day care.

### *Zero Suicide*

The National Action Alliance for Suicide Prevention identified a range of best health care practices, collectively called Zero Suicide, for improving outcomes among individuals at risk for suicide. The Zero Suicide framework of preventive practices includes risk screening, treatments that target suicide risk (e.g., CBT and dialectical behavioral therapy), follow-up phone calls, and caring communications interventions. Research has identified that care transitions are high-risk periods for suicide<sup>35</sup> and overall mortality.<sup>57</sup> The Zero Suicide approach may help reduce suicide risk during transitions (e.g., from inpatient psychiatry to outpatient mental health) through enhanced continuity of care. Ongoing studies are testing various components of the Zero Suicide model. For example, the Emergency Department Safety Assessment and Follow-up Evaluation, which focused on emergency department (ED) patients at risk for suicide, found that brief interventions in EDs and up to seven follow-up phone calls to the patient by a clinician reduced suicide attempts by about 30% during a 12-month period.<sup>58</sup>

### *Evidence-Based Strategies in Community Settings*

Community-based interventions are those in which a community (e.g., neighborhood, city, or county) is the setting for interventions.<sup>59</sup> Recognizing that one intervention in isolation is not enough to prevent suicide, community-level interventions are generally multicomponent interventions that tackle individual and environmental factors across multiple settings to prevent community barriers and promote well-being among populations in a specific community. Usually, entire communities are used as units of intervention, as everyone benefits from prevention, and it may create the opportunity of a cultural change.<sup>60</sup>

### *Connectedness*

One factor that community-based programs may promote is connectedness, which refers to a sense of being cared for, supported, and belonging, and can be centered on feeling connected to school, family (e.g., parents and caregivers), or other important people and organizations in a person's life. Connectedness has been examined as a protective factor against suicidal behavior as well as a potential risk factor.<sup>61</sup>

In fact, there is an association between different domains of social connectedness and self-directed violence in adolescence.<sup>61</sup> There can also be a negative association with connectedness, which occurs when a person is linked with negative or destructive ideas or detrimental influences. The contagion process, by which suicidal behavior becomes normalized such that individuals can identify with peers or celebrities who exhibit suicidal behavior, has been consistently found to increase suicidal behavior within the community.

### *Peer Support*

Peer providers and peer support services, such as Vets Helping Vets, have been successful in different settings (e.g., community-based and primary care settings), for different conditions (e.g., substance use disorders, mental health, and chronic disease), and for issues involving homelessness.<sup>62</sup> Programs like the chronic disease self-management program and the Maryland Center for Veterans Education and Training and professional communities such as emergency personnel have also successfully used peer support models. Peer providers are also known as health navigators, peer support specialists, peer mentors, peer counselors, recovery support specialists, recovery coaches, family support navigators, and peer companions.<sup>63,64,65</sup> While promising, peer support varies widely and can have untoward effects (such as the experience of secondary trauma for those serving as peers). Future research in this area may benefit from incorporating models for providing family support either through peers or other avenues.

### *Lethal Means Safety*

The most common means of suicide worldwide are hanging, firearms, jumping, and poisoning with pesticides or drugs.<sup>66</sup> There is an evidence base that supports reducing access to lethal means as an effective intervention in preventing suicide.<sup>67</sup> As described in the Lethal Means Safety chapter, reducing access during a crisis gives those contemplating suicide more time to reconsider their decision. The vast majority of those individuals whose suicide attempts are made impulsively will not go on to die by suicide if their plan is disrupted. Reduced access may also increase the chances of survival for those who, consequently, turn to less lethal methods.

### *Reduction of Harmful Use of Alcohol*

Excessive short-term and long-term alcohol consumption can increase suicide risk. The acute suicide risk associated with alcohol intoxication may effectively be reduced by restricting access to alcohol<sup>68</sup> and by increasing community awareness of the impact of intoxication, either through general media campaigns, school health promotion activities, or information directed at vulnerable individuals by general practitioners or other health professionals.<sup>69</sup> These strategies are most effective at reducing the risks associated with alcohol consumption in populations with a lower prevalence of heavy drinking.<sup>69</sup> Legal restrictions of alcohol consumption are also effective suicide prevention measures and include enforcing beverage-specific sales licensing for drinking establishments and other outlets, regulating closing times, and increasing the minimum age for drinking.<sup>70</sup>

As the body of research for suicide prevention expands, there is growing evidence that substance use and misuse interventions may also decrease suicide risk. At the population level, increasing community awareness of the impact of intoxication, enforcing beverage-specific sales licensing for drinking establishments and other outlets, regulating closing times, and increasing the minimum age for drinking are all potentially effective suicide prevention measures.

For individuals with substance use disorders, recovery coaching that involves peers providing critical support to individuals seeking recovery from substance use disorders has the additional benefit of preventing suicide while being an effective intervention for substance misuse.

#### *Raising Awareness About Mental Health and Suicide Prevention*

Negative attitudes and perceptions about mental health disorders and psychological help seeking are common among the public.<sup>71</sup> While research is still limited specific to mental health disorders and psychological help-seeking, awareness campaigns have been designed to reduce the negative perceptions related to mental health disorders and suicide, improve help-seeking behaviors, and increase access to care. Findings from a recent study focused on the implementation of an awareness campaign in Japan suggested that the frequent distribution of campaign materials at the local level was associated with decreased suicide rates in that locality.<sup>72</sup>

It is also important to note that increased suicide rates are often reported following media coverage of suicidal behaviors.<sup>73</sup> Safe messaging guidelines, if followed, have been shown to decrease suicide rates. Important aspects of responsible reporting include avoiding detailed descriptions of suicidal acts, avoiding sensationalism and glamorization, using responsible language, minimizing the prominence of suicide reports, avoiding oversimplifications, and educating the public about suicide and available treatments.<sup>74</sup> Through a public health communications campaign, PREVENTS plans to drive behavior change around help-seeking and reduce suicidality while contributing critical research to the field.

#### *Improving Access to Health Care*

Adequate, prompt, and accessible treatment for mental and substance use disorders, when high quality, culturally appropriate, evidence-informed, and suicide focused, can reduce the risk of suicidal behavior.<sup>13</sup>

Practices to improve access include adequate payment to providers of mental health services, clear messaging to consumers about available services, appropriate use of language involving seeking care for mental health and suicide related issues by health care providers, and services that are easy to access and free of bureaucratic hurdles. As one example, to ensure that Veterans benefit from these best practices, the MyVA Access initiative was developed to:

- Provide timely mental health care, including same-day services, as needed.
- Provide Veterans medically necessary care from another VA medical center, while away from their preferred facility.
- Respond to routine clinical inquiries within two business days.
- Offer appointments and other follow-up options upon leaving clinic.
- Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances.
- Integrate community providers as appropriate to enhance access.
- Offer Veterans extended clinic hours, and/or virtual care options, such as telehealth, when appropriate.
- Report access to care data to Veterans and the public in a transparent way.

Sharing best practices such as those learned from the MyVA Access initiative across VA and non-VA health care systems to improve same-day access is one strategy to ensure each Veteran receives the right care at the right time in the right way that meets the Veteran's need.

#### *Financial and Housing Stabilization*

Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health problems.<sup>75,76</sup> Financial security can potentially buffer the risk for suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. As an example, housing stabilization programs are meant to keep people in their homes and provide housing options for those in need during times of financial insecurity.

#### *Movement Toward a Solution*

The identification of effective prevention and intervention techniques is a necessary part of reducing suicide. Interventions that are successful in broad populations should be further examined for effectiveness in subpopulations. These efforts are important because they indicate a government's clear commitment to prioritizing and addressing suicide, while providing leadership and guidance on the key evidence-informed suicide prevention interventions. Additionally, by testing these interventions in specific subpopulations of interest that may benefit from a particular intervention (based on what was learned from type I predictive analytics) compared with the general population, there is reason to be optimistic that these types of studies will improve intervention effectiveness for persons at risk. However, there is one caveat to this strategy. The field may be decades away from building individualized predictors that will guide treatment, as there is still much work to be done in first building approaches that effectively utilize risk factors to improve interventions, then in actualizing these interventions in clinical practice settings. Therefore, it is also important to emphasize implementation of currently available, effective interventions, as well as research aimed at informing the effective implementation of existing predictors.

### **Research Translation**

Researchers should quickly and efficiently translate the most promising evidence-informed suicide prevention interventions from discovery to implementation while adhering to appropriate protocols. When research translation is completed appropriately, groundbreaking innovations have the potential to affect lives quickly. On the other hand, if research translation (the application of findings) is not completed, individuals with the ability to implement new research findings into practice will most likely be unaware that they exist, or they may not have the information needed to implement them. In this section, an overview of effective interventions and how they are translated (applied) within and across diverse settings and populations are described.

## **Systems-Level Translation Mechanisms**

Standard mechanisms are needed by which research (especially that which is Federally funded), is continually evaluated for translation into practice. Research translation must include processes that enable iterative and systematic evaluation of emerging science so that the latest science is incorporated into practice (e.g., living systematic reviews). A systematic evaluation must also include diverse levels of evidence. These living systematic reviews, are maintained in a database that the public can access, would identify gaps in research knowledge and allow promising science to be further studied. Similarly, there are research findings that are immediately ready for transition into policy and/or practice. By developing a living systematic review, there will no longer be multiyear delays associated with standard systematic reviews, in its place will be continually up-to-date information. The living systematic review enables frequent updates to clinical practice guidelines, enabling development of living clinical practice guidelines. This set of “living” information can empower policy writers, leaders, clinicians, and researchers to translate the most current science into practice.

### **VA/DoD Clinical Practice Guidelines 2019**

Clinical practice guidelines (CPG) provide the most widely recognized authoritative recommendations for implementation of research into evidence-informed practice. A comprehensive 2019 “systematic review of both clinical and epidemiological evidence” resulted in the consensus VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide.<sup>77</sup> According to standard VA/DoD guideline development practice, CPG panels of experts assess the strength of each assessment or management recommendation based on confidence in the quality of evidence for that recommendation; difference in magnitude between benefits and harms of the intervention; patient and provider values and preferences; and other factors (e.g., resource use and feasibility). From this assessment, the CPG recommends the clinical practices to be prioritized based on strength of evidence. The CPG also recommends emerging clinical practices where the evidence base is growing to support the practice as well as areas for future research. In the case of the 2019 VA/DoD CPG, of the nearly 2,000 citations meeting criteria for relevance, the CPG identified just 69 discrete studies to be rated for final recommendations. Of those 69, approximately 45% were randomized controlled trials, 27% were systematic reviews, and 26% were controlled or longitudinal cohort trials (e.g., all but one passing criteria for final rating met accepted levels of evidence for practice). To that end, this chapter identifies the interventions with the strongest evidence of effectiveness, as well as the additional knowledge needed to improve interventions and yield new options for those at risk for or in crisis related to suicide.

### **Interventions Originating Outside the Traditional Research Environment**

There is opportunity to develop new prevention or intervention strategies by evaluating practices that are developed outside the typical research portfolios; these practices originate at the population and community level. They are often based on ideas that stem from personal experience delivering services to populations at high risk for suicide. Although these programs are implemented with the best of intentions, they are not always developed or evaluated in a structured way to ensure effectiveness.



For example, a community-based mental health center may decide to implement a peer support group. Because a community-based mental health center is typically not linked to a research institution, it may not have the support or resources to help it select the appropriate peer support group program, implement the program using quality improvement best practices, and evaluate the program for overall impact. However, the benefit to this community, instead of research driven process, is that the program is typically need-driven, meaning that a person or group of people working in the field have identified a real-life problem that needs to be solved.

There is benefit in drawing on the innovative ideas that begin with those clinical, nonclinical, and/or patient-driven concepts. By researchers and community-based organizations working together using the implementation resources like those described below, innovative ideas can be evaluated and translated into studies to explore their efficacy through the scientific inquiry process and, potentially, into optimized community-based prevention and intervention programs.

### **Implementation Science**

Implementation science is a relatively new field of research that studies methods to promote the adoption and integration of evidence-informed practices, interventions, and policies into routine health care and public health settings. New evidence-informed suicide prevention innovations must account for a complex mix of settings, factors, and populations. In successful implementation efforts, complex issues like these are typically addressed through a combination of implementation strategies.<sup>78</sup> Therefore, a common format for evaluating and communicating ideas will need to be developed to enable stakeholders to identify effective implementation strategies for delivering tailored evidence-informed suicide prevention approaches.

An example of an innovative intervention requiring new approaches to implementation is the use of machine-learning algorithms to help stratify the patient population and allow for tailored application of interventions. In these cases, there is no standard implementation strategy, to our knowledge. For example, VHA's Recovery Engagement and Coordination for Health — Veterans Enhanced Treatment (REACH VET) initiative is a program that leverages a machine-learning algorithm to identify Veteran patients at highest risk for suicide after high-risk hospitalization; the algorithm's results are used to alert providers. This effort is making strides. REACH VET is being evaluated to determine the best implementation strategies — including policy memos, identification of a coordinator at each facility, web-based training, educational and support materials, and technical assistance.

### **Implementation Resources**

Resources are available to help VA and non-VA stakeholders use state-of-the-art implementation strategies. For instance, the [VA Quality Enhancement Research Initiative \(QUERI\)](#) has many tools and resources, such as the [QUERI Implementation Guide](#). In addition, the [Rocky Mountain Mental Illness Research Education and Clinical Center](#) has educational materials and tools related to suicide prevention. The QUERI Center for Evaluation and Implementation Resources (CEIR) provides front-end consultation to VA operational partners scaling up and expanding policies and clinical practices related to top VA priorities, including suicide prevention. This consultation may also be available to non-VA Veteran-focused groups.



Further, CEIR supports the Implementation Research Group, a national learning collaborative that showcases implementation science topics to an audience of nearly 300 members from across the Nation (VA and non-VA) and outside of the United States.

Another resource for both VA and non-VA personnel is the Behavioral Health QUERI Implementation Facilitation Training Hub in Little Rock, Arkansas. Two other QUERI training hubs focus on VA staff: Leading Healthcare Improvement, based in Houston, provides leadership training for applying improvement strategies; the Evidence-Based Quality Improvement (EBQI) Implementation Strategy Learning Network Hub in Los Angeles provides VA stakeholders with the training and resources needed to apply EBQI.

## Research Ecosystem

A core Executive Order requirement of the PREVENTS NRS was to “improve coordination among research efforts, prevent unnecessarily duplicative efforts, identify barriers to or gaps in research, and facilitate opportunities for improved consolidation, integration, and alignment” and “develop a public-private partnership model to foster collaborative, innovative, and effective research that accelerates these efforts.” This requires evaluating not only the current state of suicide research, but also the processes that could enhance the quality and reproducibility of scientific developments in suicide prevention while seeking to accelerate the research process through systems-level changes. Researchers in many fields, including suicide prevention, encounter challenges with partnerships, data sharing, and collaboration; if addressed, these challenges could accelerate solutions for health care problems, including evidence-informed suicide prevention. For example, by coordinating efforts focused on shared datasets (and other structural changes), the research ecosystem will evolve to support innovation and reproducibility of findings more effectively. The following themes are aligned with the goal of enhancing the current research ecosystem. These shared data resources are practiced among some Federal portfolios and are worthy of evaluation for expanded use throughout Federally funded suicide research.

### Team Science

The importance of supporting team science emerged prominently at The White House Summit. For example, attendees discussed the benefits of research grants that include multiple principal investigators with varied experience for the explicit purpose of mentoring younger investigators. It was noted that Federal grants could foster this collaboration through incentives or requirements to promote teams that included investigators with a range of expertise. A second theme related to team science centered on modifying scientific grants to require a broader set of expertise for all grants (for example, including data scientists) that would complement the expertise of those studying (for example) suicide prevention. Recommendations for team science include both the need for public-private partnerships and the need for developing grant award structures — including multiple labs, universities, or groups within a single research award.

### Data-Driving Innovation

The research ecosystem concepts promote the enhanced role of data, specifically type I and type II predictive analytics, as a catalyst for accelerated science while simultaneously offering other efficiencies. A core concept that emerged at The White House Summit was the need to tailor interventions to subpopulations of Veterans based on data, rather than applying them across the Veteran population.

For example, a 26-year-old Veteran with financial distress and lacking reasonable job prospects may benefit from a different intervention than an older Veteran with PTSD and chronic pain. Grant applications, where possible, should be prioritized when linked to type II predictive analytics (those with hypotheses based on identified data patterns) because they will be more likely to identify solution sets. This requires investments in the development of an advanced computational infrastructure, data expertise, and novel data integration techniques and technologies.

Additionally, more efficient use of time and funding may be promoted by co-locating data expertise and data storage activities. This would allow the government to fund a central body with expertise in data management and maintenance; consequently, this would also empower teams of researchers who would have access to data science expertise throughout the life cycle of their research. This includes leveraging deep expertise across the data sciences, supercomputing capabilities, and data workflows to enhance not only the speed of analysis but to exercise data in novel ways and drive innovation. Additionally, secure data storage infrastructure and data management plans decrease risk surrounding adherence to data governance and privacy laws, while maintaining fostering continued collaboration among funded researchers. This concept is also highlighted in the Data Sharing and Integration section of the PREVENTS NRS.

These research ecosystem changes would help promote efficiencies by linking these shared services in a coordinated fashion across the entire Federal suicide research portfolio. An example of this concept is the TRACK-TBI effort that is funded by DoD, VA, and NIH, includes scientific collaborators in the public, private, and nonprofit sectors, and leverages DOE supercomputing capabilities and data curation expertise to increase utility of data for scientific advances. (TRACK-TBI stands for Transforming Research and Clinical Knowledge in Traumatic Brain Injury.)

### **Interagency Coordination**

To “improve coordination,” “prevent unnecessarily duplicative efforts,” and develop “improved consolidation, integration, and alignment,” there is a need for a centralized coordination mechanism with input and participation from all relevant agencies. Unlike prior efforts to coordinate, this effort could leverage existing Federal research coordination processes, such as the National Science and Technology Council within the Office of Science and Technology Policy or another coordinating body and would bring both health and data experts to the table.

### **Incentivizing Innovation**

The PREVENTS NRS requires evaluation of how novel funding mechanisms or practices applied to grant making could incentivize collaboration and communication. Through funding requirements, Federal agencies can prioritize funding linked to metrics on sharing of well-curated datasets (with points for low burden to reuse). Similarly, as more scientists write code to analyze data and datasets, requiring publication of the algorithms in addition to the scientific findings will enable improved use of Federally funded research, enhance secondary data analysis, and improve quality assurance. Partnerships with professional societies and journals will increase acceptance of studies with multiple authors, particularly in the more prominent journals, and help eliminate artificial barriers to team science.

Finally, the PREVENTS NRS calls for novel funding of core or shared services in order to create efficiencies, such as agencies moving data curation and storage funding from individual investigators to a central curation point, so as to build a core capability that maximizes utility of the Federally funded data analysis and empowers existing investigators with increased computing capability.

## Data Sharing and Integration

The rate of proliferation of data is so rapid that 99% of the world's current data has been created within the past 18 months.<sup>79</sup> Technological advancements and wide deployment of digital technology have resulted in the availability of exponentially large data assets, some in the exabyte scale ( $10^{18}$  bytes); concurrently, this has driven efforts to advance six components of big data analytics: data generation, acquisition, storage, advanced analytics, visualization, and decision-making or decision support for value creation. Each of these components holds the promise to develop new capabilities, leading to actionable insights for real-world and even real-time impact, saving lives, and supporting large scale improvements to health and well-being across the Nation.<sup>80</sup>

Suicide research today has often focused on the identification of the risk factors critical for preventing suicide in those posing the greatest risk of self-harm. However, the greatest opportunity to prevent suicide exists long before an individual is at highest risk. The timely availability of robust, high-quality data plays a critical role in furthering our understanding of suicide and suicidal behaviors and developing mitigation and prevention strategies to effectively intervene at individual and community levels.

The timely availability of robust, high-quality data plays a critical role in furthering our understanding of suicide and suicidal behaviors. Further, data aid in developing strategies to effectively ensure a Veteran is provided interventions targeted to his/her risk profile. There are large gaps in availability of Federal administrative, health care, and research data that can be used to this end, including those datasets from VA, DoD, HHS, and other relevant agencies. While there are data repositories that can be used in part or in whole for this purpose, most of them are not linked to one another, and the data variables are collected in a nonuniform, non-standardized manner, making the technical task of data integration difficult.

Data integration is critical to the PREVENTS NRS, because the vast array of data assets and data sources relevant to understanding, detecting, and preventing Veteran suicide are varied, fragmented, and disconnected. Even when evidence exists, the appropriate systems for capturing, translating, and sharing these data are not in place. As a result, datasets are left in isolation, unable to be combined with other data, with untapped potential to obtain relevant insights that move scientific discovery forward. Unused data increases the likelihood that intervention selection is not based on best available evidence

The integration of data is needed to conduct a new generation of scientific research and discovery; this could be facilitated through the development of a data integration virtual data enclave, leading to the development of data integration tools and techniques to provide solutions supporting novel groundbreaking research to address a broad range of complex health and biomedical research problems extending far beyond Veteran suicide.

The phenomenon of suicide is inherently complex, involving dynamic interactions at multiple levels. To date, attempts to capture such complexity include the use of conceptual models and visualization methods, such as the social-ecological and multicausality models.<sup>81,82</sup>

Such models require the integration of individual- and population-level data across an array of distinct, often unrelated data sources. Population-level data sources may include Federal, state, and local governments; public records and administrative data; and personally created or digital data, including the "internet of things" and other nontraditional sources. The integration of diverse population-level data can be used to visualize, estimate, and anticipate population trends, typically by geographic location (e.g., ZIP code, county, city, state) or by demographic groups (e.g., sex, race/ethnicity, Veterans and non-Veterans, etc.); for instance, it can be used to monitor trends in suicide among Veterans over time and to identify geographical "hot spots" where population-level intervention strategies can be targeted.<sup>83</sup>

It is important to distinguish between data integration for individual versus population-level analyses. The integration of individual-level data is essential for maximizing the utility of the data uses envisioned by the PREVENTS NRS; it requires the ability to link individual-level data across multiple sources. In the absence of a single individual identifier for consistent use across data sources, linking of individual data is often performed through use of various probabilistic matching algorithms matching personally identifiable information from one dataset to another.<sup>84</sup> Individually linked data and integration, through use of personally identifiable information, is necessary to address an individual's risk for suicide, an assessment of said risk, and the prevention of suicide among Veterans, underpinning the need for data scientists, policymakers, and researchers to establish the systems solutions necessary for data sharing and integration included in the recommendations below.

### **Government's Role in Data Sharing and Integration**

Several collaborative government initiatives facilitated by the integration of shared data assets have delivered important medical advancements and serve as important proofs of concept for leading a data-driven paradigm shift in science and research. For example, the Human Genome Project, initiated in 1990, led to sequencing of the human genome<sup>85</sup> and spurred the development of rapid DNA sequencing technologies. Another relevant example is the Cancer Moonshot initiative designed as a whole-of-government approach, marshaling resources from across the Federal government to accelerate advancements in cancer research.<sup>86</sup> These programs represent a concerted effort to solve inherently complex problems through coordinated and gap-driven research, promoting the assignment of tasks to those identified as best equipped to deliver results based on their scientific resources and capabilities. Similar commitment, coordination, identification of capabilities, and dedication of resources can help to prevent suicide in the Veteran population.

#### *Select Federal Datasets Important to Suicide Studies*

Many Federal data assets and related national surveillance systems already exist that are relevant to suicide research, suicide prevention, and public health more broadly (see the Appendix for a representative list), that could be leveraged to spur suicide prevention research initiatives. VA's REACH VET program employs big data analytics and predictive modeling to direct clinical services to Veterans in VHA care whose records indicate the highest statistical risk for suicide.<sup>87</sup> The REACH VET algorithm was adapted to VA data from a previous machine-learning-based algorithm from the Army Study to Assess Risk and Resilience in Servicemembers — Longitudinal Study, which combines administrative data with clinical data and surveys to produce type I predictive analytics.

VA and DoD have invested in suicide surveillance and analytics infrastructure linking VA and DoD records to annual searches of CDC's National Death Index (NDI) to facilitate analyses focused on suicide risk factors, which paves the way for research and surveillance analytics (see description below). CDC's National Violent Death Reporting System (NVDRS) covers all types of violent deaths — including suicides — in all settings for all age groups. NVDRS acts as a central repository including information from existing data systems like death certificates, coroner/medical examiner reports, law enforcement reports, toxicology reports, and detailed life histories, compiled into one anonymous database. Data elements collected by NVDRS provide valuable context about violent deaths, such as relationship problems; mental health conditions and treatment; toxicology results; and life stressors, including recent money- or work-related problems or physical health problems.

The Million Veteran Program — Computational Health Analytics for Medical Precision to Improve Outcomes Now (MVP-CHAMPION) is a collaborative VA-DOE Big Data Science Initiative leveraging DOE's expertise and technologies in AI, big data, and secure high-performance computing with VA's digital health and genomic data. MVP-CHAMPION's ongoing programs further the understanding and support the development of new treatments and preventive strategies across a spectrum of Veteran health concerns.<sup>87</sup>

**Suicide analytics rely on a variety of data sources, including:**

- Death certificate records collected by state vital statistics offices and compiled in CDC's NDI.
- Electronic health system records, such as those of VHA, DoD, and private health systems.
- Claims data collected by the CMS.
- Social and community data available from the United States census and other public records systems.

1. **National Death Index.** The VA and DoD Mortality Data Repository supports studies, in addition to other research, subject to CDC and state data use requirements. Although there are a large number of datasets relevant to suicide among Veterans, these datasets, with a few notable exceptions, have not been integrated. The CDC's NDI is the primary source for information on the cause of death of individuals in the United States, including suicide; it can be used to create linkages with other approved data sources.

It is important to note that death certificate records are collected by states and compiled in the NDI. However, there is not a standard process for classifying, collecting, or reporting the cause of death across states and, in some cases, across counties in a state. For example, it may be difficult to determine intention in the case of an overdose death. Therefore, states often classify deaths according to different standards. These inconsistencies affect the quality of data and contribute to lengthy processing times that prevent quick retrieval of data by researchers.

2. **Defense Manpower Data Center (DMDC).** The DMDC is the primary source for information on military service and Veteran status. The DMDC was used in prior research to evaluate suicide among Veterans of the Gulf War,<sup>88</sup> but required triangulating various beneficiary data sources with state vital statistics records to ascertain suicide status. Similar structures are needed to support suicide analytics conducted by other scientists.

Examples of ongoing suicide surveillance reporting include the CDC's Wide-ranging Online Data for Epidemiologic Research system and VA's annual national suicide reports.

3. **The Federal Interagency Traumatic Brain Injury Research Informatics System (FITBIR).** Suicide-related research data is also available from sources like FITBIR. FITBIR is an informatics system created through a collaborative effort between the Department of Defense (DoD) and the NIH National Institute of Neurological Disorders and Stroke (NINDS) and serves as the premier platform to share human subject data in the field of TBI. The goal of FITBIR is to accelerate research progress by allowing for the reanalysis, aggregation, and rigorous comparison of deidentified data to facilitate new insights in the understanding, diagnosis, and treatment of TBI. FITBIR contains over 3.5 million data records for over 64,000 subjects from 190 studies funded by the DoD and NINDS. This comprehensive dataset includes demographics, outcome assessments, imaging, and biomarkers that can be used in suicide research. As of June 2020, data from 20 studies and over 761,000 study records are shared publicly.

#### *Early Lessons Learned About Data*

There are important gaps in currently available data resources. For example, as noted above, although VA surveillance incorporates VHA records, there are few data available regarding health care use by the estimated 50% of registered Veterans who are not receiving their care from VA.<sup>89</sup> Separately, a lack of consensus for data standards exists — particularly for data representing the social determinants of health — creating barriers to its collection and use and to navigating the legal parameters for cross-sector data sharing and integration. A substantial amount of data exist that carry inherent value; however, these data remain largely unlinked, were acquired in a non-standardized manner, and lack common data elements— all factors that complicate the highly technical task of data integration.

### **Data Sharing and Integration**

#### *Protecting Privacy*

Today, protocols and practices governing data sharing vary widely and depend on the policies instituted by each data holder, the identity and affiliation of the researcher requesting the data, its intended use, and the nature of the approval from the researcher's institutional review board (IRB), governance board, or other research oversight authority. Informed consent with study participants provides privacy safeguards and permissions for the study data.

Researchers and data stewards are each responsible for the secure handling and use of data in compliance with ethical standards of research, regulatory requirements, and laws designed to secure and protect the privacy of individuals or groups that the data represent. The requirements for individual medical records are laid out in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.<sup>90</sup> The standards governing all applicable research must be consistent with the ethical principles of the Belmont Report, and each data owner develops policies to ensure compliance.<sup>91</sup> Human research subjects involved in Federally funded research are further protected by the Federal Policy for the Protection of Human Subjects, 45 CFR part 46, or the "Common Rule," outlining the basic provisions for IRBs, informed consent, and Assurances of Compliance for all participating Federal agencies.

### *Data Accessibility*

There is tremendous value and promise in unlocking Federal data for measurable societal impact, and so a considerable focus has been placed on establishing a Federal Data Strategy to serve as a framework of operational principles and best practices, which empowers agencies to deliver on the promise of data in the 21<sup>st</sup> century. As designed, the Federal Data Strategy enables agencies, and government as an enterprise, to use and manage Federal data as a strategic asset, promoting data-driven innovations of value to the public and serving the needs of the American people. The Federal Data Strategy will also pursue critical parallel goals of obtaining optimal value from data assets and of protecting security, privacy, and confidentiality.

### *Evidence-Based Policymaking*

On January 14, 2019, President Trump signed the Foundations for Evidence-Based Policymaking Act of 2018 (the Evidence Act), also containing the Open, Public, Electronic, and Necessary Government Data Act, providing a sweeping, governmentwide mandate for Federal agencies to publish all their information as open data through the use of standardized and nonproprietary formats. The Evidence Act requires agencies to share even individual-level data with Federal statistical agencies, provided those data will be used exclusively for statistical purposes; it also implements the creation of a single hub for non-Federal researchers to request access to Federal data. The OMB Council is to establish governmentwide best practices for data collection, use, storage, and sharing. The Evidence Act aligns with the President's Management Agenda, particularly Cross-Agency Priority Goal 2: Leveraging Data as a Strategic Asset, which is designed to use data to "grow the economy, increase the effectiveness of the Federal Government, facilitate oversight, and promote transparency."<sup>92</sup>

In combination, the policies and processes outlined above provide the Federal government and associated agencies both the power to protect data and the charge to drive innovation through the liberation of data assets. These efforts combine to enhance researchers' abilities to use data to inform new solutions for preventing Veteran suicide.

### **Creating a Collaborative Data-Driven Research Ecosystem**

Through the promotion of an interdisciplinary research ecosystem, researchers will be better able to connect with experts across scientific domains to:

- Leverage technological and advanced computing expertise.
- Access resources and infrastructure.
- Harness existing siloed (and ever-growing) data investments.
- Develop leading-edge techniques and methodologies.
- Improve the reproducibility and replicability of research.
- Revolutionize how to derive actionable insights from data.

Interdisciplinary teams of researchers, including those with expertise in machine learning, AI, analytics and statistics, medicine and biomedical informatics, computational and decision sciences, and domain-specific or related subject matter expertise will work together to enhance the body of knowledge in the fields of suicide and suicide prevention through collaborative data sharing.



A data infrastructure could combine tiered levels of data protections and controlled access and involves ongoing data curation and management, consistent standards and documentation implementation, and a structure similar to the data sharing policies and requirements analogous to other Federally funded research and data integration efforts, such as the National Science Foundation’s Big Data Regional Innovation Hubs. The infrastructure will span public and private research efforts to aggregate disparate and diverse data sources and focus on facilitating interdisciplinary team science collaborations that comply with legal and ethical requirements for data use, according to data type, level of sensitivity, and required cybersecurity.

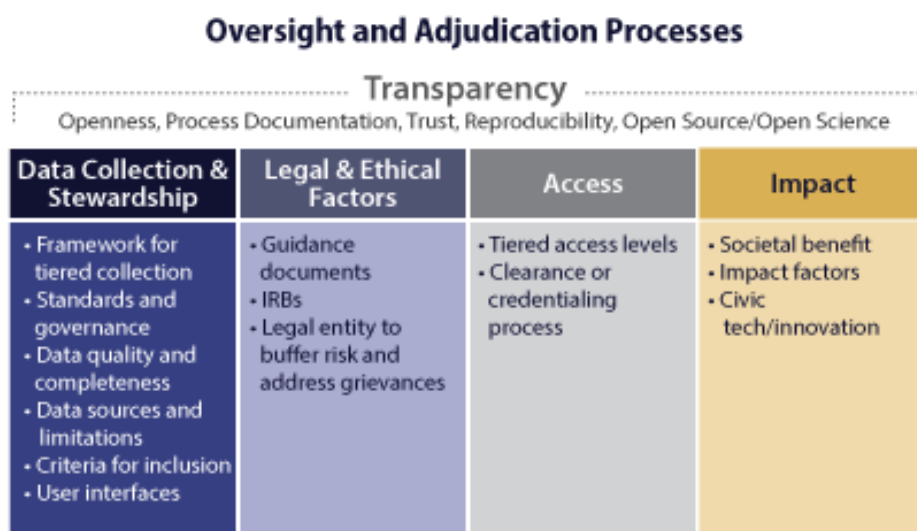


Figure 3-6

The collaborative interdisciplinary research ecosystem will require deploying state-of-the-art technology and infrastructure focused on building and maintaining public trust, while facilitating the level of multidisciplinary research and data integration required to solve inherently complex national-scale data and public health challenges, as depicted in Figure 3-6,<sup>93</sup> such as the need for:

- Transparency at all stages: data curation, sharing, integration, and use, including communication strategy for outcomes and advancements.
- Tiered data access by data type, sensitivity level, and user credentials.
- Data sharing and cybersecurity technologies that can move data safely and efficiently as close to “real time” as feasible.
- Metrics evaluating the efficiency and interoperability of infrastructure and the associated platform.



## Challenges to Achieving the Desired Future State

The U.S. government is at an inflection point for scientific research and discovery. Years of research investments have resulted in the accumulation of an extensive collection of curated, high-quality data assets, further enriched by an ever-increasing availability of data from sources not traditionally used for research, which are therefore difficult to incorporate into research. However, in many ways, the culture, practice, and coordination of research have struggled to keep pace with data-generating technology. Ending the national tragedy of suicide demands interdisciplinary research to reach meaningful, actionable solutions. Furthermore, research is becoming increasingly reliant on advanced data techniques and large-scale computation, but such infrastructure and resources are too costly and/or are beyond the scope and expertise of domain-level research groups.

Additional challenges include incomplete knowledge about what research is underway across agencies and how to access and properly use existing data. Further, while technological solutions for secure data sharing, transfer, and integration exist, they are not necessarily deployed where they are needed. In addition, the policies for data governance and access often lack clarity and this results in differential interpretation and inconsistent implementation of data policies.

Practically speaking, gaps in governance documents or lack of clear policy guidance are major challenges. Overcoming these challenges will require adaptive strategies for evaluating risk that guide changes to existing practices, regulations, or laws. Given the potential for wide-reaching benefits to public health through the effective use of data assets and investments, the risk and reward for health innovation must be weighed objectively. Although there is always risk involved in data sharing, transfer, and integration, it is vital to ensure that researchers have access to the information they need to develop innovative techniques that save lives in the fastest and most efficient way possible.

## Research Gaps and Recommendations

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### Risk Identification

As noted above, understanding pathways of risk and variations of these pathways across time, location, and specific contextual factors is vital to preventing suicide in Veteran populations and beyond. Each individual experiences a wide range of socio-environmental, cultural, and contextual factors, meaning a generic one-size-fits all approach that targets a single risk factor or broad group of risk factors will not solve this puzzle. Risk is determined by individual, socio-environmental, life history, and genetic factors. Therefore, it is vital to better understand individual risk profiles to promote risk identification that is both fast and accurate for individuals inside and outside of VA.

Below are the primary gaps identified by the PREVENTS NRS team related to risk identification. There is limited information on:

- Risk factors targeted to Veteran populations, because of the geographic dispersion of Veterans and wide range of socio-environmental contexts and life history factors that must be considered.
- Medical records for the many Veterans who are not associated with VHA — data that would provide rich insight for research purposes.
- Advanced qualitative or quantitative methods for measuring and tracking life transitions, socioeconomic stress, psychosocial factors, and collateral information.

- High-quality natural history and surveillance data for Veterans at risk.
- The public-private partnerships that are necessary to support scientific research of Veteran suicide.
- Veteran-relevant databases and a lack of coordination among those that exist to improve the development and validation of predictive models.

Multiple recommendations are being proposed to address the gaps in risk identification listed above and to address Goal 1, Promote individualized Approaches to Suicide Prevention and Intervention and Goal 2, Enhance the Research Ecosystem.

In particular, the following list of recommendations relate to expanding research on risk profiles in subpopulations to identify individuals who are at risk for suicide more accurately and swiftly.

#### Recommendations for Goal 1: Promote individualized Approaches to Suicide Prevention and Intervention

- Understand better who is at risk, when, and why. Important considerations for risk include:
  - Discharge following psychiatric hospitalization and other settings.
  - Transition out of active military service.
  - Veterans outside of VHA.
  - Special occupational groups (such as women Veterans).
  - Individuals who experience suicidal ideation, posttraumatic stress disorder, traumatic brain injury, current psychiatric conditions or symptoms and aspects of personality.
  - Individuals who have not sought behavioral health care.
  - Genetic risk.
  - Risk related to propagation in social media.
  - Family violence.
  - Legal issues.
- Study the **time course of suicide risk across the military life cycle**, including military service time, deployments, and transitions.
- Understand better the **trajectories** of Service member and Veteran suicide risk (e.g., think, then plan, then attempt).
- Develop and test the effectiveness of enhanced interventions for Veterans within and across successive risk strata.
- Develop **predictive models of suicide risk**, through Federal agencies' combining or sharing databases and research teams and focused especially on the association between experiences during military service, and suicide risk in the period soon after separation from military service (e.g., within 1 to 3 years).

Additionally, the following recommendations relate to developing systems to enable identification and analysis of how risk factors and preventive efforts differ among Veterans within VA care to those outside of VA care for determining effective approaches.

## Recommendations for Goal 2: Enhance the Research Ecosystem

- Increase the number of opportunities for the Federal government to **collaborate** to examine suicide risk in the population of Veterans who participate in programs such as **Medicare and/or Medicaid**.
- Develop additional **partnerships** to better identify at-risk Veterans **not receiving VHA care**.
- Develop **partnerships between the Federal government and non-VHA health systems** and hospitals to encourage and facilitate wider screening for suicide risk, especially universal screening in emergency departments.
- Develop interagency collaborations that leverage shared data infrastructure to more rapidly and effectively identify risk factors across the life-course of suicide.

## Prevention and Intervention

Research is needed to build, strengthen, and test multipronged approaches that address multiple aspects and levels of risk; these approaches should examine prevention efforts across all aspects of our communities, in a variety of settings, and in diverse populations. Health care settings, including VHA and civilian settings, have made progress in delivering preventive care and interventions for suicide, but additional research may inform how to coordinate across care systems to better serve Veteran, military, and civilian health care users. Additionally, care delivered outside of traditional health care delivery, including care delivered in community-based programs, is researched less frequently. Therefore, benefits for enhancing and/or reducing the need for health care services remain unknown.

The top gaps identified by the PREVENTS NRS team related to interventions focused on prevention are below. Research must also include a plan for understanding how to determine need for an intervention, and the best time to apply the intervention. More research is needed on:

- Collaborative care, which is a promising primary care treatment model that has not been tested with a suicide-prevention component in either VHA or non-VA health settings.
- Family or peer support for suicide prevention in the military and Veteran populations.
- Efficient ways to increase the number of providers who are competent in evidence-informed suicide prevention intervention across settings with patients of diverse cultural backgrounds, including Veteran status.
- Telehealth, a promising approach to overcoming behavioral health shortages, which could expand access to evidence-informed practices or improve suicide prevention health care practices.
- Combining treatments for rapid action to reduce high suicide risk.
- Community crisis support interventions (e.g., caring texts, telephone contacts, and treatment team approach, including peer providers) through multiple delivery modes.
- Appropriate delivery of economic support interventions for Veterans based on their unique needs to reduce suicide risk (e.g., unemployment benefits and other forms of temporary assistance, medical benefits, retirement and disability insurance, affordable housing programs).

Multiple recommendations are being proposed to address the gaps in prevention and intervention listed above and to address Goal 1, Promote individualized Approaches to Suicide Prevention and Intervention, and Goal 2, Enhance the Research Ecosystem.

In particular, the following recommendations relate to prioritizing targeted approaches to prevention and intervention studies that take into account personal, social, and environmental risk and protective factors across the lifespan.

Table 3-3

#### Recommendations for Goal 1: Promote individualized Approaches to Suicide Prevention and Intervention

- Test **collaborative care models** with a suicide prevention component in civilian and VHA primary care settings.
- Test **telehealth** in different health care settings.
- Test combinations of **rapid-acting interventions** and more durable evidence-informed psychosocial treatments to facilitate the recovery process in acute care settings.

The following recommendations relate to Goal 2, conducting rigorous prevention and intervention studies within and beyond health care delivery settings, including community settings.

Table 3-4

#### Recommendations for Goal 2: Enhance the Research Ecosystem

- Evaluate the role of using electronic health record data to contribute to targeted approaches in suicide prevention.
- Ensure systems like VA and non-VA hospital settings are operating under **evidence-informed structures** and make changes to those systems that are not.
- Build on existing resources to establish a **national learning health care network** across the Federal government, linking studies on suicide prevention across VA and non-VA health care settings to standardize measures, measure results, implement improvements in services, and answer new research and care questions.
- Develop and test **family- and peer-support programs** or components of larger programs for suicide prevention in both health care and community settings.
- Link VA patient care data to information on all-cause mortality from the **Social Security Administration’s full Death Master File**, and on cause/manner of death from the **CDC’s NDI**, and allow access for non-VA researchers as well.
- Further test “**caring communications**” approaches through multiple delivery methods and with peers.
- Identify the critical components of interventions to **reduce negative attitudes and perceptions** about mental health and how they can lead to more help seeking and reductions in suicide attempts and deaths.
- Study how **suicide contagion** operates via social networks; test models that make individuals more resistant to contagion and decrease their overall suicide risk.
- Test interventions that address suicide risk factors among Veterans in **community settings** such as drug courts, prisons, American Indian reservations, and tribal communities.
- Test ways to **maximize community interventions** by combining surveillance and prevention efforts.

## Research Translation

Research must be quickly implemented into actionable solutions that will prevent suicide. However, several common barriers are evident. For example, as described above, it takes years to rigorously evaluate interventions to ensure that they meet research guidelines for effectiveness similar to those described in CPGs. Additionally, many suicide prevention programs are being run by individuals or agencies lacking connections with researchers who could help evaluate their effectiveness. Therefore, the programs are designed and implemented without rigorous evaluation or measurement of outcomes. Without systematic strategies to collect information and provide an evidence base for effectiveness, these programs cannot be evaluated for consideration of further implementation or discontinuation of use. In addition, little is known about which specific proven interventions must be delivered in different contexts. For example, little is known about which providers in which settings with which patients (and, further, which community elements in the health system) will affect the successful implementation of interventions.

These questions need to be answered in order to meet the diverse array of needs from stakeholders at all levels of the research ecosystem and ensure that individuals receive the most effective targeted care as fast as possible through the research pipeline from discovery to implementation.

The primary gaps identified by the PREVENTS NRS team related to research translation are:

- Best practices for taking proven interventions to the populations that need them are understudied.
- More research is needed on how to implement suicide and mental health interventions to specifically treat Veteran populations.
- There is a lack of understanding as to what extent known treatments are being successfully executed with fidelity for major prevention efforts.
- More communication is needed among VA, professional organizations, and state and local communities to determine which settings and individuals are high priorities for screening of risk.
- It is challenging to capture risk in EHRs because there are limitations on what EHR data are available — and can be used to support research translations — for suicide risk and prevention.
- The payment structure for health care services may serve as a barrier to accessing and completing preventive screenings.
- Lethal means safety approaches have been applied at the community level but have been less frequently evaluated, and ecological models are not typically included in systematic reviews focused on clinical prevention and interventions.

Multiple recommendations are being proposed to address the gaps in research translation listed above and to address Goal 1, Promote individualized Approaches to Suicide Prevention and Intervention and Goal 2, Enhance the Research Ecosystem. In particular, the following list of recommendations relate to developing an interagency process to quickly translate research findings into policy solutions, health care delivery practices, or further refined investigation.

Table 3-5

Recommendations for Goal 1: Promote individualized Approaches to Suicide Prevention and Intervention
<ul style="list-style-type: none"> <li>• Recommend a process for <b>evaluating recommendations</b> that emerge in the years between VA/DoD CPG releases.</li> <li>• Supervise and train health care staff members according to the VA/DoD CPG; health care systems and administrators (e.g., VA, HHS, CMS) should <b>work collaboratively</b> to support this effort.</li> <li>• Rigorously develop and evaluate community program metrics in the way that hospital metrics were developed and evaluated to identify optimal patterns of care and use of appropriate level of care.</li> <li>• Establish a mechanism whereby prevention and intervention strategies that are delivered (both consistent with current evidence and outside of it) track and publicly <b>report outcomes</b> to allow for future research as well as adaptation and tailoring of content to subpopulations, including those at risk for suicide after discharge from the emergency department (ED).</li> </ul>

Additionally, the following recommendation suggests identifying a location and program office that enables a gap-driven analysis across the Federal suicide research portfolios.

Table 3-6

Recommendation for Goal 2: Enhance the Research Ecosystem
<ul style="list-style-type: none"> <li>• Mandate at the state level (and monitor for completeness) external cause reporting within ED data. States with hospital coding systems for external injuries (mostly used in EDs) are a model to monitor ED-based detection of suicide behavior injuries, as well as monitoring disposition. Uniform coding systems could be broadly developed nationwide from best models available.</li> <li>• Promote use of “living systems” to accelerate research findings to practice.</li> </ul>

## Data Sharing and Integration

Successfully taking on the national public health crisis of suicide demands interdisciplinary research to develop actionable solutions that address the primary issues facing data sharing and integration, including siloed data; lack of policy guidance; cost of and access to infrastructure required to manage big data; and lack of standardized protocols and policies for collecting, sharing, and integrating data.

The PREVENTS research ecosystem goals are designed to ensure that researchers will be better able to connect with experts across scientific domains, leverage technological and advanced computing resources, harness existing siloed (and ever-growing) data investments, work collaboratively to develop leading-edge methodologies, improve reproducibility and replicability in research, and revolutionize how solutions are derived.

The primary gaps identified by the PREVENTS NRS team related to data sharing and integration are:

- Research remains in siloes despite the increasing need for interdisciplinary focus.
- Research findings increasingly rely on advanced data analytics techniques and large-scale computation, but the infrastructure and resources required to leverage and manage big data can be costly and are often beyond the scope of the expertise of relevant research groups.
- Suicide experts often have incomplete knowledge about what research is underway and lack knowledge on how to access and properly use existing data.
- While technological solutions for secure data sharing and integration generally exist, they are not necessarily deployed where they are needed.
- Policies governing data access may lack clarity, resulting in differential interpretations and inconsistent implementation.

As a result of the development of the PREVENTS NRS, multiple recommendations are being proposed to address the gaps in data sharing and integration listed above and to address Goal 1, Promote individualized Approaches to Suicide Prevention and Intervention and Goal 2, Enhance the Research Ecosystem.

Table 3-7

Recommendations for Goal 1: Promote individualized Approaches to Suicide Prevention and Intervention
<ul style="list-style-type: none"> <li>• Call and extract data on-demand from disparate sources using application programming interfaces.<sup>94</sup></li> <li>• Develop <b>virtual data enclaves</b> where researchers can perform data analytics without requiring data to be transferred and limiting the need for data extraction to promote security.</li> <li>• Deploy data technologies supporting secure data transfer, storage, anonymization, and enhanced protection of sensitive information during processing to streamline data sharing, access, and analytics processes.</li> <li>• Develop a data framework for <b>tier-level assignment</b> and tier-level access based upon data type, sensitivity, use case, and user; broadly, tiers could include restricted access data, access defined by stipulations of data use agreement, and nonsensitive, open data, and open science.</li> <li>• Establish a personally identifiable information data security clearance process similar to the security clearance process used by the government for access to classified data to grant access to tiered data.</li> </ul>

Additionally, the following recommendations relate to removing barriers and standardizing protocols, methods, and agreements to promote timely and effective data sharing and integration to support Veteran suicide research efforts.

Table 3-8

Recommendations for Goal 2: Enhance the Research Ecosystem
<ul style="list-style-type: none"> <li>• Develop an educational campaign to make the public aware of the system and its objectives, educate researchers on the value of ethical data sharing and allow stakeholders to contribute data to the virtual data enclaves and be involved in decisions about data uses. Data will not be public facing to avoid the risk of receiving incorrect or incomplete information but will include functionality to obtain data from private companies. Specifically, this will include: <ul style="list-style-type: none"> <li>○ Veterans contributing their personal data.</li> <li>○ Researchers sharing data and adhering to data-sharing rules in order to maintain funding.</li> </ul> </li> <li>• Incentivize collaboration and responsible data sharing in the face of cultural barriers (e.g., academic institutions versus private industry).</li> <li>• Design and institute mandatory <b>standardized data collection</b> and aggregation protocols<sup>95</sup> through: <ul style="list-style-type: none"> <li>○ Unique patient identifiers to aid the linkage of individual-level data across multiple data assets.</li> <li>○ Universally unique dataset identifiers to identify each unique dataset/asset.</li> <li>○ Common data elements as standards for research.</li> </ul> </li> <li>• Develop a new, quantitative metric, the “<b>data impact factor</b>,” to help assess and communicate the use and impact of individual data assets, particularly those used in research.</li> <li>• Perform a <b>comprehensive assessment</b> of existing data assets relevant to suicide prevention, public health, and social determinants of health, including identification of the current data sharing and access policies and procedures governing each data asset. This process should also include assignment of <b>unique digital identifiers</b>, leading to implementation of the data impact factor.</li> <li>• Develop a <b>centralized clearinghouse</b> consistent with current work in open data and open science to improve the discoverability of ongoing research and existing data assets.</li> <li>• Develop an <b>interagency leadership group</b> to improve coordination and cooperation between Federal agencies.</li> <li>• Create an <b>independent body</b> to objectively assess the new data infrastructure and its policies and practices, coordinate stakeholder input, and establish and conduct investigations or decision reviews through a streamlined adjudication process.</li> <li>• Create a process to oversee the development and operational management including evaluating applications for data and data-tier access, monitoring, and assessing outcomes of data use, developing, and implementing standardized data governance documents, and providing continual oversight and accountability.</li> <li>• Make full information available for research purposes without compromising data security.</li> <li>• Link <b>VHA</b> patient care data with <b>Veterans Benefits Administration disability program data</b> to improve coordination of services.</li> <li>• Link research data on individuals with <b>private/commercial health insurance</b> to Veteran data and mortality data, which may be achieved through the use of global unique identifiers.</li> <li>• Include military service (current or ever-served) for Active Component, Reserve Component (National Guard and Reserve), and Coast Guard within the National Violent Death Reporting System (NVDRS), with appropriate data integration strategies to ensure data is compared with existing DoD, VA, and DHS data.</li> </ul>



- Include Veteran status within the HHS, **Indian Health Service (IHS)**, electronic health record, and datasets.
- **Create mechanisms** for generating or collecting data about Veterans and families under the new framework, with appropriate consent mechanisms, potentially including new ways of:
  - Identifying Veteran status in datasets/collection where it is not typically tracked.
  - Identifying and using information and measurable indicators for social determinants of health identified as risk factors for suicide and other suicide risk factors.
  - Collecting and improving data to identify and learn about deaths of despair among Veterans.
  - Linking the NVDRS, IHS, and VHA datasets to determine Veteran status.
- Pursue research investigating the role of **synthetic data** or semisynthetic data to enhance data sharing, improve data analytics, and drive progress in research.
- Inform and **empower IRBs** and other governance bodies to ensure consistent, timely, and effective oversight of data-driven and technology-enabled research.
- Develop clear **guidelines and protections** for those who safely (consistent with legal and ethical standards of practice) make data actionable and enforce accountability for those who unnecessarily perpetuate data sharing bottlenecks to enhance support for data holders' effective data sharing.
- Develop a **standard for acceptable interpretations** of ethical and legal policies so as to avoid inconsistent decision-making and communication about best practices and appropriate uses of data.
- Develop a **Suicide Prevention Data Sharing and Ethical Use Toolkit** with policy guidance, case studies, and digital tools.
- Evaluate the need for a U.S. government **Health Data Sharing Consortium** to mitigate legal risks and liability concerns.

## Research Ecosystem

The primary gaps identified by the PREVENTS NRS team related to the research ecosystem are:

- The system for funding science does not support or encourage collaboration, including sharing data and research techniques among researchers from different labs and forming partnerships to leverage different kinds of expertise both within and outside of the Federal government. Therefore, in some cases, funded efforts may be duplicative and lack the necessary expertise and continuity to ensure redundancies are reduced and science is accelerated.
- The decision to fund a suicide prevention research project is based on a number of factors that are not typically the same across agencies. As a result, the ability to prioritize proposals with data-driven solutions for health, safety, and well-being is currently limited.
- Reliance on big data can inappropriately bias data against patterns with low prevalence.
- There is no standard process for evaluating science for readiness for translation or ensuring quick translation.
- Significant administrative barriers impede the ability to efficiently conduct research. For example, administrative requirements created by some laws unintentionally slow the pace of research across the Federal enterprise.

Multiple recommendations are being proposed to address the gaps in the research ecosystem listed above and to address Goals 1 and 2. In particular, the following list of recommendations focus on removing longstanding administrative barriers that affect the communication of Veteran status across Federal, state, and local systems of records. These barriers consistently delay and complicate research and surveillance data accuracy.

Table 3-9

#### Recommendations for Goal 1: Promote individualized Approaches to Suicide Prevention and Intervention

- Research the most effective way to track, record, and integrate information about social determinants of health.
- Develop a mechanism for identification of, and communication with, Veterans outside VHA that can support research on all Veterans, not just those accessing services at VHA.
- Evaluate the maturity of the Federal research portfolio on biomarkers to establish better targeted medicine predictors of suicidal behaviors.
- Support research to further investigate the roles of social connectedness and social isolation in suicide.
- Conduct a gap analysis of community interventions and research to inform scientific guidance on social connections and isolation as it pertains to suicide.
- Evaluate mechanisms to promote adoption of a team science or systems approach that identifies needed studies, focuses on mentorship of principal investigators, and establishes core expertise (including data scientists) on interagency or interorganizational teams.
- Invest in type I predictive analytics to establish enhanced understanding of risk profiles of individuals.
- Prioritize prevention/intervention studies that build on type I predictive analytics to test effectiveness of type II predictive analytics.

Additionally, the following recommendations relate to developing processes to promote collaborative research teams, public-private partnerships, shared resources, and frequent engagement with government funders and regulators.

Table 3-10

#### Recommendations for Goal 2: Enhance the Research Ecosystem

- Develop a team of specialists to identify an interagency process to generate, implement, and execute a PREVENTS NRS work plan, leveraging best practices and lessons learned from other similar efforts, and identifying how the work plan may overlap with existing interagency collaborative efforts.
- Identify interagency processes that will be used to ensure coordination of the Federal research portfolio to:
  - Identify all Federally funded research on suicide and brain health.
  - Create program management tools to support gap-driven investment.
  - Enable interagency coordination of research processes and funding.
  - Enable complementary policy and portfolio management.
  - Evaluate recommendations to ensure they are not duplicative of existing efforts.
- Identify formal processes that accelerate timely translation of science. Include mechanisms as appropriate that evaluate results for translation into policy, clinical guidance, or future research.

- Evaluate existing Federal funding models for novel mechanisms that promote expedited funding and/or shared costs.
- Evaluate ways to modify public and private incentives, including professional societies, nonprofit, and for-profit stakeholders, to promote team science, open science principles, sharing of well-curated datasets and expertise, and communication of unpublished or negative results.
- Enhance the research ecosystem to eliminate data hurdles that are specific to policy and culture change challenges.
- Evaluate the feasibility of a consolidated research data system that is supported by shared access to data science expertise and equipped with supercomputing capabilities to maximize the power of Federally funded data and empower existing investigators to draw on shared resources.
- Evaluate how to coordinate with public, private, and nonprofit entities regarding data sharing and integration to accelerate discovery in the research portfolio.
- Evaluate the funding, information technology, policy, and legal mechanisms of data surveillance systems to inform administrative and scientific gaps.
- Leverage a gap-driven research portfolio to evaluate the role of community resiliency and strengthen community infrastructure to prevent Veteran suicide.
- Evaluate the feasibility of building a living systematic review and generating living clinical guidelines as a mechanism for knowledge translation and return on investment within the Federal research portfolio.
- Evaluate ways to incentivize desired outcomes within the public-private research ecosystem with funding incentives to increase participation of private industry.
- Evaluate the benefit of Federal support for learning collaboratives to help communities share ideas and resources while facilitating determination of effective interventions.
- Expand the implementation science portfolio to eliminate the gaps in knowledge about the effectiveness of interventions, particularly those in the community or public health settings.
- Ensure research budgets reflect the true value of quality data, including budgeting for secure data infrastructure and advanced data science expertise.

## Conclusion

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The PREVENTS National Research Strategy (NRS), a critical element of the PREVENTS Roadmap, will promote foundational changes to the way suicide prevention research is conducted. The NRS was designed with two primary goals in mind. First, the NRS will identify and prioritize research studies that will lead to each Veteran receiving the most effective suicide prevention strategy tailored to meet his or her unique needs and circumstances. Second, the NRS will improve the speed and accuracy with which research is translated into practice, improving efficiency through data sharing and data curation practices, and promoting innovative funding techniques to drive change. These goals address the most pressing needs in suicide prevention research. Combined with the entire PREVENTS Roadmap, NRS recommendations (e.g., enhancing interagency coordination processes and data sharing practices) will help ensure suicide prevention efforts are not only supported, but sustained long term.

## Learn More

### Summarized RFI Themes<sup>96</sup>

#### Emotional, Physical, and Behavioral Health Risk Factors

- The term “condition” was used commonly by both organizations and individuals to describe multiple factors.
- Both organizations and individuals cited “pain” as a major contributing factor.
- Organizations and individuals identified multiple forms of trauma including premilitary, military, and postmilitary trauma factors.

#### Social and Environmental Risk Factors

- Both organizations and individuals cited “isolation” as a key risk factor.
- The review of “employment”-related terms indicated an overall recognition that socioeconomics can be risk factors.
- Social support and other social determinants of health were closely related to isolation and socioeconomics as risk factors.
- Text analysis also indicated that “lethal means” were closely related to other social risk factors.
  - Individuals cited more concerns with firearms or access to lethal means.
  - Individual responses for risk factors also identified potentially overlooked factors

#### Risk Factor Assessment

- Organizations identified insufficient data collection.
- Organizations identified many issues with self-reporting and self-administration of assessments.
- Individuals highlighted the factors missed by most assessment methods.
- Individuals described fear of assessments.
- Individuals suggested examining other factors to identify those at risk and how to help them.

#### Prevention and Intervention

- Organizations provided examples for the need for, and use of, comprehensive approaches to treatment and care.
- Individual responses indicated an interest in complementary and integrative health approaches and provided examples they have tried.
- Organization and individual responses related to comprehensive treatment approaches also identified therapy animals as an area of treatment specialty.
- Organizations and individuals described challenges with current pharmacological approaches. Nonlegal pharmacological approaches were described by both groups.

**Transition From Military to Civilian Life**

- Organizations and individuals indicated that transition begins in theater.
- Organizations identified VA or other clinical programs as key post-service support.
- Individuals identified military or peer-to-peer programs as key post-service support.
- Individuals indicated peer-to-peer connectedness is vital for successful transition.

**Protective Factors**

- Organizations identified the importance of resilience tied to community integration, education level, and reduced access to lethal means.
- Individuals emphasized connectedness, resilience, and access to specific resources to reduce risk factors.
- Both organizations and individuals indicated caregivers and peers are protective factors that can support Veterans.

**Barriers to Care**

- Organizations and individuals indicated a major barrier to using care is a concern for negative consequences associated with receiving care.
- Individuals indicated concern with clinician burnout in suicide prevention efforts.
- Individuals indicated a reluctance to be assessed by clinicians with little first-hand knowledge of military or Veteran culture. They emphasized a need for education and training for clinicians as well as all persons involved in Veteran support.
- Some organizations indicated an awareness that a lack of education/training may be a barrier to providing successful intervention when it matters most.

**Access to Care**

- Both organizations and individuals identified access to care options as a general but important barrier.
- Organizations emphasized resources, analytic tools, and staffing concerns to address suicide specifically.
- Individuals indicated access issues such as availability of services including immediate and long-term support and access for underserved groups (e.g., women) or services (e.g., same-day mental health).
- Pain management was identified as a barrier by both organizations and individuals, with an emphasis that this needs to be an ongoing effort.

**Health Care Economics**

- Funding for services is a concern identified by both organizations and individuals.
- Individuals identified barriers with disability and insurance claims.

**Data**

- Both organizations and individuals described the need for further data collection efforts.
- Organizations emphasized a need to further analyze existing data.
- Organizations and individuals described how coordinating efforts between systems collecting or analyzing data might improve collaboration to reduce suicide.

**Research**

- Organizations and individuals identified research needs for multiple, co-occurring conditions.
- Organizations and individuals cited a need for research related to military transitions and the connections to suicide risk.
- Organizations and individuals recommended assessing the efficacy of current Veteran intervention programs.

### *VA/DoD Clinical Practice Guidelines (CPG) Recommendations*

Provision of evidence-informed clinical care is now almost universally accepted even if it is not universally implemented. Before changes to treatment, prevention, or other health interventions are introduced to clinical or public health practice, they first must be shown by rigorous research to meet required standards of evidence for safety, efficacy, effectiveness, feasibility, clinical meaningfulness, and importance. In most instances, the highest quality of evidence is established by systematic reviews, meta-analyses, and/or one or more randomized controlled trials.<sup>95,97</sup> In most instances, anything less is viewed conventionally as insufficient for evidence-informed practice.

CPGs provide the most widely recognized authoritative standards for implementation of research into evidence-informed practice. Recommendations for or against a particular practice by CPGs typically result from a systematic review by a panel of subject matter experts of both clinical and epidemiological evidence, informed by the required standards for evidence-informed practice. According to standard VA/DoD guideline development practice, CPG panels assess the strength of each assessment or management recommendation based on confidence in the quality of evidence for that recommendation, difference in magnitude between benefits and harms of the intervention, patient and provider values and preferences, and other factors (e.g., resource use and feasibility). CPG work groups typically use the Grading of Recommendations Assessment, Development and Evaluation system to assess the quality of the evidence base and assign a strength for each recommendation<sup>98</sup> CPG positive recommendations are either *Strong For* or *Weak For*.

A *Strong For* recommendation is defined by the CPG as “high confidence in the quality of the available scientific evidence, a clear difference in magnitude between the benefits and harms of an intervention,” by implication a candidate intervention for implementation. In practice, a *Strong For* recommendation in the 2019 VA/DoD CPG maps closely to the higher accepted levels of evidence for practice. The *Strong For* criterion of a “clear difference in magnitude between the benefits and harms” is an important distinction. CPG *Strong For* recommendations will define the primary evidence-informed practices that have sufficient evidence to be considered candidates for translation or implementation.

In contrast, a *Weak For* recommendation is defined by the CPG as “less confidence” and a belief “that additional evidence may” (be needed to) “change the recommendation.”

By this definition, a *Weak For* recommendation is viewed as analogous to “promising” research with enough rigor and preliminary evidence to track and monitor for future progress, but not (yet) enough to support **full** implementation. Numerous controlled trials of feasibility, psychometrics, acceptability, secondary outcomes, and other aspects of an intervention rated as *Weak For* may already have been conducted and published, but unless one or more studies has shown a clear efficacy/effectiveness of the intervention on the important outcome, more study is needed because the intervention has not yet risen to the level of *Strong For* and it should not yet be implemented. CPG *Weak For* recommendations will define the Additional or Secondary Strategies that currently have insufficient evidence to be considered strong candidates for immediate translation or implementation, but additional scientific evidence might change the recommendation. These strategies are considered “promising.” If implemented, simultaneous evaluation of both operational procedures and outcomes is warranted. See a list of primary VA/DoD CPG recommendations below.

#### **Primary Evidence-Based Practices (CPG *Strong For* Recommendations)**

Two CPG *Strong For* recommendations should be considered for **full** implementation.

**Assessment**—The CPG recommends “an assessment of risk factors as part of a comprehensive evaluation of suicide risk, including but not limited to current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms” within health care settings.

**Psychotherapy**—The CPG recommends “using cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence to reduce incidents of future self-directed violence.”

#### **Additional or Secondary Strategies (CPG *Weak For* Recommendations)**

The following CPG *Weak For* recommendations may be offered as promising practices but are not yet ready for **full** implementation due to their lack of evidence base.

- **Screening**—A validated, **universal screening tool** (e.g., the Patient Health Questionnaire-9 item) to identify individuals at risk for suicide-related behavior should be used. In terms of a Universal Screening Tool, the CPG “...suggest[s] the use of the Patient Health Questionnaire-9 to identify suicide risk.”
- **Non-Pharmacologic Treatment**—In the continuity of care from risk identification through intervention delivery and follow up, a **crisis response plan** for individuals with suicidal ideation and/or a lifetime history of suicide attempts may serve as an adjunctive component of care.

- Non-Pharmacologic Treatment—
  - “... suggest offering **Dialectic Behavior Therapy** to individuals with borderline personality disorder and recent self-directed violence.” Patient profiles including comorbidities, behavioral and psychiatric histories must be considered and may indicate that a targeted treatment to address additional patient needs is warranted (e.g., problem solving-based psychotherapies for: patients with a history of more than one incident of self-directed violence to reduce repeat incidents of such behaviors or patients with hopelessness and a history of moderate to severe traumatic brain injury, DBT for individuals with borderline personality disorder and recent self-directed violence).
  - “... suggest offering **problem-solving** based psychotherapies to a) patients with a history of more than one incident of self-directed violence to reduce repeat incidents of such behaviors; b) patients with a history of recent self-directed violence to reduce suicidal ideation; c) patients with hopelessness and a history of moderate to severe traumatic brain injury.”
- Pharmacologic Treatment— “In patients with the presence of suicidal ideation and major depressive disorder,” the CPG “... suggest offering **ketamine** infusion as an adjunctive treatment for short-term reduction in suicidal ideation.” There are both a number of fast acting and traditional pharmacologic treatments available with FDA indications for use. In some cases, medication must be delivered under an FDA approved Risk Evaluation and Mitigation Strategy. It is clear that there is no single medication that is universally indicated to prevent suicide and the often-complex psychiatric profile patients present with.
  - “... suggest offering **lithium** alone (among patients with bipolar disorder) or in combination with another psychotropic agent (among patients with unipolar depression or bipolar disorder) to decrease the risk of death by suicide in patients with mood disorders.”
  - “... suggest offering **clozapine** to decrease the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt(s).”
- Post-acute Care—
  - “... suggest sending periodic **caring communications** (e.g., postcards) for 12-24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt.” General support may be conveyed through caring communications (e.g., postcards, letters, texts), for 12 to 24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt.
  - “... suggest offering a **home visit** to support reengagement in outpatient care among patients not presenting for outpatient care following hospitalization for a suicide attempt.”
- **Other Management Modalities**—Voluntarily reducing **access to lethal means** may decrease suicide rates at the population level.



## *Data Types and Funding Sources*

<b>Data Type or Title</b>	<b>Data Steward and/or Funding Source</b>
<b>Electronic Health Records</b>	VHA, DoD, and private health systems
<b>Claims Data</b>	Centers for Medicare & Medicaid Services
<b>Social and Community Measures</b>	U.S. Census Bureau, other public records systems
<b>VA/DoD Mortality Data Repository</b>	VA/DoD Board of Governance; VA/DoD
<b>DoD Suicide Event Report (DoDSER)</b>	DoD
<b>National Death Index</b>	CDC
<b>National Violent Death Reporting System</b>	CDC
<b>National Vital Statistics System</b>	CDC
<b>Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal Injury Data</b>	CDC
<b>WISQARS Nonfatal Injury Data</b>	CDC
<b>Wide-ranging Online Data for Epidemiologic Research (CDC WONDER) reporting system</b>	CDC
<b>The National Survey on Drug Use and Health</b>	SAMHSA
<b>Youth Risk Behavior Surveillance System</b>	CDC
<b>Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)</b>	Interuniversity Consortium for Political & Social Research (ICPSR), DoD, NIH
<b>Congressionally Directed Medical Research Program (CDMRP)</b>	DoD
<b>Military Operational Medicine Research Program (MOMRP)</b>	DoD
<b>Millennium Cohort Study</b>	DoD prospective study >150,000 active and nonactive military personnel, all service branches

<b>STRONG STAR Multidisciplinary PTSD Research Consortium</b>	STRONG STAR Multidisciplinary PTSD Research Consortium
<b>Federal Interagency Traumatic Brain Injury Research Informatics System</b>	NIH
<b>Suicide Prevention Applications Network</b>	VA
<b>Behavioral Health Autopsy Program</b>	VA
<b>Veterans Crisis Line/Military Crisis Line</b>	VA

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs



## Chapter 4 State, Local, and Community Action

## Mission and Vision

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The State, Local, and Community Action effort focuses on identifying proven effective elements of community-based efforts and examples of best practices in order to develop a strategy and approach to facilitate the care and support of Veterans and their families. Effective suicide prevention programs and initiatives are critical in the development of comprehensive and coordinated systems of care in our communities. In addition, efforts that focus on empowering individuals and families through nonclinical programs have clear value and play a critical role in overall health and well-being for all citizens. Such nonclinical suicide prevention components may include those related to job training and employment; physical health; alcohol and substance misuse programs; housing, including transitional housing programs; benefits; recreation; education; and faith-based and peer support programs. These services complement clinical efforts to promote a sense of purpose and mission throughout the military life cycle by connecting Service members and Veterans with each other and with their communities through a range of programs that empower and develop independence and well-being.

It is important for the organizations providing these services to collaborate to ensure streamlined care and support for Veterans and connection to a variety of mental health, substance use, and nonclinical services — as well as enhanced coordination, care management, and follow-up for Veterans in crisis.

These community-based suicide prevention efforts must also address the needs of a number of unique and specific groups that include Veterans, including residents of rural communities, tribal communities, and U.S. territories, as well as communities of older adults. Improving suicide prevention for all members of the community will enhance suicide prevention for Veterans in those communities, just as increasing suicide prevention capacity for Veterans in local communities will also help to prevent suicide for all Americans.

## Approach and Objectives

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As stated in the Executive Order, reducing suicide rates requires coordinated suicide prevention efforts and strengthened collaboration across the public and private sectors. To ensure that suicide prevention efforts are both coordinated and adequately resourced, two work groups consisting of subject matter experts from Federal and non-Federal agencies and organizations were convened under the State, Local, and Community Action effort: the Grant Making Work Group and the Community Coalitions and Partnerships Work Group. The Grant Making Work Group focuses on ensuring that suicide prevention efforts are adequately resourced, and the Community Coalitions and Partnerships Work Group focuses on ensuring that efforts are coordinated and include the full range of community and governmental organizations necessary for comprehensive suicide prevention efforts. The specific aims of each work group are described below.

### Grant Making and Legislation

To be responsive to the requirements of the Executive Order and the recognized need for improved infrastructure and funding of comprehensive suicide prevention efforts, a grant-making structure that prioritizes a public health approach is needed.

The State, Local, and Community Action effort seeks to support the development of programs that promote accountability standards and incorporate evaluation metrics, including those that assess technical assistance and collaborative partners, to result in measurable outcomes that may include improved rates of employment, independent living, family or social relationships, and community engagement.

There were four objectives for this effort:

- Create a grant proposal framework to be used for future legislative efforts to establish a structure for making grants to local communities, which will enable communities to increase their capacity to collaborate with each other and coordinate service delivery and resources for Veterans.
- Develop milestones and metrics in pursuit of:
  - Forging community integration that brings together Veterans Service Organizations and Military Service Organizations as well as other community organizations to provide Service members, Veterans, and their families with better coordinated and streamlined access to a multitude of services and supports.
  - Empowering Veterans with a stronger sense of belonging and purpose by better connecting them with each other, with civilians, and with their communities.
- Build upon the foundation of existing suicide prevention efforts and infrastructure to strengthen Veteran suicide prevention efforts, improve coordination, and minimize duplication of effort.
- Support whole-of-community public health efforts — championed by state and local governments — that deepen the overall PREVENTS public health messaging and efforts.

## Community Coalitions and Partnerships

Successful implementation of a public health approach requires that communities have:

- Strong partnerships among a diverse set of public and private stakeholders.
- Infrastructure to support the coordination of information on effective practices, programs, and resources while avoiding duplicative efforts.
- Human and financial resources to implement community interventions.
- Capacity to collect data and evaluate progress.

One mechanism for convening such a diverse group is a community coalition. Community coalitions bring together multiple stakeholders with diverse essential capabilities and backgrounds, engaging partners to work collaboratively to achieve a common purpose or reach agreed-upon goals. No single entity can provide the full array of resources to meet the evolving needs of Service members and Veterans in their local communities. Successful coalitions must bring together diverse stakeholders at the national, state, city, county, territory, and tribal levels to build a robust infrastructure capable of connecting those in need with effective interventions and services. Such coalitions should involve faith-based, nonprofit, and corporate members; they should represent diverse sectors such as workplaces, educational institutions, first responders, and more.

The Community Coalitions and Partnerships Work Group developed the Community Integration and Collaboration Proposal, a part of the PREVENTS Roadmap that outlines improved coordination and alignment of existing efforts and services for Veterans to promote their overall quality of life.

The proposal has three main objectives:

1. Articulate standards of community collaboration for Veteran suicide prevention. The proposal highlights the types of individuals, groups, and community-level organizations that make up strong coalitions. It also describes the existing infrastructure, resources, and common elements found in a sample of coalitions from across the country.
2. Demonstrate at a tangible, practical level how coalitions and partnerships enhance or improve a Veteran's ability to access the help that is needed when it is needed. The approach goes beyond simply providing evidence-informed behavioral health practices and services; instead, it aims to shift the culture to normalize seeking help and allow for a stable, comprehensive, coordinated Veteran suicide prevention program at the community level.
3. Identify opportunities and develop recommendations to improve upon what exists as well as to determine what is needed. The proposal shares insights from experts and key stakeholder groups about how the Federal government can work to both sustain and improve the vital lifesaving efforts underway to address suicide for our Nation's Service members, Veterans, and their families.

## Current State

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*"Honor to the soldier, and sailor, everywhere, who bravely bears his country's cause.  
Honor also to the citizen who cares for his brother in the field and serves...the same  
cause." — Abraham Lincoln*

The words of President Lincoln illustrate that caring for those who served in the U.S. armed forces is a shared responsibility that extends to all citizens in whatever way they can assist. The devastating loss of life to Veteran suicide requires our entire Nation to come together to take action. Suicide prevention-focused community coalitions, and the subsequent partnerships that they bring forward, provide an opportunity for civilians to serve and support Service members, Veterans, and their families. These coalitions and partnerships also serve as a vehicle for Veterans to continue to serve while they support those communities that they protected while in uniform.

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*Coalitions are defined as alliances created out of a diverse set of stakeholders who  
work together on a combined action, for a shared cause.*

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Coalitions allow communities to achieve outcomes through a collaborative and adaptable process that safeguards the public's use of resources. Coalitions typically come together to work on education, awareness, service delivery, and advocacy to solve complex challenges in the community or region.

Psychologists highlight that community coalitions represent a structure that can be used to facilitate change in almost every community and are a highly utilized vehicle in the public health field.<sup>99</sup> Coalitions and partnerships are ideal mechanisms to engage stakeholders at the local level.

## Building Coalitions – Existing Guidance and Resources

Many Federally created resources are available to assist communities in developing successful coalitions. Creating a Federally led coalition focused on suicide prevention would allow for infrastructure to be bolstered and improve communities' capacity to adopt the public health approach to support Service members, Veterans, and military families.

Below are two examples of coalition-building strategies that could be adapted for broader application:

### 6 Steps for Building an Effective Coalition

<b>1</b>	Develop your leadership team
<b>2</b>	Recruit diverse community organizations and convene the coalition
<b>3</b>	Assess community strengths, assets and resources
<b>4</b>	Develop a community action plan with feasible and appropriate goals, objectives and strategies
<b>5</b>	Implement and sustain policy and environmental change strategies to reach goals
<b>6</b>	Evaluate and improve the coalition and its strategies

Figure 4-1



Figure 4-2

There are countless resources and frameworks, such as the [Collective Impact Framework](#), that can be used as resources for coalitions to seek guidance as they begin this process. The [Suicide Prevention Resource Center](#) and the [National Action Alliance for Suicide Prevention](#) offer the most robust collection of resources on this topic for the general population.

The PREVENTS Office can advance and support community-level suicide prevention efforts by working to adapt existing coalition toolkits and resources to be culturally competent and inclusive of specific factors related to Service members, Veterans, and their families.

Most of the existing toolkits and resources lack specific details about how to appeal to and engage Service members, Veterans, and their families on the topic of suicide prevention. Together With Veterans, a rural Veteran suicide prevention program focused on engaging Veterans, is one notable exception to this. The Veteran population can offer unique, firsthand insight into their lived experiences. Veterans have a shared cultural competency that requires very little formal training to connect and relate to other military and Veteran families.

## Infrastructure, Programming, and Resources at the Federal, State, and Local Levels

In a landscape with limited resources, efforts that emphasize and support coordinated, cross-sector collaboration are critical for leveraging data and resources that exist at the Federal, state, and local levels. The programs, staffing, and resources offered can particularly benefit community coalitions and partnership efforts. To ensure that suicide prevention activities achieve their maximum impact and do not become fragmented and disconnected, there must be an infrastructure in place to support these efforts. The Substance Abuse and Mental Health Administration's National Strategy for Suicide Prevention Implementation Assessment Report<sup>1</sup> found that a comprehensive suicide prevention approach in states and communities is hampered by the absence of state, tribal, and community infrastructure. Examining the infrastructure in place across the Federal, state, and local systems was a critical step in identifying gaps and opportunities.

### Federal Systems

The three primary departments that lead suicide prevention efforts at the Federal level are the Department of Veterans Affairs (VA), the Department of Health and Human Services (HHS), and the Department of Defense (DoD). This section of the PREVENTS Roadmap includes an appendix that highlights, in detail, the programming that is available. It focuses on programs, staffing, and resources that particularly benefit community coalitions and partnerships efforts.

#### Department of Veterans Affairs — Current Initiatives

VA's Office of Mental Health and Suicide Prevention (OMHSP) has the most robust Veteran-specific suicide prevention programming at the Federal level. OMHSP has led national campaigns, such as the [Make the Connection](#) and the [Coaching Into Care](#) programs. These efforts educate, support, and empower Veterans' families and friends to find information and services to help care for Veterans and encourage them to get support when they need it. VA's Suicide Prevention Program (SPP) within OMHSP directs VA's suicide prevention efforts for all Veterans, both inside and outside the Veterans Health Administration (VHA), through community-focused interventions, outreach, and resources.

One of the most valuable staffing resources that comes from this office is the Suicide Prevention Coordinator (SPC) program. VA SPCs are clinically trained experts who are located at VA medical centers and Veterans Integrated Services Networks (VISNs) nationwide. VA SPCs engage community collaborators to train individuals on suicide prevention practices and ways to connect Veterans to care and support as needed.

Recognizing the opportunity to leverage the power of community support, SPP partnered with researchers at the University of Pittsburgh to create a pilot program in VHA's VISN 23, which covers several Midwestern states, to create additional community outreach and support for those in need. Education and outreach specialists were trained to build local coalitions and use public health data to tailor community-specific interventions. This pilot contributed to the development of the Suicide Prevention 2.0 effort, a national staffing model for suicide prevention at VA designed specifically to reach Veterans who are not currently enrolled in VA health care. Additionally, SPP partners with SAMHSA for the Governor's and Mayor's Challenges in cities and states across the U.S. to implement suicide prevention best practices in local communities.



VA also houses the Veterans Crisis Line/Military Crisis Line (VCL/MCL), the largest clinically trained hotline network for Service members and Veterans, which has responded to over 3.5 million calls since 2007. VA has a robust health care network that provides access to clinical evaluation and health care services for millions of Veterans each year. Coalitions and groups should engage their local VA resource experts to ensure access to expertise and tools through the Federal system.

VA and the Department of Housing and Urban Development (HUD) have also partnered for many years on issuing grants through programs such as HUD-VA Supportive Housing, Supportive Services for Veterans and Families, to prevent Veteran homelessness, given that homelessness is a primary risk factor for suicide.<sup>100</sup> Other preventive VA grant programs include the Adaptive Sports Grant Program, which helps disabled Veterans and members of the armed forces; the State Home Per Diem program; and Highly Rural Transportation Grants, which help Veterans in rural areas travel to VA-authorized facilities.

Additionally, recognizing that Veterans who self-identify as LGBTQ experience higher rates of several health conditions and suicide compared with non-LGBTQ Veterans, VA is working to ensure that high-quality care is provided in a sensitive, respectful environment at all VA health care sites nationwide.

#### **Department of Health and Human Services – Current Initiatives**

HHS houses several operating divisions that focus on supporting communities to address suicide risk. Three that lead the way are the Centers for Disease Control and Prevention (CDC), SAMHSA, and the Health Resources and Services Administration (HRSA).

A public health approach must be data-driven and facilitated by tools and resources that enable states and communities to learn more about the burden of suicide within their own boundaries. CDC tracks suicide rates through the National Violent Death Reporting System (NVDRS) and the National Vital Statistics System (NVSS). The Mortality Data Repository (MDR) is a singular system that integrates Service member- and Veteran-specific data from eight databases across the DoD, VA, and CDC. Also available is the CDC's Web-based Injury Statistics Query and Reporting System (WISQARS), a public-facing online database that provides information about the public and economic burden associated with unintentional and violence-related fatal and nonfatal injury. Beyond data, CDC's [National Center for Injury Prevention and Control](#) offers many tools and resources that aid communities in taking a public health approach to suicide prevention.

SAMHSA has also played a critical role in supporting suicide prevention efforts for the Nation. It supports and partially funds the National Suicide Prevention Lifeline, a network made up of over 150 local crisis centers that provides a 24/7 hotline for individuals in crisis or needing support. The hotline answered more than 2.2 million calls in 2018, and SAMHSA and VA estimate that adoption of a new 988 three-digit national suicide prevention number will significantly increase the number of calls. Many communities elect to use these numbers in media and messaging efforts. SAMHSA is also home to several technical assistance resources through the [Suicide Prevention Resource Center](#) and the [Service members, Veterans, and their Families Technical Assistance \(SMVF TA\) Center](#). A growing portfolio of community and state-based grants for community-based suicide prevention is overseen by SAMHSA's Center for Mental Health Services, Suicide Prevention Branch.

Since 2017, SAMHSA has collaborated with VA to provide cities and states with the tools and technical assistance needed to adopt a public health suicide prevention model, based on VA's National Strategy for Preventing Veteran Suicide, through the Mayor's and Governor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families. Further, SAMHSA is responsible for coordinating the Federal Working Group on Suicide Prevention and participates in the National Action Alliance for Suicide Prevention, a public-private working partnership that advances the National Strategy for Suicide Prevention by collaborating with over 200 organizations.

HRSA has numerous work groups that play a critical role in building community engagement and widespread collaboration. HRSA's Office of Regional Operations was created to improve health equity in underserved communities in 10 geographic areas through on-the-ground outreach, education, technical assistance, and partnerships with local, state, and Federal agencies. Since 2014, Region 8, which is headquartered in Denver, has led a Veterans work group to bring together national, state, and local stakeholders to enhance the effective use of Veteran community care programs, increase Veteran access to community health care services, monitor Veterans' issues, and provide relevant grant funding information and support.

The Region 8 Veterans work group has an established infrastructure, providing an opportunity for expansion for quick and efficient potential support for an agency-wide Veterans' initiative. Expansion efforts can leverage the Region 8 work group's capacity to disseminate information and resources to key Veteran stakeholders, its implementation of successful community-based mental health suicide prevention efforts, and its coordination at the state and local levels. Region 8 expansion efforts may provide the opportunity to rapidly implement PREVENTS recommendations and serve as a model for other local, state, and Federal efforts.

HHS is the largest grant-making agency in the U.S. Most HHS grants are provided directly to states, territories, tribes, and educational and community organizations. Some of these HHS grant initiatives focus on the Veteran population, while others are larger in scope. Some initiatives address preventive services, and others target specific risk factors associated with suicide, such as substance use and domestic violence. Grants such as the Garrett Lee Smith (GLS) Youth Suicide Prevention grants have produced a clear reduction on suicide rates (see Figure 4-3). In addition, the Administration for Community Living awards grants to support nutrition innovation within programs such as Meals on Wheels, which equips drivers in some communities with skills to provide suicide intervention through a program called Applied Suicide Intervention Skills (ASIST). This program teaches participants to recognize when someone may have thoughts of suicide and gives participants the tools needed to create a safety plan.

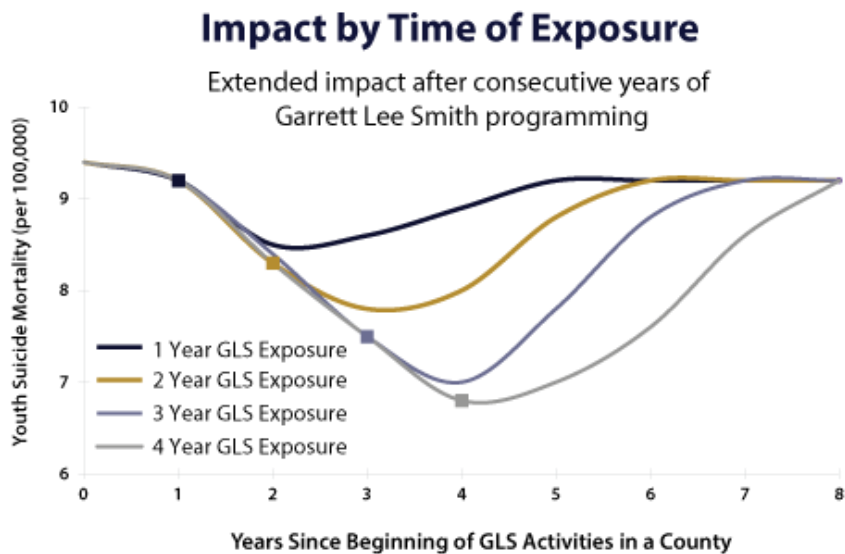


Figure 4-3

#### Department of Defense – Current Initiatives

DoD continues to lead suicide prevention efforts through multiple offices and programs. The Defense Suicide Prevention Office (DSPO), the Office of the Assistant Secretary of Defense for Health Affairs, the military services, and the National Guard Bureau work together to provide an array of nonclinical and clinical support to Service members and their families across the world. DoD works to advance holistic, data-driven suicide prevention initiatives in the military community through policy, oversight, and engagement, both enterprise-wide and in each service (Army, Navy, Marines, and Air Force). To positively impact individual beliefs and behaviors, as well as to instill systemic culture change, DoD actively engages with other government agencies, nonprofit organizations, and the broader community to support Service members and foster a climate that reduces stigma and promotes help-seeking behavior.

In addition to developing, implementing, and assessing departmentwide efforts to prevent suicide among Service members, DoD publishes the Annual Suicide Report, the first of which was published in September 2019. The report released the official 2018 annual suicide counts and unadjusted rates for DoD. It also contained data for military family member suicide deaths for 2017 — the first time this data has been published. Additionally, DoD publishes the long-standing Annual DoD Suicide Event Report, which is used to track and share general and military-specific risk factors that contribute to the occurrence of suicide. This valuable information allows DoD to refine its suicide prevention programs and strategies to better meet the needs of Service members.

The online Defense Suicide Prevention Office's Fulfillment Center provides free resources and materials to organizations that support Service members and their families. DoD also offers free resources through the [Real Warriors Campaign](#), an outreach effort that encourages help-seeking behavior and reduces barriers to seeking care and support for Service members and their families, among other DoD outreach efforts.

The National Guard Bureau (NGB) also plays a large programmatic role in addressing suicide prevention for citizen soldiers and airmen, many of whom do not qualify for VA services because they do not satisfy the criteria for requisite Federal activation. To care for this population, NGB employs Directors of Psychological Health to provide assessment, coordinated care, referral services, and case management to the 450,000 members of the National Guard. Efforts to examine and address gaps in the ability of National Guard members to access care and support are ongoing and have resulted in unique partnerships across DoD, VA, and HHS.

Like VA, DoD has a number of initiatives designed to leverage community coalitions and partnerships to promote the health and well-being of its population. These coalitions help relevant partners at the local, state, and Federal levels to collaborate on behalf of Service members and their families to increase and promote resilience, while working to prevent adverse outcomes that can negatively impact health and wellness. Each of the military services implements unique efforts to leverage comprehensive strategic coalitions, consisting of actionable members who are charged with formalizing prevention efforts and actions across military installations. These are built upon a strong public health foundation — with a focus on health promotion, risk reduction, suicide prevention, overall health, and personal readiness and resiliency — to build and maintain strong and resilient communities.

DoD suicide prevention programs benefit from receiving data from an agency-wide program evaluation framework. This framework informs how military suicide prevention efforts are assessed. The associated logic model begins with aligning the Defense Strategy for Suicide Prevention (DSSP) goals to departmentwide and service-specific initiatives, and then aligning these goals and initiatives to desired outcomes.

### **Programming in Other Federal Agencies and Departments**

Beyond VA and DoD, many Federal agencies offer an array of suicide prevention-focused efforts, including technical assistance programming and operating divisions that have put forward resources and grant funds. For example, The White House has established a VA Hotline, in addition to the crisis lines, which refers at-risk Veterans to the Veterans Crisis Line. The White House also helps to identify systemic issues within VA.

Looking beyond just the departments that have clinical suicide prevention programming is critical when using a public health approach. CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices details strategies that are relevant to the work across several sectors of the executive branch. For example, a suicide prevention strategy of strengthening economic supports would directly benefit from the work of the Department of Labor's Veterans' Employment and Training Service (VETS). Countless other Federal departments and agencies have resources that would benefit this effort. Although not a comprehensive listing of Federally supported programs, VA's National Resource Directory provides a snapshot of the programs that vary in the scope of work, scope of reach (national, regional, local, tribal, and academic), and scope of risk factors.

Communities would benefit from having access to a complete compilation of all executive branch Veteran-focused resources that integrate with the CDC strategies for suicide prevention.

## State Systems

There has been progress in the development of state infrastructure for suicide prevention. Recommendations for improving state infrastructure to achieve effective, comprehensive, sustained suicide prevention were recently published by the SPRC. Currently, there is no formal, nationwide Federal funding mechanism for all states to support comprehensive suicide prevention efforts. While all states have received a SAMHSA youth-focused suicide prevention grant at some point, there is no existing funding that would support coordination and infrastructure for suicide prevention efforts across the life span of a program.

Having a State Suicide Prevention Coordinator (SSPC) to coordinate, monitor, and implement suicide prevention policies, programs, grants, and training is critical; however, many states struggle to fund this role, and SSPCs frequently lack sufficient resources to meet the needs and requests of communities. Some states have assigned a representative to serve as the designee for state suicide prevention, though these individuals may often have other duties outside of suicide prevention efforts. The most coordinated SSPCs perform critical tasks, such as coordinating the development and implementation of a comprehensive approach to suicide prevention, monitoring interagency progress on their state suicide prevention plan, and monitoring implementation of Zero Suicide approach and suicide prevention policies, programs, grants, and training.

The CDC conducted an environmental scan of suicide prevention across all states, territories, and select tribes in 2018. While the official survey results are forthcoming, the scan found that, in general, infrastructure, budgets, and staffing are limited, and there is variation in reported readiness and capacity for public health action. Some states have a statewide group or coalition that assists the state in creating strategic plans for suicide prevention. The work of these groups is critical: It allows key state-level stakeholders to connect and to bring resources and information to inform efforts. However, formal reports on these efforts, while shared often, do not typically go beyond the handful of individuals to whom they are submitted.

While increasing visibility and awareness of these reports themselves will be beneficial, it is not a stand-alone solution. It must be recognized that Veterans who are already experiencing suicidal ideation are not likely to peruse government public health websites for resources. Establishing a shared national suicide prevention communications plan could bring expert communication strategies forward that would then be adoptable to support local coalition efforts, allowing messaging, recommendations, and resource promotion to reach those who would benefit.

SPRC's 2019 guidance document, State Suicide Prevention Infrastructure, outlines how states can work to achieve an effective and comprehensive model of suicide prevention.<sup>101</sup> This document includes six sections on how states can authorize, lead, partner, examine, build, and guide these efforts. This document is unique in its inclusion of sections that directly reference the importance of addressing the needs of Veterans at the state level. While this document was intended for states and macro-level suicide prevention infrastructure development, the six key concepts are also very applicable at the micro level in developing infrastructure across the military life cycle for Service members, Veterans, and their families. More tools targeted to support state leadership that include Veteran-specific components are needed to advance the public health suicide prevention models.

Some states have adopted unique coalition infrastructures to go beyond suicide prevention efforts and focus on statewide coordination of broad public and private Veteran-focused services and resources. The Arizona Coalition for Military Families (ACMF) is a strong example of how a nonprofit, coalition-based organization can help address the needs of this population. ACMF's model and components of its work have been examined and adopted by other states that have had the opportunity to learn from its model of service navigation. There are, however, more avenues and opportunities for state-to-state sharing of innovations concerning suicide prevention that are currently limited by a general lack of resources, awareness, or appropriate infrastructure.

### Local Systems

The coalitions and support groups that serve and touch Service members, Veterans, and their families are at a grassroots level: local municipalities, cities, and counties. While state coalitions can ensure that larger resource-rich partners are present, locally driven efforts and partnerships are where many community services, sources of information, and resources are provided. While some of these community-driven efforts have been sparked by Federal innovations, such as the newly created Community Veterans Engagement Boards (CVEBs) or Mayor's Challenge Suicide Prevention Teams, the work itself is carried out by local leaders and stakeholders. These communities — as well as schools and training centers, houses of worship, and social groups — often have informal information on where Service members, Veterans, and their families live in their communities and how to reach them; they can tailor programming to meet their unique characteristics and needs.

Local systems often have a strong understanding of the needs of their citizens. They should be given the support through larger state infrastructure to have a seat at the table when determining how Federal and state resources are developed and distributed.

However, while there has been some progress in the development of state infrastructure for suicide prevention, there has been much less progress in building community-level infrastructure to support collaboration and coordination in suicide prevention. Critical partners at this level include public health care and crisis systems, faith-based partners, and Veteran-serving care coordination organizations. Peer support and case management system navigators, such as the Texas-based Military Veteran Peer Network (MVPN) and its Texas Veterans + Family Alliance Grant Program, have been widely successful models used to support Veterans across communities. Recent reports show that MVPN peers serve as the gateway to the Veteran community across all 254 counties in the state. No other mechanism for creating community impact, including VA, has demonstrated the same level of Veteran community market saturation that Texas has achieved, and no other coordinated statewide effort exists to meet the mental health needs, including suicide prevention, of Service members, Veterans, and their families.<sup>102</sup>

Faith-based efforts have also been found to be effective in the prevention of suicide. Over the last 50 years, research has consistently demonstrated that high levels of participation in a faith-based community are associated with lower suicide risk and rates.<sup>103,104,105,106,107</sup> For example, the suicide risk for people who never attend religious services is five times greater than that of those who attend religious services at least once a week.<sup>108</sup> There are several factors that may create this protection for people of faith (e.g., moral or religious objection to suicide, increased social connection, and lower levels of aggression, substance misuse, and smoking).

Given the relationship between participation in a faith-based community and a lower rate of suicide, it is important that suicide prevention strategies involve coordination with these communities.

In addition to the protection that an individual's faith provides, faith-based communities can play an important role in overall community health and well-being.<sup>109</sup> Faith-based communities can reach vulnerable populations, including Veterans, with a whole-body-and-spirit approach that allows them to deliver interventions in a culturally competent and holistic manner.<sup>110,111,112</sup> Faith-based organizations can also be important resources for Veterans during their readjustment to civilian life, as they can offer supportive, compassionate, and private environments. In addition to providing support, faith-based organization efforts have also been used to increase physical activity, successfully implement HIV treatment and smoking cessation programs, and improve mental health through the support of faith-based leaders.<sup>113,114</sup>

As more people in the United States are encouraged to seek help for emotional suffering, many may turn to faith-based leaders. Creating partnerships, such as the Mighty Oaks Warrior Program or the Faith-based Veterans Service Alliance, between faith-based leaders, mental health professionals, and community members is helpful in developing effective interventions that support improved mental health and prevent suicide across communities.<sup>115,116</sup>

There are several other organizations with a nationwide or statewide footprint that work to support local communities in these ways. Support groups through local chapters of organizations such as the Tragedy Assistance Program for Survivors and the American Foundation for Suicide Prevention allow individuals to find support in their own backyards or online. The National Alliance on Mental Illness (NAMI) has a nationwide system of support groups for both people with mental illness and their families, some of which offer Veteran-specific groups. NAMI also has Homefront, a six-week, in-person or online course for families, caregivers, and friends of Service members and Veterans with a mental health diagnosis. Other community programs use trained experts to offer care coordination, as in models employed by America's Warrior Partnership and AmericaServes.

## Findings

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### Building Effective Coalitions for a Comprehensive Public Health Approach to Suicide Prevention

#### Key Stakeholders

The existing literature on successful coalitions emphasizes the need to bring together diverse stakeholders at the state, regional, and local levels to identify needs and work collaboratively to build a robust infrastructure capable of connecting service systems and educating the public about critical health messages and resources. The PREVENTS Office found that the most effective partnerships and coalitions include, at a minimum, stakeholders from the following types of groups: Federal, state, and local government agencies; faith-based organizations; tribal communities; nonprofit agencies; philanthropic organizations; health care institutions; private benefactors; educators; criminal justice systems; community advocates; first responders; and public and private professional organizations.



As an example, communities can look to the structure of the National Action Alliance for Suicide Prevention as a model of a public-private partnership that was formed around the shared goal of suicide prevention.

Compared with the coalitions that focus on the general population, there are unique stakeholders that must be considered to reach Veterans in their communities. These include Veteran- and military-affiliated groups and organizations, such as state military departments, National Guard and DoD installation leaders, Federal and state VA offices, community health care providers, and public and private institutions, including universities with student Veteran chapters, schools attended by the children of Veterans, and businesses where Veterans and their families are employed and engage with for services or goods. In order to be successful, coalitions that serve this unique population must also include Veterans themselves, their families, peers, and those who are survivors of suicide attempts or suicide loss.

Veterans Service Organizations (VSOs) that have national and local chapters serving both Veterans and their families are also critical partners. Communities can locate these organizations by visiting the [National Resource Directory](#).

### **Key Components and Common Elements of Successful Coalitions**

In reviewing a sample of effective Veteran-serving coalitions and partnerships, the following common elements have stood out across these models as crucial to their success:

1. Aligning efforts to connect with the five conditions of collective impact: a common agenda, shared measurement, aligned activities, communication, and a backbone team.
2. Taking a flexible, localized approach that allows local experts to inform development of tailored solutions that are unique to the population served while being translational across broader platforms.
3. Leveraging the power of personal relationships within community-based initiatives in order to reinforce broad stakeholder engagement.
4. Providing recognition for shared success and publicly acknowledging and appreciating accomplishments and mutually beneficial outcomes.

### **Engaging Service Members and Veterans in Coalitions**

There is a great deal of activity underway that serves as a strong foundation for additional suicide prevention efforts to support the Veteran and military community. While examining the key components of successful Veteran- and military-serving coalitions and groups, it is important to consider the social makeup of communities as well as the place of Veterans within those communities.

There are a few common factors to keep in mind when considering how best to engage and foster strong relationships with people across the military life cycle and their families living in the community. Beyond increased, improved communications efforts, a shift from the “build it and they will come” model to the “go find them and serve them where they are” model would be beneficial when considering the budgeting, staffing, and strategic planning for all public resources.



For coalitions looking to support and engage military families and Veterans living within their regions, stakeholders have said the message is clear: “Start by going to where Veterans gather.”<sup>102</sup>

**In reviewing current efforts, three concepts that enhanced collaboration in the Veteran space were:**

1. Go prepared to share information about your mission and communicate the need for Veteran and military involvement clearly.
2. Listen to what members of the Veteran community has to say about their local needs and pay attention to the context in which they are sharing.
3. Design the efforts by integrating Veterans’ ideas when possible, communicating, and updating regularly.

## Grant-Making Proposal

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As stated in Executive Order 13861, the PREVENTS Task Force is responsible for developing a legislative proposal to establish a program for making grants to local communities to increase their capacity to collaborate with each other, to integrate service delivery to Veterans, and to coordinate resources for Veterans. The following section is the recommended structure and approach for the legislative proposal.

### Grant Funding Functions

To be able to implement a comprehensive public health approach to suicide prevention that meets the diverse needs that exist among our Nation’s Veterans, the grant-making structure must use various funding mechanisms, each with distinct strengths and weaknesses. The proposed structure will support states and local communities in achieving the goal of reducing Veteran suicide rates through both block grants and discretionary grants, including the permissive use of matching funds. A Federal agency with grant-making authority (e.g., VA, SAMHSA, CDC) will oversee and coordinate grant mechanisms.

One vital function for Veteran suicide prevention grants is to support the basic infrastructure of Veteran suicide prevention efforts within states, territories, tribes, and local communities that is necessary to implement comprehensive suicide prevention programs. This can include building suicide prevention strategic plans, funding statewide suicide prevention coalitions, supporting the utilization of data, funding Veteran workforce development initiatives to empower Veterans, and building replicable suicide prevention programs. To increase the likelihood of successful implementation for all supported programs, the involvement of all state agencies with a role in suicide prevention — including those with data expertise — needs to be facilitated.

The expectation of the state, territory, or tribal government is to leverage collaboration across government entities to reduce waste by maximizing resources and systems coordination to prevent Veteran suicide.

Allowable activities include the following:

- Develop a data-driven, public health strategic plan to prevent Veteran suicide that lays out a roadmap to:
  - Prevent suicide risk before it develops.
  - Support Veterans who are at risk.
  - Prevent recurring suicide attempts.
  - Respond after suicide (postvention).
- Support state, territory, tribal, and community infrastructure to execute the developed public health strategic plan to prevent Veteran suicide. Examples include:
  - Supporting community-based coalitions.
  - Funding state, territory, or tribal Veteran suicide prevention coordinators.
  - Funding local communities to address Veterans' health and wellness.
  - Funding community-based suicide prevention, treatment, crisis intervention, and recovery support services that have demonstrated success in improving suicide-related outcomes (e.g., outreach and follow-up with Veterans in crisis and supporting treatment and recovery support services that are not covered by Medicaid, Medicare, or private insurance).
- Develop or enhance state, territory, tribal, and local government Veteran suicide data collection, evaluation, and interoperable data sharing across multiple agencies that support state, territory, and tribal Veteran suicide prevention programs and initiatives.
- Fund technical assistance that supports state, territory, tribal, and local community strategic plan development, program development and implementation, workforce development, financing, performance measurement, and sustainability.
- Develop Veteran suicide prevention partnership networks that may include state/tribal level partnerships (e.g., involving the mental health authority, public health, housing authority, Veteran services, etc.) and/or local partnerships (e.g., involving Veterans Service Organizations, community-based organizations, faith-based organizations, public health entities, health care providers, etc.).

It is important to identify and engage Veterans within the communities where they live and work. The PREVENTS Office recommends the funding of programs that advance one or both of the following goals:

**Goal 1:** Develop a comprehensive, results-based strategy for reducing the Veteran suicide rate in the community.

**Goal 2:** Reach large numbers of Veterans in the community to increase access to evidence-informed, promising, and/or innovative approaches or supports, while concurrently evaluating their effectiveness and pursuing their sustainability beyond the end of the grant period.

Veterans need easy access to the evidence-informed, promising, and/or innovative services in their communities that empower and enable them to live healthy and fulfilling lives. Partnerships and collaborations are encouraged but not required, given the difficulty that establishing them could pose for resource-poor rural and tribal communities.

Continual evaluation and improvement, shared outcome measurement and accountability, and efforts to build sustainability are also encouraged.

The organizations that receive grants are encouraged to both:

1. Prevent Veteran suicide through upstream prevention.
2. Address the needs of Veterans at increased risk for suicide and/or who are actively suicidal through downstream prevention and intervention.

The PREVENTS grants will provide applicants with the flexibility to address the areas of greatest need among Veterans living in their states, regions, and communities, as well as ensure the collaboration necessary to initiate, continually improve, and sustain action to prevent Veteran suicide.

Allowable uses for grants include funding for:

- Innovative models of reaching Veterans at risk for, or experiencing, social isolation.
- Supporting local community suicide prevention coalitions.
- Building a Veteran peer workforce, which would include evidence-informed approaches for standards, training, and supervision.
- Community suicide prevention programming, including reaching Veterans who are homeless or live in remote or rural areas.
- Care coordination for Veterans in crisis who are not yet enrolled in VHA health care.
- Public health efforts that specifically target Service members, Veterans, and their families.

### **Use of Matching Funds**

To have the strongest possible effort to reduce local Veteran suicide rates, the business, corporate, and philanthropic communities must also be fully engaged. To avoid putting tribes and other communities with less access to corporate or philanthropic funders at a disadvantage in competing for these discretionary grants, a traditional Federal matching requirement is not being proposed.

Rather, the willingness of such funders to participate in this critical effort to prevent Veteran suicide can be maximized by the establishment of an organization modeled after the CDC Foundation. This foundation is used to help the CDC launch new programs, expand existing programs that show promise, and establish pilot projects to determine whether programs should be scaled up — none of which would be possible without external support that complements government investments.

By serving as a strategic implementing partner, a PREVENTS-focused foundation, established to support these efforts, could effectively manage a wide range of collaborations between VA and other Federal partners. The PREVENTS-focused foundation would include the provision of supplemental matching funds for PREVENTS discretionary grants as an initial component. Successful applicants for discretionary grants would be given the opportunity to further extend their reach and impact by applying for dollar-for-dollar matching funds from private donors who may wish to participate. The establishment of such a supporting foundation would include a national advisory council to review requests and recommend matching funding for particularly promising grants.

### **Promoting coordination between states and communities**

A lack of coordination between communities and state efforts and agencies can limit the impact of available programs and resources focused on suicide prevention.

Alignment between states and local communities is critical and should be facilitated and supported whenever possible. Coordinated efforts maximize the likelihood that all Veterans will be aware of the range of systems of support available to them. The following table provides examples of the types of activities that communities and states can engage in and collaborate on to ensure success. Ideally, Federal, state, and local efforts will be aligned to maximize impact by generating new knowledge and effective models that can be deployed broadly.

Table 4-1

Component	
Needs Assessment	Describe the incidence and prevalence of suicide and suicidal ideation, suicide risk and protective factors, and existing suicide prevention programs and infrastructure. Demonstrate how the proposed resource or program will address the local need.
Administrative	Support infrastructure that encourages collaboration and ensures high-quality implementation and evaluation of strategies that address suicide in the general public, with a focus on Service members, Veterans, and their families (SMVF).
Program Development/Implementation	Develop, implement, and evaluate evidence-informed or practice-based programs that address suicide in the general public, with a focus on SMVF, which may include training, education, and support of communities to facilitate a community-based system of care.
Program Evaluation	Demonstrate progress toward outcomes using realistic and achievable measures, including ongoing monitoring of surveillance data about help-seeking behavior.
Collaboration	Stimulate collaboration with community partners (e.g., faith-based organizations, health care providers, and local businesses) to maximize impact and reduce duplication of work at the community level and to promote sustainability beyond the conclusion of funding.

## Eligibility Criteria

Eligible entities for proposed grants would include community-based nonprofit 501(c)(3) or 501(c)(19) organizations; Federally recognized tribes; Veterans and Military Service Organizations; organizations engaged in Governor's and Mayor's challenges or other suicide prevention work; tribal organizations and Urban Indian Organizations providing services to Veterans in urban areas; academic affiliates and educational institutions; private nonprofit health care and hospital systems, health care providers, and clinicians; faith-based and other community, nongovernmental, and nonprofit organizations; and local government entities. State government entities also could apply and must incorporate rural areas of the state into their proposals.

## Application Requirements

All applications must include the following information:

1. Demonstration of burden or need. Grant applicants would be required to demonstrate knowledge of community needs and a description of the level of need in the community based on statistical data, such as the numbers and rates of Veteran suicides and suicide attempts, the poverty rate, rural or frontier location, and lack of services.
2. Demonstrated alignment with the goals and objectives of the National Strategy for Preventing Veteran Suicide and National Strategy for Suicide Prevention.
3. Work plans that demonstrate key action steps, milestones, stakeholder engagement plans, anticipated outcomes, value added components, evaluation, etc.
4. A logic model detailing resources/inputs, outputs, and outcomes (short-, medium-, and long-term) and addressing holistic needs.
5. Signed memoranda of agreement with partners.
6. Demonstrated ability to track and report on outcomes and the ability to effectively implement innovative and/or existing evidence-informed practices.

## Application Review and Scoring Criteria

All grant applications would be expected to show:

- **Data:** Ability to access and monitor suicide morbidity and mortality data/outcomes (e.g., the ability to partner with entities in the community or state that have this data).
- **Coordination:** Demonstrated ability to reduce duplication of effort and increase interoperability and coordination with existing programs and services.
- **Collaboration:** Demonstrated multisector suicide prevention collaboration, including Veterans groups, and memoranda of agreement or letters of involvement from all key local collaborators.
- **Knowledge/Experience:**
  - Demonstrated understanding of public health principles.
  - Demonstrated understanding of or experience with implementing and evaluating a comprehensive public health approach with broad-based universal, selective, and indicated prevention strategies.
  - Demonstrated understanding of or experience with Veteran health issues and risk factors related to suicide and suicide prevention.

Based on the current understanding of best practices for the design and implementation of a coordinated and comprehensive public health approach to suicide prevention, the PREVENTS Roadmap recommends that grant applications be assessed based on whether their efforts contribute to this goal by:

### **1. Using a Collaborative Multisector Approach**

A collaborative multisector approach would engage partners from multiple sectors in Federal, state, tribal, territory, and local government that play a role in Veteran well-being and suicide prevention, including:

- VA and non-VA health care (e.g., hospitals, crisis centers, or behavioral health centers)
- Veterans and Military Service Organizations
- Faith-based organizations
- Community-based organizations (nongovernmental)
- Community services agencies
- Nonprofits and nongovernmental organizations
- Social service organizations with a government underpinning, such as food stamp programs, child family support programs, and aging and disability programs
- Academic institutions
- Law enforcement and criminal justice agencies
- Employers
- Media and entertainment outlets
- Private sector industries
- Public-private partnerships

Additionally, this would include partners from sectors that represent entities focused on social determinants of health and a broad range of suicide risk and protective factors related to:

- Health care (e.g., medical/mental health coverage, provider availability, provider linguistic and cultural competency, and quality of care).
- Community and social context (e.g., social integration, support systems, community engagement, discrimination, and stress).
- Economic stability (e.g., employment, job training, income, expenses, debt, medical bills, and financial support).
- Neighborhood and physical environment (e.g., housing, transportation, and safety).
- Education (e.g., literacy, language, vocational training, and higher education).
- Food (e.g., food security and access to healthy options).

### **2. Using a Public Health Approach**

Creating a comprehensive public health approach also requires access to, and utilization of, multiple sources of data; an understanding of the segments of the population most at risk; implementation of multiple interventions with the best available evidence to reach the populations at risk; and rigorous evaluation.

Therefore, applicants would be expected to show how their efforts are:

- Data-driven (e.g., assessing risk and needs based on population-level data, including evidence-informed practices).
- Population-based for broad impact at multiple levels of the socio-ecological model (individual, family/relationship, community, and societal levels).
- Inclusive of primary prevention (e.g., address a broad range of risk and protective factors, incorporating upstream approaches addressing social determinants of health), as well as Veterans at risk for suicide or in suicidal crisis.
- Multidisciplinary to include perspectives from diverse stakeholders.
- Committed to increasing understanding of suicide prevention through evaluation and assessment.

### **3. Implementing Comprehensive Suicide Prevention**

Comprehensive suicide prevention activities include:

- Evidence-based or evidence-informed interventions, which may be clinical, community, supportive, or educational in nature.
- Multiple prevention strategies (universal, indicated, selective) that are matched to varying levels of risk.
- Prevention policies and programs to reduce suicide risk factors (e.g., gatekeeper training of community and providers, life skills training, stigma reduction, postvention, safe messaging, systems change, promoting connectedness, and workplace wellness policies).
- Activities addressing the needs of individual Veterans within the community response.
- Crisis services and care coordination for Veterans at acute risk, especially those accessing community crisis, emergency, and acute care services, as well as those discharged from community inpatient units and emergency departments.
- Person-centered planning that identifies individual strengths, goals, preferences, needs (for medical and home and community-based services), and desired outcomes, with ongoing case management services addressing a range of needed services.
- Effective services that support recovery-oriented systems of care.
- Stimulating growth of faith- and spiritually based recovery support services and providers in the substance use treatment and recovery field.
- Mental health treatment services.

### **4. Using or Building Upon Existing Infrastructure and Promising Models**

Applications should clearly demonstrate how efforts will use and build upon existing infrastructure to promote collaboration and integration with:

- State/tribal/territory suicide prevention programs/coordinators.
- State suicide prevention coalitions.
- Veteran SPCs.
- Veteran outreach/education coordinators.
- VA Mobile Vet Centers.
- Military bases and installations.
- National Guard units.

Applicants would also be encouraged to refer to current strategic plans as well as promising models of community-based suicide prevention and other successful programs as guides. Recommended programs include:

- Governor’s and Mayor’s Challenges to Prevent Veteran Suicide.
- Colorado Comprehensive Approach.
- No Wrong Door/Aging and Disability Resource Center.
- Veteran Directed Care Program.

## **5. Demonstrating Impact and Sustainability Through Rigorous Evaluation**

Evaluation is a vital part of suicide prevention work. Evaluation helps build knowledge and develop best practices from successes, improve effectiveness and efficiency of programs or processes, and assist in understanding the impacts of suicide prevention work. A successful effort to address Veteran suicide must contain evaluation to allow for continual improvement, accountability, and responsiveness to change in needs over time — and most important, demonstrate that funding is related to saving lives. At the Federal level, metrics and evaluation criteria must be articulated in advance of issuing grants and assessed after issuance on an ongoing basis. The PREVENTS Office will provide the initial framework for evaluation and tracking of both implementation and outcomes. More information about the proposed evaluation framework is presented in the next section.

## **6. Addressing Vulnerable Subpopulations**

Demonstrating an awareness of the needs and barriers of vulnerable populations that are at increased risk for suicide is critical. Unique barriers for these vulnerable groups are presented in detail in Chapter 7: Examples of High Risk Groups. In addition to these subpopulations, other vulnerable groups exist and should also be included in suicide prevention activities.

### **Existing Legislation for Veteran Suicide Prevention**

Current legislation addressing Veteran suicide prevention includes the Joshua Omvig Veterans Suicide Prevention Act (H.R.327)<sup>117</sup>, passed in 2007, and the Clay Hunt Suicide Prevention for American Veterans Act (H.R.203),<sup>118</sup> passed in 2015.

The Joshua Omvig Veterans Suicide Prevention Act (H.R.327) directs the Secretary to develop and carry out a comprehensive program designed to reduce the incidence of suicide among Veterans.

It requires the program to include: (1) mandatory training for appropriate staff and contractors of VA who interact with Veterans; (2) mental health assessments of Veterans; (3) designation of a suicide prevention counselor at each Department medical facility; (4) research on best practices for suicide prevention; (5) mental health care for Veterans who have experienced sexual trauma while in military service; (6) 24-hour Veterans' mental health care availability; (7) a toll-free hotline; and (8) outreach and education for Veterans and their families. These have become foundational elements of VA’s approach to suicide prevention within VHA.



The Clay Hunt Suicide Prevention for American Veterans Act (H.R. 203) was designed to expand suicide prevention programs at VA by increasing access to mental health care by creating a peer support and community outreach pilot program to assist transitioning Service members; developing a one-stop, interactive website of available resources; starting a pilot program to repay the loan debt of students in psychiatry so it is easier to recruit them to work at VA, thus better meeting the demand for mental health care; requiring collaboration on suicide prevention efforts between VA and nonprofit mental health organizations; and boosting the accountability of mental health care by requiring an annual evaluation of VA mental health and suicide prevention programs.

## Evaluation

The proposed grant program will require robust evaluation by all participating grant recipients. Each grant recipient would be expected to follow a process for clearly articulating a pathway by which they intend to prevent Veteran suicide. Each step in the pathway, as well as the overall outcomes, would require monitoring and evaluation.

An example of this can be found in SAMHSA's Garrett Lee Smith Youth Suicide Prevention Grant evaluation study. The initial evaluation showed that counties implementing grant-supported youth suicide prevention activities had lower rates of youth suicide than matched counties that did not. These studies demonstrated that it is feasible for a Federal suicide prevention grant program to be able to demonstrate that it is saving lives.

Applicants would be required to provide a logic model and an evaluation plan. A logic model would show the relationship between community need, proposed activities, and intended outcomes. An evaluation plan would include SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) goals to clearly demonstrate proposed activities and outcomes to identify success. Additionally, this information allows for continual program improvement to maximize health impacts.

Both process and outcome evaluations that assess whether implementation and outcomes are occurring as laid out in the logic model, and impact evaluations that assess overall program effectiveness, would be required for grantees.

### **CDC's Framework for Evaluation**

The six-step CDC Evaluation Framework is a free, publicly available resource that would assist applicants in meeting the evaluation requirements. This framework includes six steps:

- 1) Engage stakeholders.
- 2) Describe the program.
- 3) Focus the evaluation.
- 4) Gather credible evidence.
- 5) Justify conclusions.
- 6) Ensure use and share lessons learned.

In addition to the individual grantee evaluation requirement, the overall PREVENTS grant-making process should include evaluation processes. This continual improvement and measurement would enable identification and promotion of successful activities associated with preventing Veteran suicide.

### **Evaluation Barriers and Challenges**

*Data for Decision-Making.* For robust evaluation to take place, data must be available to identify changes in Veteran suicide rates at the community, state, and national levels. This may require linkages between data sources to accurately identify Veteran suicide attempts and fatalities. Once communities can accurately identify Veteran suicide attempts and fatalities, it becomes possible to examine barriers to accessing and using existing resources and to identify gaps or needs. However, significant barriers exist in data concerning Veteran suicide. Timeliness of mortality and morbidity data is a particular challenge due to a lag in reporting. Data may be inaccessible to communities or nongovernment entities, may not provide Veteran-specific data but rather provide only population-wide data, or may not be conducted on a regular basis (thus making tracking change over time impossible). Further, despite best efforts, variability in data collection methods may also affect the reliability of data.

*Metrics and Indicators.* When complex circumstances contribute to an issue, no single entity or effort can address the issue alone. However, because the number of deaths by suicide in any given community may be relatively small, it is difficult to conclusively attribute any reductions in the number of suicide deaths in that community to the intervention. Further, it is difficult to effectively measure the impact of different interventions that are executed in tandem, especially those supported with separate funding streams. Therefore, even when programs are demonstrated to be effective in reducing suicidal behaviors, they may not be implemented to scale across the country.

To evaluate the success of the PREVENTS initiative, the grant structure requires metrics and indicators to determine improvement and success across grantees.

While specific program evaluation will need customized indicators for their specific intervention, local communities and states need clear shared metrics to show change over time in the numbers of suicide attempts and fatalities in their areas. This allows for targeted efforts where it is most needed for the greatest public health impact. An example is the success of the President's Emergency Plan for AIDS Relief and The Global Fund to Fight AIDS, Tuberculosis and Malaria. These efforts use a scorecard or index with shared metrics and indicators to identify improvements and areas needing attention for the overall prevention effort. Shared metrics and indicators would be similarly valuable in preventing Veteran suicide.

These challenges highlight a key need to establish partnerships and systems (e.g., through hospitals or state epidemiology offices) to share information that is accessible by both state and Federal entities and incorporates all available morbidity and mortality information for a given individual.

### **Evaluation Metrics**

The overall purpose of evaluation in this context is to determine the local and universal impact of the funded initiatives and what key factors led to the success or lack of success of the initiative. This gleans both best practices for implementation in other areas and lessons learned to make sure that the initiative improves with time.

These findings can then be promoted in other areas — ideally, both to achieve a nationwide reduction in the number of Service member and Veteran suicides and to focus on areas not achieving reductions to assist with overcoming barriers.

The Executive Order calls for metrics and milestones that promote:

1. *Improved community integration* that brings together Veteran-serving organizations to better provide Veterans with coordinated care and access to a range of services.
2. *A sense of belonging and purpose*, both among Veterans and between Veterans and their communities.

These are two interim outcomes on a comprehensive pathway to Veteran suicide prevention to include in program evaluation plans.

A mechanism would need to be established for:

- Collecting and reporting to the PREVENTS Office's Federal interdepartmental evaluation group the outcomes mentioned above on a yearly basis.
- Reporting on program outcomes (e.g., number of Veterans served, referrals or linkages to services made, trainings completed, along with measures of Veteran satisfaction, hope, empowerment, and sense of belonging, as applicable).
- Tracking the number of community partnerships and the quality of those partnerships on an annual basis.

Grant recipients would be responsible for:

- Reporting to the PREVENTS Office's Federal interdepartmental evaluation group on program interim and overall outcomes associated with their program plans.
- Tracking the number of community partnerships as well as the quality of those partnerships.
- Tracking results of surveys on Veteran suicide risk and protective factors. These may also be collected and reported in aggregate by organizations.

Given the expected diversity of types of interventions that local grantees may try, a methodology may be used in which grantees are asked to categorize their interventions using a framework such as the CDC Technical Package's seven types of suicide prevention strategies.

It is anticipated that a measure of intensity (e.g., reach, number of strategies used) would also be included. The PREVENTS Office would work with national experts to establish an overall evaluation plan for estimating the impact on the numbers of Veteran suicide deaths and attempts.

### **Technical Assistance**

The PREVENTS Office recommends that technical assistance (TA) be provided to both grant applicants and grant awardees. TA for grant applicants should include the use of conference calls and webinars to help applicants understand the basic grant application requirements. The evaluation requirements may be challenging for some applicants to successfully address without pre-award TA. However, this assistance would be limited to provide equal opportunity for selection among all applicants while also not providing unfair advantage to any specific grantee (e.g., a webinar about conducting a query within a public access database).

TA for grant awardees would include support in accessing and using data to clarify the grantee’s logic model and evaluation plan, translating intended goals into implementation, ensuring the collection of appropriate metrics to report outcomes, and helping to assess outcomes and program effectiveness. TA should also assist with implementation challenges and barriers and facilitate learning and sharing across grantees. TA would need to be available to support the development and execution of evaluation plans. Tribes and territories may have particular needs for such TA. In addition, TA should draw upon the expertise of existing Federal TA resources to build capacity among those government entities. A successful example of this can be found in the Building Evaluation Capacity Among Veteran Serving Organizations collaborative project by the CDC and the CDC Foundation.

## Recommendations

The PREVENTS Office makes the following recommendations for state, local, and community action and recognizes that some of these recommendations may already be embedded as aspects of current or future funding initiatives. Others may be more aspirational in nature and are noted with an asterisk.

Table 4-2

Recommendations
<p>Establish a grant-making program that:</p> <ul style="list-style-type: none"> <li>▪ Is supported through coordination between Federal, state, local, tribal, and territory entities.</li> <li>▪ Funds programmatic and innovative approaches at the community level (e.g., through faith-based, private, and nonprofit organizations), including the use of philanthropic matching funds to help empower individual Veterans.</li> <li>▪ Helps to prevent Veterans from becoming suicidal and ensures that Veterans in suicidal crisis receive high-quality care, regardless of where in the community they might be encountered.</li> </ul>
<p>Provide comprehensive and high-quality technical assistance to both grant applicants and grant awardees.</p>
<p>Establish a Federal interdepartmental evaluating team, initially within the PREVENTS Office, to create a structure in which grant data are assessed and reported on an annual basis and where progress in reducing the numbers of Veteran suicides, suicide attempts, and Veterans seriously considering suicide can be assessed at the national level.</p>
<p>Ensure an annual review across Federal departments of suicide-related data and surveillance with analysis of implications of current data for suicide prevention. Include this as a component of the Federal Working Group on Suicide Prevention’s annual report.</p>
<p>Establish a sustainable funding mechanism for supporting care coordination (including telephonic follow-up) for Veterans who are in contact with community crisis and emergency systems.</p>

Recommendations
<p>Improve data systems that track Veteran status. For example, increase access to and use of National Survey on Drug Use and Health data on Veterans, including Veteran suicidal ideation, plans, and attempts; update annually the latest VA state summaries; encourage updating of the Census Bureau's State Veteran profiles; and encourage existing systems that do not include Veteran status, such as hospital non-personal discharge data, and emergency department data, to add Veteran status.</p>
<p>Require all Federally provided grants and programs that focus on suicide prevention to include, where appropriate, outreach to military and Veteran populations within the areas they plan to serve.</p>
<p>Work to increase government-collected data on minority Veterans groups and tailor programming to those groups through annual review by the PREVENTS Office.</p>
<p>Enhance state suicide prevention infrastructure.</p> <p>Provide funding to states that need an SPC and require engagement with Veteran suicide prevention. For states that have an SPC, fund a plan for public health approaches that will require further infrastructure development for sustainable suicide prevention and Veteran and military integrated strategies and programs and to ensure that Veterans receive a follow-up contact at 24, 48, and 72 hours after initial counseling.*</p>
<p>Increase the use of suicide risk screening and safety planning in community emergency departments along with appropriate referral and follow-up to VHA or community care.</p>
<p>Incorporate a family education and support component in grant-supported Veterans' programs, unless the Veteran does not consent or it is an emergency.</p>
<p>Fund an additional SPC (40-hour or full-time equivalent) for each state who will serve as a military and Veteran expert. This individual would coordinate with the existing state SPC and connect with the VHA and DoD/National Guard Bureau SPCs and the community-based suicide prevention/local coalitions. They would be responsible for integrating Service member- and Veteran-specific content into the state suicide prevention plan annually. They would also coordinate policy and projects to advance statewide coordination of military and Veteran behavioral health and suicide prevention initiatives and identify service gaps for Veterans at risk for suicide.*</p>
<p>Develop community-based programs that identify and build resources for the National Guard and Reserve.</p>
<p>Create an interdepartmental Federal monitoring team within the PREVENTS Office focused on the management of government resources designed to serve Veterans and Service members to ensure effective and efficient use of funds and integration of ongoing state and Federal suicide prevention efforts.</p>

Recommendations
Create an interdepartmental Federal monitoring team within the PREVENTS Office focused on the management of government resources designed to serve Veterans and Service members to ensure effective and efficient use of funds and integration of ongoing state and Federal suicide prevention efforts.
Ensure continued progress and implementation of recommendations from Executive Order 13822, <i>Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life</i> , focused on the period of transition from active duty to Veteran status.
Encourage faith-based organizations to develop specific Service member- and Veteran-focused ministries.
Encourage faith- and community-based educational programs and support services focused on strengthening families.
Identify and strengthen faith-based and community programs that focus on empowering Service members, Veterans, and their families.
Expand Department of Housing and Urban Development – Veterans Affairs Supportive Housing vouchers and promote eviction prevention programs.*
Encourage the designation of SPCs in community mental health centers to serve as liaisons with VA SPCs to ensure care coordination as well as support adherence to the requirements and recommendations of the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.
Increase the outreach that crisis lines make to Veterans’ families, friends, and co-workers and ensure family member input.
Identify, train, and recruit more “nonclinical” community partners, such as veterinarian offices, faith-based communities, and animal shelters or motel owners and operators, who can serve to identify and assist people in crisis or stress who may be suicidal.
Develop an online clearinghouse that includes resources and guidance, to be hosted on the PREVENTS and/or partner websites.
Increase access to peer and family support networks in community settings for Veterans and their families and explore evaluation of “caring contacts” projects to decrease risk after hospitalization and increase access to follow-on treatment.
Enhance training in military culture and awareness of Veterans and military resources by community-based crisis centers and increase collaboration with the Veterans Crisis Line. Maximize use by Veterans through alternatives such as chat and text.

Recommendations
Increase training for homeless and housing agencies, employment and financial services agencies, and faith-based communities on suicide warning signs and how to effectively refer Veterans to needed health care and other services.
Develop local VHA SPCs to help with outreach and training among community stakeholders, including faith-based leaders, to help provide public health leadership and coordination in their communities, including identification of service gaps.*
Adapt existing frameworks and coalition toolkits to be culturally competent and tailored to Service members and Veterans.
Develop more tools for state leadership that include Service member- and Veteran-specific components to advance public health suicide prevention models.
Encourage the development and posting of annual statewide coalition reports on a publicly accessible, web-based platform that would also house resources and offer opportunities to share promising efforts and best practices.
Provide additional staffing support for the Federal Working Group on Suicide Prevention — a part of the National Action Alliance for Suicide Prevention — through the PREVENTS Office or other means — and require annual reports on the status of suicide prevention efforts, including those for Veterans, and recommendations for needed improvements.
Create a comprehensive catalog of Federal resources, tied to the CDC's Preventing Suicide: A Technical Package of Policies, Programs, and Practices, that is available for a review of gaps and shared with states and communities.

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs



## Chapter 5 Workforce and Professional Development



The Workforce and Professional Development (WPD) effort focuses on the essential role of the workplace in the lives of Veterans and their families and the communities in which they live. The focus on reaching Veterans in the workplace provides a critical opportunity to influence health and well-being for Veterans — and, by extension, all Americans. Because not all Veterans who die by suicide are connected to the Department of Veterans Affairs (VA), the workplace offers an important opportunity to reach some of those individuals.

## Background

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The burden of suicide continues to significantly impact all demographics of the U.S. population. In 2017, of those who died by suicide, working-age Americans, ages 24–64, carried the largest burden.<sup>119</sup> While the workplace can be a source of unique risks, it also provides many opportunities for employees to gain a sense of fulfillment and build positive connections. The U.S. workforce, including Veterans and their families, can benefit from universal public health efforts to promote health and wellness in workplace settings.

Professional training and employee health programs found in healthy work environments can have a positive impact on Veterans and provide essential resources, particularly for those who may not have access to VA services. Having a healthy, well-trained, and fulfilled workforce is critical not only for employers but also for Veterans and society at large. Because beliefs continue to shift within the workplace and there is currently an increasing focus on the importance of health and well-being, the PREVENTS Office determined that a Workforce and Professional Development (WPD) effort would be helpful to glean promising practices and opportunities, share lessons learned, and make recommendations for best workplace wellness practices across the private, public, and academic sectors.

In order to better understand the need for a dedicated chapter focused on workforce and professional development, it is useful to understand the history, risks, impact, and costs versus benefits associated with the inclusion of proper mental health and suicide prevention practices and policies in the workplace.

### History of Mental Health and the Workplace

Wellness within workplace culture within the U.S. has evolved since the 1970s. Over the past 50 years, there have been meaningful steps taken on the national, state, and local levels to support and improve employee health and wellness, including specific efforts focused on suicide prevention. The passage of the Mental Health Parity Act of 1996 (MHPA),<sup>120</sup> which requires insurance companies to cover mental health care, was a significant moment. Prior to passage of this law, coverage varied widely across the country, which resulted in limited access to care.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) went further than MHPA by including treatment for substance use disorders (SUD) and by mandating that covered plans and issuers provide comparable coverage for mental health and substance use (MH/SU) services and medical-surgical benefits. The law also prohibits the imposition of copayments, deductibles, or other costs for MH/SU care that are substantially greater than those that apply to all medical-surgical benefits in the same classification. While MHPAEA neither requires coverage of MH/SU nor specifies which treatments or procedures should be covered as a mental health condition or SUD, MHPAEA regulations provide guidance on how one determines which MH/SU and medical-surgical services should be deemed comparable for purposes of determining compliance with the law.

With the increased focus on employee health came funding efforts such as the “President’s New Freedom Initiative,”<sup>121</sup> which promoted the Americans with Disabilities Act and encouraged the full participation of people living with disabilities, including mental health-related disabilities, in all areas of society. The law increased access to assistive and universally designed technologies, expanded educational opportunities, increased integration into the workforce, and promoted increased access into daily community life.

## Good Mental Health Is Good Business

Negative perceptions about mental health challenges — or stigma — have been identified as critical barriers to the implementation of effective workplace wellness, in addition to employees seeking help and resources provided by their employers.

Employers are also increasingly aware of the importance of employee mental health, and many are in various stages of developing programs that will support their workforce. One indicator of increasing employer interest in employee health and wellness is the development of organizations focused on mental health within the workplace and the increase in national convenings, such as the One Mind at Work annual conference. One Mind is a national nonprofit organization that amplifies mental health research and develops cross-sector collaborations. This organization convenes innovators in clinical, research, and advocacy settings and provides funding and advocacy to improve the field of mental health. The One Mind at Work branch brings together private and public sector employers, as well as mental health experts, to discuss innovations in the field of mental health and their application to the workplace.

At the 2019 One Mind at Work convening, attendees from across sectors described “whole health,” including mental health and well-being, as the “last frontier” for employers. Participants noted that research, national efforts, and legislation lagged in drawing the connection between mental well-being and work outcomes. Participating employers noted an interest in the need to proactively address mental wellness and offer options for addressing mental health, from episodic crisis to chronic conditions. This new way of thinking among organizational leaders is a positive first step in developing programs, services, and a culture that fosters holistic care.

Other significant examples of organizations that have developed and promoted programs to improve mental health in the workplace include:

- American Psychiatric Association Foundation (APAF): APAF’s Center for Workplace Mental Health<sup>122</sup> collaborates with employers across the country to improve awareness and understanding of mental health issues that can impact the workforce and to destigmatize, promote, and improve employee access to mental health resources.
- American Psychological Association (APA): The APA Center for Organizational Excellence<sup>123</sup> provides mental health education and resources for organizations across all sectors in the U.S. and Canada. These resources include support for program and policy implementation designed to improve employee health, employee well-being, and organizational performance.
- Mental Health America: Workplace Mental Health supports employee health through data collection efforts such as the Workplace Mental Health Survey. The 2019 survey captured responses from approximately 10,000 employees across the U.S. concerning communication, company culture, and employee engagement and well-being. These results are available for employers across sectors to review.<sup>124</sup>

- The Path Forward for Mental Health and Substance Use:<sup>125</sup> The Path Forward represents the collaborative efforts of the National Alliance of Healthcare Purchaser Coalitions, American Psychiatric Association Foundation, and Meadows Mental Health Policy Institute. These organizations created a targeted approach for private sector employers to utilize best practices that focus on mental health and substance use.
- Employee Assistance and Resource Network on Disability Inclusion (EARN): EARN'S Mental Health Toolkit provides background, tools, and resources that can help employers learn more about mental health conditions and create a safe, welcoming workplace for employees who may be facing mental health challenges.

### Suicide Risk in the Workplace

Suicide prevention research has become focused on how and why different populations can be stratified for based on suicide risk. According to the Centers for Disease Control and Prevention (CDC),<sup>126</sup> 46% of individuals who die by suicide have a diagnosable mental health condition.<sup>127</sup> In addition, research has found that mental health disorders account for almost one half of the disease burden among young adults in the U.S.<sup>128</sup> This amplifies risk for many college students within this age group, particularly since the onset of most lifetime mental health disorders occurs by age 24.<sup>129</sup> While mental illness is a common human condition across ages and groups, situational crises brought on by life events and risks specific to certain industries also point to a need for a broad public health approach that reaches everyone.

In addition to differences across age ranges, different professions are associated with distinct risk factors. Certain professions require work and create conditions that may increase employees' risk for suicide due to the levels of repeat exposure to strain, pressure, or trauma.<sup>130</sup> In 2018, the CDC published Suicide Rates by Major Occupational Group– 17 States, 2012 and 2015 listing the 10 industries with the highest suicide risk based on 2012 and 2015 suicide data from 17 states.<sup>131</sup> Considering reports that suicide rates in the U.S. have reached a historic high, the lack of more current, detailed, and inclusive suicide data segmented by profession is of concern.

The following industries appear to have elevated risk for suicide: construction and extraction; arts, design, entertainment, sports, and media; installation, maintenance, and repair; transportation and material moving; production; first responders (e.g., police, ambulance personnel, etc.); protective services; building and grounds cleaning and maintenance; health care practitioners and technicians; farming, fishing, and forestry; and sales and related work. Given the higher suicide risk in these industries, workplace suicide prevention efforts in organizations within these sectors have an even higher potential to reach people who are directly impacted by suicide and experiencing increased suicide risk.

### Impact and Cost-Benefit Analysis of Suicide Prevention in the Workplace

Untreated mental illness and suicidal behavior can lead to higher health care costs for employers. Mental health conditions are some of the most expensive conditions affecting employers in the U.S.<sup>132</sup> In fact, mental health conditions have been found to be more expensive than cancer, obesity, heart disease, and stroke. Approximately one third of this cost burden has been tied to loss in productivity, diminished work performance, and disability-associated absence.

In 2018, mental illness costs for the U.S. were upwards of \$193.2 billion in lost earnings per year<sup>133</sup> and, currently, depression is thought to account for up to 200 million lost workdays — or \$16.8 billion in lost employee productivity — each year.<sup>134</sup>

Conversely, when employees with depression are connected to mental health care and receive treatment, 86% showed an improvement in work performance.<sup>135</sup> Additionally, some studies have found that the treatment of depression has been shown to decrease absenteeism and presenteeism (working while ill or injured) in employees by 40% to 60%.<sup>135</sup> Furthermore, when looking at the cost-benefit analysis of employee assistance programs (EAPs), it has been found that for every dollar spent, there is an expected return on investment in the range of \$5.17–\$6.47. These analyses do not include the impact on employee risk and morale when there is a suicide of a coworker or on a job site.<sup>136</sup>

### Cost-Benefit Analysis of EAPs

**86%** *of employees who were connected to care and received treatment showed an improvement in work performance and a decrease in absenteeism and presenteeism*



*For every dollar spent there is an expected return on investment in the range of \$5.17-\$6.47.*

Figure 5-1

The emotional and economic impact of employees who attempt or die by suicide is also significant — not only to the organizations they are a part of but also the communities they interact with and support. Suicide deaths on a job site are associated with significant costs from work stoppages and postvention care of surviving employees. Furthermore, there is an invisible cost to recruiting and retaining a high-quality workforce in professions whose members are seen as prone to suicide.<sup>137</sup>

In the wake of any loss related to suicide, employee morale and productivity can decrease if a workplace culture does not provide proper support. Surviving employees can often feel complex and long-lasting emotions including grief, guilt, and trauma. Due to the discomfort and cultural barriers often associated with discussing the topic of suicide, organizational leaders can play a critical role in modeling appropriate responses and providing support and guidance on how to respond to a coworker who has engaged in self-harm. This assists employees who have lost someone to suicide and employees who may be struggling with suicidal thoughts or mental illness.

## Approach and Goals

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### Key Objectives and Work Group Stakeholders

#### Key Objectives

The Workforce and Professional Development (WPD) effort was charged with reviewing the existing practices of Federal agencies, public and private sector organizations, and academic institutions pertinent to mental health in the workplace. The WPD effort developed an initial set of recommendations that aimed to identify organizational actions for employers to:

- Create a workplace and academic culture emphasizing the importance of integrating mental health and wellness.
- Adopt policies promoting and facilitating evidence-informed approaches to suicide prevention.
- Ensure that employees receive comprehensive end-to-end mental health and suicide prevention care.
- Ensure that health professionals receive the training and development required to identify those who are at risk and provide them with well-informed care.

The initial recommendations are meant to be shared with all employers to encourage the broad adoption of comprehensive suicide prevention packages for employees.

#### Environmental Scan

A key objective of the WPD effort was to identify existing employee mental health and “whole health”<sup>138</sup> resources and amplify better practices for employers to follow. In order to obtain a baseline understanding of the existing landscape, a preliminary environmental scan was conducted across the Federal, public, private, and academic sectors. This initial scan aimed to identify best practices and existing gaps among various organizations and agencies as the first step of a larger effort to gather information.

The environmental scan survey was sent to all Federal agencies as well as interagency groups, such as the Chief Human Capital Officers Council. Respondents were asked to provide information on collective mental health and wellness efforts within their organizations. Additionally, the scan sought to learn about which efforts had the potential to be adapted and amplified across the Federal government to reduce suicide rates both generally and among the Veteran population. Examples of the resources submitted from respondents included:

- Screening tools that identify individuals potentially at-risk
- Compassionate customer service training
- De-escalation protocols
- Destigmatizing efforts with respect to mental health
- Internal mental health and counseling resources
- Peer-based support programs

## Stakeholder Engagement and Literature Review

To gain a preliminary understanding of the prevalence of programs dedicated to mental health and emotional well-being, as well as of the ease of access and types of mental health services being offered by employers, the WPD effort conducted an initial review of existing mental health and suicide prevention programs using a multipronged approach. This approach included:

- Discussions with thought leaders across academia, private and public sectors, professional groups (e.g., physicians, nurses, psychologists) and Veterans Service Organizations (VSOs).
- A preliminary literature review of existing workplace mental health resources.
- A comprehensive online search to identify programs from academia, public and private sector organizations, insurance companies, and advocacy groups.
- A review of current scientific research regarding prevalence, risk, protective factors, and national trends on suicide.

This literature review revealed four areas of needed concentration:

- Improve quality and quantity of data.
- Provide support systems in the workplace to decrease risk.
- Provide training and education so that individuals in the workforce can recognize people at risk and identify sources of help.
- Mitigate psychological harm in the face of workplace violence involving a crisis event (e.g., suicide, homicide, or acts of terrorism).

These four areas underscored the importance of the overarching goal of the WPD effort: namely, to improve how mental health is addressed in the workplace.

## Current State

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When approaching suicide prevention, the workplace offers an excellent opportunity to engage employees, including the majority of Veterans who are not connected to VA, and empower them to become part of the cultural change needed across the country. Experts in workplace suicide prevention note that there is currently great opportunity to raise awareness, lead workplace culture change around suicide and mental health, and influence the development and implementation of best practices. Strategies for employers include providing education and training programs that foster psychological safety, offer self-help tools for employees, and increase employee access to and navigation of available resources.<sup>139</sup>

According to the CDC, weaving mental health efforts into workplace culture and providing whole health resources for an employer's workforce is key to improving productivity, reducing turnover rates, and providing a healthy place of work for their employees. Because of the versatility of the model, the public health approach is being adopted by many major stakeholders, such as the Department of Defense (DoD), VA, and the Substance Abuse and Mental Health Services Administration (SAMHSA) to meet people where they are.

To better understand programs and resources needed within organizations, some organizations have begun evaluating the prevalence of mental health challenges and suicide in their respective workforces.

In 2018, three nonprofit organizations collaborated to develop “A Report of Findings to Direct the Development of National Guidelines for Workplace Suicide Prevention.”<sup>140</sup> The report represents an important first attempt to collect workplace suicide data from the participating organizations’ partner organizations. Data was collected from 13 focus groups, 15 in-depth individual interviews, and a 16-question survey of 256 people.

Despite data limitations, this report provided an important example of the impact of suicide on a workforce. Nearly half of the surveyed workforce knew someone who had attempted or died by suicide, including 20% who reported having lost a coworker to suicide. More than one third of respondents had lost a family member to suicide, had been a caregiver to someone who had experienced suicidality, or reported that they had experienced suicidal thoughts at some point in their life. Fifteen percent of participants reported having survived a suicide attempt. Significantly, only 11% of those surveyed reported that they had not been directly affected by suicide.

This data suggests a high probability that organizational cultures that openly support employee mental health and encourage conversations about mental health in general and suicide specifically will reach people whose lives have been touched by suicide. These efforts address risk and leverage protective factors and resources across systems and communities and integrate partners where beneficial and necessary.

### **Risk Factors**

As discussed earlier in the chapter, in addition to mental health-related factors, there are many suicide risk factors not necessarily associated with a diagnosable mental health condition that an employee may bring into the workplace, including sleep deprivation, chronic pain, traumatic brain injury, or any other life-altering or chronic health concern.<sup>141</sup> This underscores the need for employers and employees to be appropriately educated to identify these risk factors and know where and how to provide support. Additionally, economic and social factors like legal concerns, homelessness, unemployment or underemployment, and significant relationship issues are risk factors and need to be understood and addressed by leaders and managers in the workforce and in our communities.<sup>142</sup>

### **Protective Factors and Resources**

For most people, balancing work with personal life, family obligations, wellness, and other needs is challenging. As a result, many workplaces have employee wellness efforts incorporated into daily operations. These routine wellness and safety practices include an emphasis on protective factors that promote emotional well-being, which reduces the risk for suicide. Organizations have adopted a variety of protective efforts, including wellness programming, on the value of maintaining “interpersonal connectedness” at work and at home — as well as using mental health care benefits and EAP resources to support employees in times of poor mental health or crisis.

In addition, employers can implement appropriate screening and risk identification for employees in high-risk professions (e.g., first responders, law enforcement, and health professions); provide lethal means safety education for staffs in professions with access to lethal means (e.g., firearms and pharmaceuticals); and encourage employers to offer trainings such as Mental Health First Aid and crisis safety planning, in the same way that they offer other basic first aid and self-care wellness training. Employees who are equipped with the knowledge of upstream (preventive) resources and are empowered to use them are better equipped to address emotional pain and stress prior to escalation and to support themselves and others more effectively.



Finally, teaching life skills that address social concepts, integration, emotional regulation, and resiliency may also have a profound upstream impact consistent with a public health approach that provides tools across the life span and settings including work, school, and daily living.<sup>136</sup>

The CDC Work@Health resource highlights several recommendations for employer-based education and training programs and encourages mental health and stress management education.<sup>143</sup> CDC identifies complementary and alternative health options (e.g., yoga, meditation, tai chi, and mindfulness), work-life balance examples, and tips to reduce stigma. This resource is available to the public and provides foundational recommendations addressing culture, education, and prevention.

## Employee Engagement

Engagement is a protective state in which employees see their work as having a higher purpose, energizing them to go above and beyond regular work duties.<sup>144</sup> Engaged employees feel their job is about more than just a paycheck — which translates to better performance, greater creativity, and reduced turnover, resulting in stronger business outcomes for organizations.

Additionally, engagement at work positively affects employees' personal lives, through greater life satisfaction, reduced burnout, and reduced depression.<sup>145</sup> Staff who perceive meaning in their jobs and/or connect to the aspects of work that are meaningful to them will feel personally and professionally enriched. Feelings of purpose and connection are critical to helping empower individuals while reducing feelings of isolation, which are among the known risk factors for suicidal ideation and action.

Employers can increase the meaningfulness of work in several ways:

- First, ensure that the person-job fit is appropriate. In other words, hire and place individuals into roles that provide them with the opportunity to excel and thrive.
- Second, encourage employees to take a proactive approach to crafting their jobs to best match their strengths and interests. Job crafting leads to greater engagement because it helps to offset high job demands and low resources.
- Third, foster supportive supervisory relationships with staff, which means investing in, caring for, and developing mutual trusting relationships between staff and supervisors. Increased job control can also positively impact the meaningfulness of work and increase engagement.
- Finally, develop leaders who are visionary, authentic, and passionate about the organization. This type of transformational leadership style makes employees feel that their work impacts the organization at a higher level, leading to greater connection and engagement.

In summary, a whole health approach to employee well-being that includes efforts focused on improving mental health and preventing suicide creates a healthy work environment and increases employee engagement — which ultimately contribute to increased productivity and employee satisfaction.



## Current State of the Federal Government’s Workplace Mental Health Landscape

The Federal employment sector is large and influential: it contains over 2 million Federal employees, including more than 633,000 Veterans.<sup>146</sup> Historically, the Federal government has led change through early adoption of employment best practices at a national level. An example of this was The White House’s announcement in March 2014 that stated that improving employee engagement in the Federal government was an explicit goal of the President’s management agenda.<sup>147</sup> The Office of Personnel Management (OPM) quickly followed this announcement by adopting employee engagement into its strategic priorities and has since published research,<sup>148</sup> created a website,<sup>149</sup> and provided resources on the topic to government organizations, leaders, and employees.

Due to its diverse workforce and range of resources, the Federal government is positioned well to coordinate widespread development, implementation, and evaluation of strategies promoting a culture focused on mental wellness, resiliency, and suicide prevention. Additionally, cultivating a culture that includes easily accessible resources for millions of employees affects employees and their families, friends, and communities. Such a move within the Federal workforce can also encourage and reinforce cultural change in the academic, public, and private sectors.

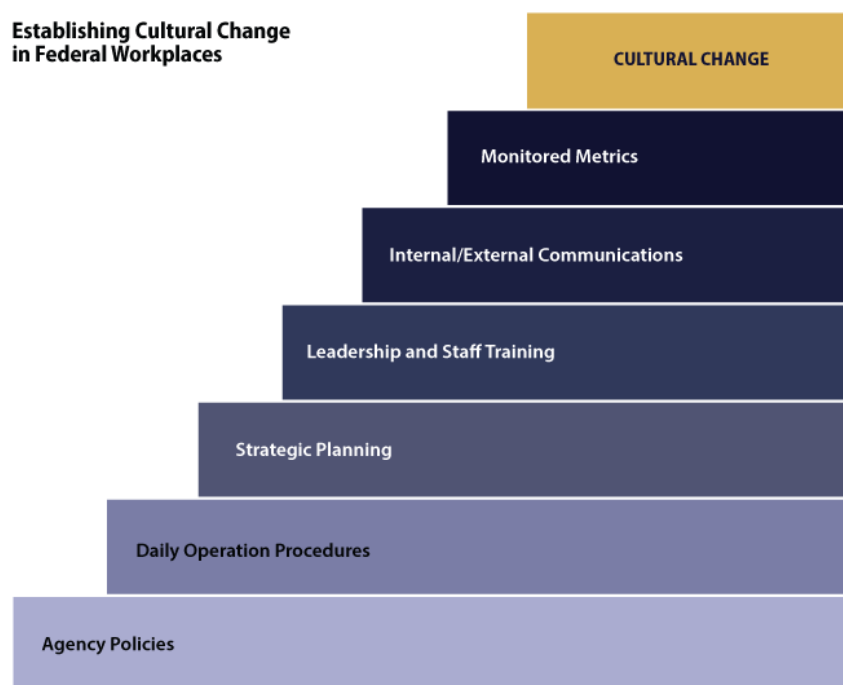


Figure 5-2

### Mental Health Data

While there has been an elevated level of risk for suicide among Federal employees since 2011,<sup>150</sup> the Federal government has provided resources and opportunities to address increasing rates of suicide within its workforce. Of the 35 Federal employees who died by suicide in 2018, 28 were employed by national security agencies. This finding underscores the wisdom and importance of focusing on specific agencies within the Federal workforce.

Despite improved understanding of metrics related to suicide in the Federal workforce, experts from the WPD effort highlighted that data collection barriers negatively affect the timely collection of data and types of data collected. The PREVENTS Executive Order creates a unique opportunity to encourage collaboration across government agencies and to overcome barriers and drive the shared mission forward.

One example of an innovative data concept includes collecting data around “emotional labor.” According to the Sociology of Emotional Labor, “emotional labor” refers to the process by which workers are expected to manage their feelings in accordance with organizationally defined rules and guidelines. Research was conducted around “emotionally laborious work” by the U.S. Merit Systems Protection Board to identify the impact of emotionally difficult situations prevalent in many Federal positions, such as medical professionals or law enforcement and corrections officers. This is a prime example of collecting data around upstream risk factors before the point of crisis or death by suicide that can allow for changes to be made to support systems that could potentially alleviate risk. Additionally, many public companies gather similar data related to the perceived support or well-being of their employees. This data, if aggregated and analyzed appropriately, could give a picture of where efforts need to be focused within the workplace.

## **Training and Education**

### *Gatekeeper Trainings*

As noted earlier, providing training and education can help individuals recognize people who are at risk, including themselves, and identify sources of help. An article in Harvard Business Review recommended investing in educating and training employees, especially managers, to name, normalize, and navigate mental health at work. Military-based employment settings employ resiliency training to help people identify ways to enhance coping and problem-solving and recognize when there is need for further support. Resiliency training is designed to build one’s ability to develop healthy adaptations when dealing with stress and to recover quickly after stressful, traumatic, and/or emotionally strenuous situations. Several organizations, including VA, have adopted resiliency training as part of their routine employee offerings.

Gatekeeper training, a type of resiliency training, is a well-recognized practice in suicide prevention and is appropriate for the general public. This form of training helps educate people about emotional crisis, improves their ability to identify and respond effectively to someone who is in crisis or thinking of suicide, and teaches them to make a warm hand-off to professional care. Many organizations have developed their own gatekeeper training, which can be tailored to the needs of a specific population.<sup>151</sup>

Within the Federal government, DoD and VA have historically adopted suicide prevention programs that focus on how their embedded health care systems can adopt a gold standard that serves their customers (Service members, Veterans, and their families), but not necessarily their employees. In recent years, these agencies have expanded efforts to increase the focus on upstream suicide prevention, including the implementation of routine suicide prevention gatekeeper training for all DoD and VA employees as a recommended best practice.

In VA, a focused effort to provide yearly gatekeeper training for all Veterans Health Administration (VHA) employees using S.A.V.E. training was initially rolled out in 2016.<sup>152</sup> This rollout is in the process of expanding to all employees in the Veterans Benefits Administration and National Cemetery Administration and focuses on basic education about suicide as a public health issue, specific risk factors for Veterans, recognizing a Veteran in crisis, opening a conversation, and helping a Veteran get to crisis care.

While the information and skills in this training can be generalized to all colleagues in the workplace, VA's S.A.V.E. training was designed with an explicit focus on engaging with Veterans. To evaluate the efficacy of S.A.V.E. training, VHA conducted an evaluation of 7,431 VHA nonclinical staff members who completed training. Participants from this study reported increased confidence in their ability to respond to Veterans in crisis and the positive impact of the inclusion of suicide screening as part of their job.<sup>153</sup> These outcomes were similarly positive for VA clinicians, which may indicate that programs like S.A.V.E. can be an effective suicide prevention resource for employees overall.

### **Employee Assistance Programs**

Each Federal agency offers a voluntary, confidential EAP to support employees through life's challenges. Some agencies have expanded EAPs to offer support to employees' families as well. While there is variation in the services and programs offered by EAPs, there are similarities among efforts that can be gathered to share potential best practices among agencies. Although EAPs are currently available, opportunities clearly exist to enhance and/or expand the services offered based on employee feedback and data on EAP usage.

In an effort to evaluate the impact of EAPs across different Federal agencies, the Office of Personnel Management distributed a Federal Work-Life Survey Report in 2018. Currently, EAP services are the most underused Federal work-life program and have the greatest gap in employee desired usage. Approximately 13% of Federal employees had used an EAP-related service over the previous 12 months, yet more than half of employees (55%) indicated their desire to use one or more EAP services. Negative perceptions regarding EAP reputation and usage, lack of program awareness, and lack of agency support were key drivers of underutilization. Interestingly, satisfaction with the use of EAP services was moderately high (60%), which highlights the value of EAP services and represents missed opportunities for those who do not use such services. In fact, these programs positively impact various outcomes: improved morale (48%), increased performance (41%), intent to stay (40%), improved health (40%), and better stress management (49%).

## OPM 2018 Federal Work Life Survey Report



Figure 5-1

In order to increase EAP usage, agency leaders can explore opportunities to better promote resources and improve tracking and reporting of usage rates. In places where resources may be hard to access, leaders can conduct an organizational needs assessment to identify opportunities for using technology to better serve employees. Federal employers can lead change by requesting that human resources and EAP teams work together to identify transition challenges and gaps for employees and to propose process solutions to improve coordination of support for employees in various types of work and life transitions.

Additionally, Federal employers can work with human resources staffs, EAP, and health insurance plan providers to identify the current rates at which employees use wellness and mental health services/benefits. Employers can identify employee needs and gaps in service and benefits and seek options for closing the gaps. Strategic internal communications, such as email blasts, can be used to encourage employees to use wellness and mental health resources for themselves and their families. Of course, utilization is one metric for tracking and measuring success.

### All Employee Survey

Social connectedness is a hallmark of mental health, improves resiliency, and reduces suicide risk. Tools, such as VA's All Employee Survey (AES) that tracks information on the Federal employee experience, can be used to help employers identify how close and connected employees feel with their teams and the broader organization.<sup>154</sup> Where social connectedness is identified as an organizational need, leaders can work with teams to implement programmatic strategies to improve connectedness at work. Digital and technology solutions can be used to promote connectedness among Federal teleworkers.

Furthermore, organizations can use the AES or similar surveys to identify the degree to which their work teams feel their work-life balance is enhanced and supported by the structure and schedules of employment. For on-call and shift work, especially, social connectedness outside of work can be lacking, and employers need to make the effort to mitigate negative impacts. Where employers identify significant needs for building resiliency by helping employees stay connected to others outside of work, leaders can model prioritizing work-life balance and demonstrating that the whole health of employees is valued, beyond what they contribute to meeting productivity benchmarks.

While the preliminary feedback from the environmental scan was limited to the DoD, Department of Labor, VHA, OPM, and the Department of Homeland Security, these initial findings support information gathered from previous efforts, such as the National Action Alliance's National Strategy for Suicide Prevention. Additionally, this early scan supports the need for a further in-depth evaluation of existing mental health efforts across all sectors.

In summary, this initial scan found that the Federal government has developed metrics, data collection protocols, training and education, and comprehensive services for employees that can be amplified across sectors. Additionally, these tools and resources were developed with a diverse employee population in mind, which can improve future implementation outside of the Federal government.

## Current State of the Public and Private Sector Workplace Mental Health Landscape

Corporate leaders, particularly in the medical and insurance fields, have recognized that in order to successfully develop and implement programs to improve employee mental health and prevent suicide in the workforce, a coordinated approach that engages employers, health care practitioners, and other stakeholders, such as professional associations, is required.<sup>155</sup> One example of a need for this type of coordination was identified in the preliminary WPD environmental scan. Currently, workers' compensation claims associated with mental illness are not tracked or reported in the same manner as those related to physical illness. This issue demonstrates that employers and insurance companies have not reconciled variations in coding or documentation, which may result in underreporting of both the financial impact and human resource implications of mental health and wellness efforts.

An additional finding from the environmental scan is that, from a public health perspective, the dialogue around mental health and wellness needs to change with respect to mental health in the corporate culture across sectors.<sup>156</sup> Many organizations are currently working to improve this by developing partnerships and leveraging and adapting best practices validated by other corporations.

One example of an organization developing partnerships involving the corporate sector in the U.S. is the National Action Alliance for Suicide Prevention, which has been a primary convening organization for public-private partnerships in suicide prevention and connecting stakeholders with subject matter experts in suicidology.<sup>157</sup> Their seminal work, the National Strategy for Suicide Prevention,<sup>29</sup> organizes national advisory groups and task forces outside of traditional suicide prevention organizations around this strategy.<sup>158</sup> This approach acknowledges the fact that while subject matter experts often understand the issues involved in suicide prevention work, engaging front-line stakeholders, such as employers, is essential.

Since 2018, the Action Alliance's Workplace task force has collected and disseminated key suicide prevention information annually. Their 2018 findings indicated that more than half of those who died by suicide did not have a known mental health condition, and that other life stressors such as financial concerns, relationship problems, and job strain/transition contributed to suicide risk. Additionally, the report emphasized the need to look beyond mental health support for prevention so as to include employer prioritization of suicide prevention and the inclusion of psychological safety as a key priority in the corporate culture.<sup>159</sup>

Another example of public-private partnership comes from a well-established PREVENTS partner, the U.S. Chamber of Commerce Foundation.

Through a partnership with the National Council for Behavioral Health, the foundation is expanding the Mental Health First Aid Training at Work program to teach employers and employees how to help people with mental health or substance use issues get proper care. Companies such as Deloitte, Johnson and Johnson, and Lendlease have also already implemented Mental Health First Aid in their efforts to integrate wellness in the workplace cultures.

An example of a robust suicide prevention program that engages employers at the state level is Together With Veterans (TWV), a program specifically focused on providing support to Veterans living in rural areas. TWV involves partnering with these Veterans and their communities to implement community-based suicide prevention.

Five evidence-informed strategies are used by TWV to support local planning efforts:

- 1) Building partnerships involving traditional and nontraditional partners.
- 2) Conducting a community needs and readiness assessment.
- 3) Identifying interventions and practices to implement.
- 4) Developing an action and evaluation plan.
- 5) Evaluating programs to develop a sustainability plan.<sup>160</sup>

These strategies are designed for employers and other leaders in the community for communitywide implementation to increase awareness and knowledge about Veteran suicide and improve community response to the needs of local Veterans. Currently, TWV is deployed in several states: Colorado has two programs and Montana, New Hampshire, North Carolina, Texas, and Virginia each have one. TWV is anticipating the launch of programs in 18 more states in calendar year 2020.

### **Workplace Suicide Prevention Partnerships**

Workplace suicide prevention partnerships and efforts in the U.S. and globally are in their infancy. Several convenings among wellness and safety leaders in industries with the highest suicide rates have engaged in discussions to improve workplace suicide prevention efforts. These convenings have included organizations in the public, private, and nonprofit sectors focused on the identification of promising practices that can translate across all sectors and may ultimately lead to the standardization of language, definitions, and data collection. This standardization would make comparisons and sharing possible. Because this process of growth and integration is still in its early stages, these developing partnerships should also consider including people with lived experience, affected families and caregivers, and suicide survivors, who will provide an essential dimension to the discussion and humanize the experience of suicide.

### **Opportunities for Technology To Augment Programs and Services**

There are a variety of technologically based tools and resources currently being used to reach and support different populations in need. Some of these tools — like S.A.V.E. training — make use of online educational training videos. S.A.V.E. was developed for VA in partnership with PsychArmor, a nonprofit organization that has created a collection of training videos — many of which focus on topics including educating companies on military culture, the prevalence of suicide, warning signs for identifying Veterans who may be at risk, and best practices for referring Veterans to resources.

The market for mental health tools is evolving quickly as mental health receives increasing attention and organizations work to create innovative technological solutions.

Some efforts involve gamification to enhance the user experience, create more lasting knowledge, and increase the acquisition of skills.<sup>161</sup> Early indications suggest that these types of tools and training efforts are effective in educating people about mental health challenges and in helping to train users on valuable skills.

## Current State of the Academic Sector's Mental Health Landscape

Academic institutions are uniquely positioned to prepare the workforce of tomorrow, including Service members and Veterans who have education benefits to use. While academic institutions serve to provide and disseminate knowledge, providing education and training around mental health for staff members and students has only recently become an area of focus at institutions of higher education.

As in other sectors, academic institutions include a wide range of at-risk populations including minority, nontraditional, and Veteran employees, and students. Suicide is currently the second-leading cause of death among people ages 10–34; deaths by suicide have increased among this age group since 2008.<sup>162</sup> Additionally, for many students in these settings, conventional college age (from the late teens to early twenties) can also be the age of onset for mental health issues.<sup>163</sup> Further, students, staff, and faculty in postsecondary and graduate institutions can face periods of significant stress due to high pressure to succeed, a high prevalence of substance misuse, and other factors that contribute to mental health challenges.<sup>164,165</sup>

To begin to understand the risks and resources in the academic sector, the WPD environmental scan included reaching out to academic institutions across the country. While the academic sector is similar to other sectors in that there are no standardized approaches to improving mental health care generally or suicide prevention efforts specifically, there were common areas of concern noted. The environmental scan indicated an overall interest in the development of more programs focused on student and staff wellness that focus on reducing stigma but protect confidentiality.

## Findings

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### Moving Toward a Healthy Workplace

No single organization or employer group has the answers to address culture change, mental health parity, and suicide prevention. Therefore, in order to support efforts consistent with a broad-based public health approach to reduce suicide rates in the workplace overall and for Veterans in particular, strategic partnerships, policy changes, and ongoing evaluation efforts are required.

In addition to educating individuals about the risk factors associated with suicide, another key feature for successful suicide prevention efforts is to facilitate the development and practice of protective factors. Workplaces and institutions of higher education provide various opportunities and programs to support suicide prevention efforts.

There is evidence that supporting social determinants of health (SDoH) reduces suicide risk, which suggests that employers can have a positive impact on the emotional health and well-being of their workforce by developing strategies aimed at facilitating the use of existing efforts, such as EAPs.<sup>166</sup> Studies show that individuals who have all (or at least a majority) of their SDoH needs addressed or have access to supports that facilitate positive change in their needs are often more productive in their work and education, as well as less likely to be absent from work.



Simply championing efforts that bolster SDoH and protective factors (e.g., feeling a sense of connectedness) can have a positive effect and can lead to positive changes while delivering the message that these types of efforts are of value.

Many protective factors overlap with what is thought of when addressing upstream concerns. As a hypothetical example, someone may be struggling to sleep, which over time becomes insomnia and could be coupled with poor work performance, problems in their relationships, or other health concerns. If the intensity grows, such individuals may find themselves in crisis. Upstream interventions address initial concerns well before they snowball to the point of crisis. In this hypothetical case, perhaps the EAP recommends a sleep application, relaxation techniques, or a conversation with the person's primary care provider or clinician, which resolves the sleep issue, allowing the individual to lead a more productive life without a persistent cloud of exhaustion. Workplaces and academic institutions should ensure that an infrastructure necessary for this early intervention is present and meeting the needs of the population/system.

## Gaps and Barriers

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The WPD effort found wide variation across all sectors on upstream strategies aimed at increasing mental health and well-being in the workforce. Upstream prevention refers to the various negative factors that may be at play in someone's life that could, if given enough time, intensity, or increase in frequency, combine to create a crisis or lead to a death by suicide. Studies demonstrate the need for standardized protocols, education for recognizing signs and symptoms, and intervention and postvention strategies varied across all sectors. From the cumulative efforts of the WPD effort, four key areas were identified where existing gaps and barriers remain:

- Workplace culture
- Communication
- Education and training
- Voluntary data collection

Two overarching themes across each area are a lack of standardized data collection and voluntary data-sharing mechanisms to help identify organizational risks and improve existing practices.

### Workplace Culture

#### Support Systems To Decrease Risk

A "culture of wellness" in the workplace, which is defined as an environment that encourages and enables employees to practice healthy behaviors in the office, can be a critical component for promoting employees' well-being and reducing suicide. Developing such a culture can involve a wide range of workplace practices and policies. There is increasing evidence to support the direct value and returns of providing support systems in the workplace to promote employee well-being.<sup>167</sup> While there is an increasing recognition across many organizations of the value of investing in employee wellness, wide variation exists, and research is needed to identify an ideal menu of evidenced-informed programs and services to support sustainable culture change that will lead to a reduction in suicide.

Integrating health and wellness into the company structure can be supported by transparency about the common experience of stress, depression, anger, and anxiety across the workforce. To address this, organizations have developed various training opportunities, including resiliency training.



Failing to integrate mental health efforts with physical health efforts in organizations can create potential barriers to resources that promote overall well-being. To ensure that these programs and practices are incorporated into the fabric of the culture, policies with clear language need to be readily available and enforced to encourage proper resourcing by the company and proper help-seeking by the employees.

Provisions for work-life balance include workplace flexibility, family and dependent care, and EAPs supported with appropriate time off for those who wish to participate.

### **Assessments and Accommodations**

While many workplace settings may not be appropriate for clinical assessment of suicide risk, consistent with the principles of mental health parity, employers can adopt and deploy educational materials and tools so that all employees can recognize the signs of a mental health crisis and know how to respond appropriately. Further, similar to the accommodations that are provided to support employees through a major physical health event (such as a heart attack or pregnancy), employees who experience a major mental health event may need temporary workplace accommodations to support their recovery. From the lens of health equity, reasonable accommodations exist to promote recovery and resiliency for both physical and mental health events.

### **Mitigate Harm**

Suicide can have a profound impact on those involved directly and indirectly with the individual who died by suicide. Exposure to a suicide or attempted suicide is not only traumatic but also increases the risk for suicide among those exposed.<sup>168</sup> If an event occurs, organizations need to have plans and identified personnel in place to provide support and counseling as needed. Information collected through the WPD literature review, individual interviews, and anecdotal reports indicates that this is an area that has received relatively little attention, with few organizations reporting well-developed, communicated, or integrated programs around postvention for their employees.

The best examples of progress in this area can be found in academic institutions. The University of Alabama – Birmingham has guidance and supportive communication resources for supervisors in assisting employees with behavioral issues, critical incident services, and grief in the workplace. The University of California, Irvine, introduced a mobile application (red folders), a campus consultation team, and bystander intervention training to assist with students before, during, and after a crisis.

### **Communication**

Communication is a key element of a comprehensive strategy for creating and sustaining a culture of wellness and trust in the workplace. Having resources available is of little value if the intended audience is unaware of them, and yet anecdotal reports across private, public, and academic sectors indicate that many employees are unaware of the resources available and where to find information about them. At the same time, the availability of mobile applications, public-facing self-help resources, and information in the form of toolkits, roadmaps, and guides can be overwhelming at an agency or individual level.

Ensuring that available, anonymous, and agency-specific resource directories are easily understood and in searchable formats helps the workforce, students, and consumers identify and use the resources available to them. Public awareness, whether through gatekeeper training or a public service campaign, is needed. Fortright, nonjudgmental, and caring suicide prevention messaging is key,<sup>169,170,171</sup> as is correcting misinformation that appears in the media and other sources.<sup>172</sup>

This can be achieved through safe messaging of suicide and utilization of communications tools such as those developed by the Suicide Prevention Resource Center.

Similar to the ineffectiveness of resources that employees are unaware of, resources that employees are aware of but do not feel motivated to engage with will also have limited impact. Language can play an important role in encouraging participants to attend training. Using language that mirrors the profession's culture or role and acknowledges that mental health cultural barriers are still a pervasive issue and obstacle to help-seeking may lead to greater utilization of mental health resources.

Common terms related to mental health may evoke a negative reaction or be unknown to those outside of the suicide prevention field. "De-escalation techniques and protocols," for example, may evoke images of a person out of control and in imminent danger of needing some form of restraint. Instead, language that emphasizes health and wellness, upstream primary prevention strategies, work-life balance, and resiliency training may encourage participation. There is some evidence, especially in professions that have a higher percentage of male employees, that language targeting a specific sex that focuses on "troubleshooting" concerns and knowing when to "ask experts" is better received.<sup>173</sup>

A review of communication strategies revealed that employers target a few modes of transmission, but they are insufficient to reach migratory or off-shift workers. While the use of technology, such as telehealth, webinars, and mobile applications, has greatly expanded in recent years, platforms within employer groups differ significantly. It is also important to acknowledge that providing referrals is only the first step in acquiring services, and employees who receive assistance in finding and scheduling a mental health appointment may not receive the service for weeks or months. In-house resources should be available, although they may be underutilized due to negative perceptions or fear of repercussions. Thus, the need for an employer to identify appropriate, timely, and available resources across the spectrum of risk is essential to the well-being of the workforce and organization.

There are several known workplace environments where suicide prevention training is ubiquitous: within VA, DoD, and the 20 states where, at a minimum, all middle school and high school educators have mandatory suicide prevention training.<sup>174</sup> In these workplace environments, suicide prevention training focuses on providing care for the population they serve: Service members, Veterans, and students. These organized training efforts are structured and established in ways that could be adopted into most workplaces. Further, they demonstrate that suicide prevention training mandated by either workplace policy or the laws governing a profession is both feasible and acceptable.

Likewise, there is significant potential to improve the suicide care infrastructure by standardizing accreditation requirements for suicide prevention training for health care providers, even among current mental health professionals. Approximately 90% of licensed mental health providers could not pass a suicide care competency exam at the 70% mark.<sup>175</sup> The research suggests that among treating providers there are large gaps in education and training about suicide care, and risk for suicide is still largely underrecognized in primary care settings and emergency departments.

Washington state is leading the way in standardized suicide prevention training for all health care providers in the state, from nurses to dentists to pharmacists, with required continuing education hours for licensed medical personnel.

Additionally, suicide among health care providers is a growing concern. Physicians and trainees have higher rates of burnout, depressive symptoms, and suicide risk than the general population, and an estimated 300–400 physicians die by suicide in the U.S. each year.

As suicide numbers increase, more and more doctors are dealing with the terrible loss of a patient to suicide. To address this, training in coping with suicide loss, confidential counseling, and cultural change within the medical profession should be considered.

Suicide prevention training should also be required for EAP and contract providers to ensure that all access points for employees at risk and in need are prepared to support the employee. Programs like LivingWorks can provide comprehensive suicide prevention training to a variety of employers and industries.

Most research on suicide prevention in the workplace has focused on specific occupations that have been found to be at the greatest risk, including health care professionals, law enforcement, the construction industry, and U.S. Army soldiers. Additional research is needed to determine the effectiveness of programs that may have broader appeal and apply to a range of professions across all populations.

Gatekeeper training, or similar concepts, are being adopted in the private, public, and academic sectors to address the growing awareness of the need to develop suicide prevention, intervention, and postvention programs for employees, students, caregivers, and others. Conceptually, gatekeeper training is guided by a belief that developing lay persons' knowledge, skills, and attitudes related to identifying presence and level of risk and making appropriate referrals will result in improved community response. However, the curriculum, frequency, or duration of training, as well as the need for repeat or refresher training, have not been definitively established. Other examples of programs that focus on improving the community response include Mental Health First Aid, bystander interventions such as green dot,<sup>176</sup> and peer training. These programs provide a platform to increase knowledge of signs, symptoms, and risk factors of mental illnesses.

### **Training and Education Competencies**

Based on the research conducted by the WPD effort, it is clear that while the specific content and the method of delivery may vary, suicide prevention education for all audiences should reflect the following core competencies:

- Current, valid information about national and/or regional crisis centers and resources.
- Screening for unmet health needs (e.g., physical, mental, emotional, interpersonal), specifically suicidal thoughts and behaviors and how to pair needs with and make referrals to community resources or treatment, as needed.
- Ability of employees and supervisors to recognize coworkers in distress and respond appropriately.
- Ability to recognize the signs and symptoms of suicide risk and suicidal behaviors and how to reach out to those who may be at risk.
- How to increase and promote protective factors and identify and mitigate risk factors.
- Discussion of how culture and stigma impact suicide prevention and how to change systems, if necessary, to better support those in need.
- Strategies for safe firearm storage and other voluntary lethal means interventions.
- Any other relevant content based on the organization's self-assessment and its understanding of prominent or overarching factors present in the system or community.

- How to respond appropriately in a postvention situation, either when a death occurs or when someone is returning from an attempt/crisis.
- Review company/agency/organization policies to remove barriers to help-seeking behavior and ensure adequate programming and resources.

## Data Collection and Sharing Mechanisms

From an employer perspective, having an awareness of high-risk populations allows for planning of targeted education and other proactive initiatives. To ensure the success and longevity of promising programs, relevant data must be collected and shared across varied sectors. Currently, there is no mechanism to share data across sectors, and the definitions and collection methods are not standardized.

Forming partnerships with national organizations across the Federal and academic sectors will be critical to addressing this gap. Organizations such as the American Association of Suicidology and National Action Alliance for Suicide Prevention, as well as the Department of Health and Human Services, can collect current resources on workplace suicide prevention practices, develop and deploy resources, and identify gaps. Filling those gaps will require collaborative efforts across public and private settings. The PREVENTS effort provides a prime opportunity to bring industry leaders in employee wellness, workplace safety, fiscal health, academic, and faith-based services together with public and private sector leaders to explore how such programs can better align with suicide prevention public health efforts. This will result in the inclusion and alignment of promising suicide prevention public health practices across sectors.

Despite the impact of suicide on public health, surprisingly few studies are published about the impact of suicide on specific subgroups or populations. For this reason, there is insufficient data for employers to draw from that pertains to cost-benefit analyses of various suicide prevention practices across the landscape of workplace suicide prevention. This lack of data requires the development of a comprehensive effort to collect information on the current state of workplace suicide prevention practices across all populations and risk stratifications. Future data collection in this area will make a significant contribution to the understanding of suicide prevention and inform future programmatic efforts in the workplace. Further, it will enable the customization of efforts for specific populations within the workforce based on several factors such as geographic area, type of work, profession, and demographics.

With respect to improving the quality and quantity of data, wide variation exists across government, the private sector, and academia regarding the type, quantity, and definition of data being collected and reported. Current data sources on suicidality and suicide prevention in the workforce include public and private sector data. The Bureau of Labor Statistics records fatal workplace injuries in the Census of Fatal Occupational Injury from numerous sources including death certificates, administrative records from the National Institute for Occupational Safety and Health, and police and media reports. However, because death from suicide is still stigmatized, the veracity and completeness of this data are questionable. The Occupational Safety and Health Administration (OSHA) includes medical conditions in its various reports, but for a number of reasons it does not include mental health conditions, suicide, or emotional concerns that can arise from a hostile work environment. Both Census Bureau and OSHA reports show the need to collect and report data in a more systematic manner.

The Data and Surveillance task force of the National Action Alliance for Suicide Prevention reviewed suicide data sources and recommended standardizing language and definitions of data, adding new variables to surveys, expanding the geographic reach of surveys, and including more underrepresented populations.<sup>177</sup> Recent reports on populations identified to be at elevated risk, in addition to Veterans, include young adults/college students<sup>178</sup> (especially males);<sup>99</sup> older adults,<sup>179</sup> including those in long-term care;<sup>180</sup> individuals transitioning from the penal system;<sup>181</sup> opioid users;<sup>172</sup> those in manual occupations, including construction workers and tradespeople and farmers;<sup>182</sup> those in certain health professions;<sup>183</sup> and those with a high school education or less.<sup>184</sup>

The CDC evaluated mental health in the workplace<sup>185</sup> and identified similar high-risk populations and articulated the universality of stress. Of note, the CDC identified the economic and social costs associated with mental health issues and provides recommendations to address them proactively.

A 2019 study conducted by Mind Share Partners, Systems, Application and Products, and Qualtrics, titled Mental Health at Work 2019 Report, explored mental health challenges and stigma in the workplace. Many previous studies measured mental health status through diagnosable conditions or general stress, but the report concluded that these two metrics do not fully capture the breadth of mental health experiences. The study aimed to broaden the framing of questions in terms of individual symptoms.

While these examples highlight improvements in data collection and reporting, more efforts are needed to enable comparative discussions across sectors and employers. Future universal agreement on definitions, coding of employee illness and injury claims, and reporting of suicide data can compel leaders to make significant changes to address gaps. Federal agencies and research institutions continue to develop studies and conduct research to explore large-scale trends within the workforce.

## A Way Forward

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The PREVENTS National Research Strategy will promote foundational changes to the way research is conducted by identifying and prioritizing research that will meet the needs of Veterans and by improving the speed and accuracy with which research is translated into practice. Standard research practices will be bolstered by a public health approach, integrating individual, social, and environmental risk and protective factors across an individual's life span into study design, and ensuring that the data being collected as a result is shared in a way that speeds up the path to discovery.

In addition to the two overarching goals with associated strategic objectives, the full PREVENTS National Research Strategy provides detailed analysis of the state of the science, detailed recommendations on strategic research needs, and preliminary thoughts on next steps for implementation. By prioritizing data-driven science to stratify risk across subpopulations and systems, interventions can be applied strategically to enhance their effectiveness in suicide prevention. Further, by promoting and prioritizing the development of a data-rich and outcome-driven research ecosystem as outlined above, the PREVENTS National Research Strategy offers unique ways to accelerate the quality, reproducibility, and deliverability of innovative tools and solutions to be applied for suicide prevention.

## The Path to Culture Change

Successful initiatives currently underway across sectors — if properly amplified and supported by efforts like PREVENTS — can lead to widespread cultural and structural changes within the workforce.

For example, it is now common for employers to identify emergency evacuation routes and severe weather plans, write policies and procedures for these issues, and train staff so they are prepared and confident to keep themselves safe. Success in the mental health and suicide prevention arena will mean transforming systems to include a focus on whole health and psychological safety — for Veterans and all employees — in the same way. Our vision is an employment sector that has widely established “business as usual” practices in prevention, access to care, and support for those who are struggling or caring for someone who is in order to reduce suicide.

The first step to change culture is to define the end goal — what culture change will look like. Specifically, the PREVENTS effort supports cultural change that reflects positive movement in how everyone thinks and behaves around the topics of mental health and suicide in the workplace and in academic institutions. This change includes a more open, transparent, and supportive atmosphere that provides the opportunity for discussion of stressors well before the point of crisis and allows those who need it to seek support without fear.

A successful cultural change process includes an understanding of prioritized content and the audience, as well as how to incorporate suicide prevention into the existing workplace health and safety culture and structure.<sup>186</sup> Suicide prevention experts have identified several themes necessary to make a positive impact on prevention efforts, including training all individuals to recognize the signs of crisis and a focus consistent with a public health model that moves prevention efforts upstream. Analysis of data from the past decade has also shown which populations are at higher risk, such as first responders, those in transition from military service, women Veterans, and those within specific age ranges. Subsequent efforts have differentiated between the general population and those at higher risk. Further research requires ongoing evaluation of evidence-informed approach to standardization across populations and individualization within populations.

With respect to delivering messages to the workforce, best practices designed to spur culture change should be tailored to audiences to increase awareness and facilitate behavior change. While general messages are beneficial, approaches must align with the style of learning best suited to employees in that sector to ensure audience buy-in, which is needed for long-term change. For example, an educational presentation for first responders should be tailored to include protective and risk factors relevant to them.

### **How Can an Agency Assess its System Overall and its Readiness for Change?**

Successful organizational change starts with leaders who believe that a culture of wellness is possible and will benefit the organization. This core emphasis on wellness can set the foundation for a data-driven, safe, blame-free, and trusting environment that furthers employee wellness.

After a wellness-focused model is adopted, organizational self-assessment of existing practices can help identify gaps between current and ideal states. Experts in workplace suicide prevention can adapt the self-assessment tool to a variety of workplace settings and specific populations of employees. In the case of the Federal employment space, there are well-established systems for regular assessment of the workplace environment. If, during the assessment, workplace leaders identify a training or implementation gap and do not have the capability to fill the gap on their own, a partnership with an outside suicide prevention effort may be appropriate.

## How Can Efforts Be Improved?

Developing a suicide prevention program that fits a specific system is important. Two things that can improve the likelihood that employers will achieve this fit are operationalizing existing guidance and developing training models to meet organizational goals.

### *Adapt and Operationalize Existing Guidance*

In general, organizations want the best for their employees. Leaders within organizations are beginning to recognize that a healthier workforce means a more successful organizational effort. Unfortunately, tremendous variation exists when it comes to suicide prevention guidance across Federal, state, community, and organizational policies. It would be nearly impossible for one organization to sift through all the existing material; even then, the organization's leaders would not know which practices worked best, because so little data is available regarding outcomes. A comprehensive analysis is needed of existing guidance, regulations, policies, and other agreements. Such analysis should be followed by a comprehensive evaluation of existing programs to determine which policies constitute best practices, are implementable, and meet the needs of the organization(s). Following evaluation and identification of best practices, subject matter experts and stakeholders can assist with dissemination of information to inform organizational efforts and initiatives.

### *Developing Training Models To Meet Organizational Goals*

To create a suicide prevention training program for an agency or organization, a multifaceted, tiered approach is recommended. This begins with an understanding of what the system needs and what exists to meet those needs. Although many suicide prevention resources are already available, adaptation and tailoring based on the training type preferred and the intended audience may be required. Engagement with local resources can assist an organization in implementing training programs to best meet its needs.

Education and training should be implemented using a tiered approach based on the role of the individual in the organization, similar to the following model.<sup>187</sup> Research shows that the public health model of targeting the entire population at low risk benefits more individuals than interventions focused on high-risk populations alone.<sup>188</sup>

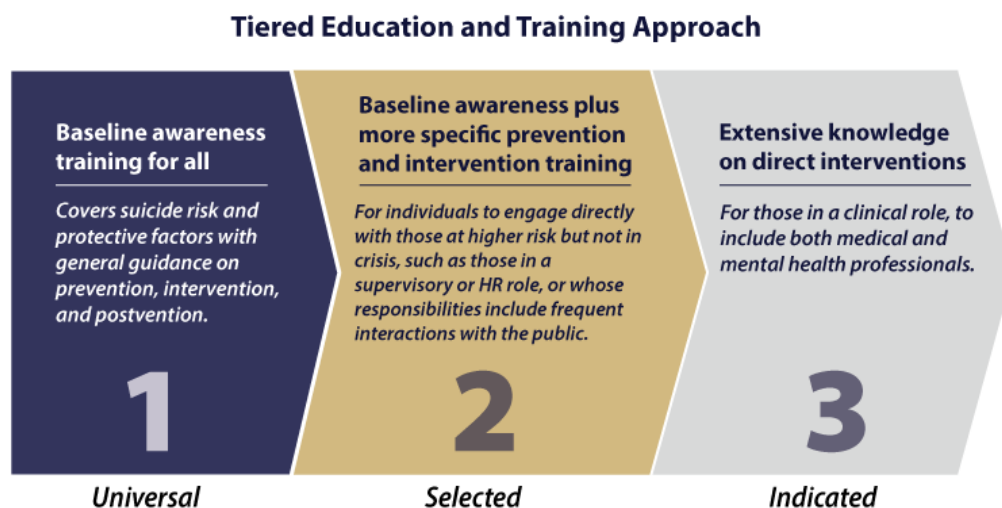


Figure 5-2



It is important to note that, within the system, there must also be considerable effort to support those who are active in each of these tiers, particularly for those engaging directly with people in crisis. The emotional labor involved can add to their own stress and protective factors should be engaged and supported to allow them to continue their personal and professional lives unhindered by their support roles.

In the example model above, Step 1 represents a general or resiliency training, which has long been the standard in the industry for widespread dissemination of information across a system or group for issues involving public health. This level would provide evidence-informed training that meets accreditation standards for all employees. This could be achieved through an online learning course or a video, which would require a one-time cost of development and potentially minor maintenance over time and could be given to a large population of participants. In fact, this level of training is already widely available, although all of these approaches need additional research as the field continues to refine training efforts. For example, VA's S.A.V.E. training can be accessed at no cost on [PsychArmor's website](#). S.A.V.E training covers the identification of risk factors, how to initiate or "ask the question" of someone believed to be at risk, and how to connect the person with crisis services. [Question Persuade Refer](#)<sup>189</sup> is another example widely available to the public and provides training for individuals and organizations on how to identify those at risk.

In Step 2, employees are taught to engage in a more direct conversation with individuals about their risks and needs using more advanced tools and skills (e.g., using a nonclinical suicide screening tool such as the Columbia-Suicide Severity Rating Scale, delivering an intervention, using safe messaging), and are given an opportunity to develop these skills in a supervised setting. Ideally, Step 2 training would include feedback from a trusted source, from predetermined responses to a hypothetical situation in an online simulation, from live observation, or from post-training consultation. This allows learners to not only practice the skills but also increase their comfort, confidence, and competence.

Step 3 training is for those who will assist in crisis care and engage more directly in a plan for immediate and long-term care based on multiple risk factors (e.g., history, current stressors). These individuals, typically health care providers such as physicians, psychologists, and social workers, would be trained to handle individual crises and mental health needs with more knowledge and access to resources.

To ensure that the appropriate level of support is available in a crisis, employees in Steps 1–3 must be trained based on their scope, responsibilities, and existing expertise. However, depending on the size and industry of the employer, there may be no Step 3-trained employees within the employer's organization; this may require seeking external support through a partnership or contract. Even when resources are available at the workplace, they may be underused due to negative perceptions. The employer must be cognizant of these concerns when identifying appropriate, timely, and available resources.

This three-tiered training development and implementation model is one example for employers who wish to engage in successful cultural and behavioral change. Regardless of the model used, employers are encouraged to provide a tiered education and training program tailored to their system, including consideration of roles and expertise available in the organization. To develop a baseline understanding of mental health and well-being, the first product(s) obtained or developed should be standardized, evidence-informed training that all must take. Standardization will allow for quality control of the messaging, the information given, and the understanding of the intervention being proposed.



Before selecting a program, organizations should engage in a substantial review of potential training or educational options to ensure that they are evidence-informed and that they include ongoing evaluation and options to evolve based on changing organizational needs.

#### *Developing Policy*

As noted, guidance and policy around suicide prevention varies considerably, and gaps exist where new organizational regulations are needed. In creating new policies and guidelines, organizations should:

- Reinforce a culture that increases one's dignity and one's sense of empowerment to make positive change and reduces fear around help-seeking.
- Promote social connectedness.
- Promote support during transitions (e.g., job, life).
- Communicate messages of resilience, hope, and recovery to employees, their families, and the community at large.
- Ensure that health and well-being services are included as a benefit in health plans and encourage employees to use these services.
- Ensure counselors in an EAP have passed a suicide care competency exam and are well equipped to assess and manage suicide risk.
- Ensure that adequate postvention resources are present in the workplace and EAP program that include grief counseling for suicide survivors.
- Reflect a sustained, comprehensive, action-oriented investment by the organization.
- Promote relevant data collection and evaluation of efforts.

#### *Leveraging Technology To Address Barriers*

By embracing telework and flexible schedules for a variety of reasons, employers face new challenges that may make it more difficult to implement promising public health and suicide prevention practices.

Potential solutions include:

- Development and deployment of low- or no-cost webinars/trainings on workplace suicide prevention.
- Technology solutions to provide more specialized resources, such as policy and procedure consultation.
- Organizational suicide prevention consultation with subject matter experts for management and human resource staff.
- Debriefing and postvention consultation and services.
- Maintenance of workplace suicide prevention promising practice resources on digital portals (e.g., websites, phone applications).
- Support and development of telehealth and tele-wellness opportunities that can be accessed in underserved and rural workplace settings.

## Recommendations

The PREVENTS Office created 10 specific and detailed recommendations aimed at closing the gaps and overcoming the barriers discussed above. Each of these detailed and specific recommendations, and their corresponding actions, have been aligned to the following two meta-recommendations that are aspirational but achievable:

- Encourage employers and academic institutions to provide and integrate comprehensive mental health and wellness practices and policies into their culture and systems.
- Provide and promote comprehensive suicide prevention training across professions.

In order to support these overarching recommendations, 10 additional specific, measurable, and actionable recommendations are offered to address existing gaps:

Table 5-1

Recommendations
Develop and evaluation peer support services for the workplace, focusing on clinical and other high-risk occupations to inform best practices.
Working in collaboration with thought leaders in workplace mental health, develop a toolkit focused on workplace mental wellness and suicide prevention efforts. Toolkits could be supported by available resources used within the Federal government (including a current toolkit from the Department of Labor, Office of Disability Employment Policy); they may include self-assessment resources, implementation recommendations, use of technology solutions, and use of digital media and other communications strategies to socialize best practices.
Develop a standardized suicide prevention course to be offered for high-risk professions to include mental health and well-being, social connectedness, and suicide prevention, intervention, and postvention.
Develop, implement, and measure longitudinal impact and cost-benefit of employee training programs focused on mental health and suicide prevention, such as Mental Health First Aid, S.A.V.E., bystander intervention, and other broad, public-facing education on suicide prevention.
Develop clear guidance on the data to be collected, measured, analyzed, and reported across the public, private, nonprofit, and academic sectors to inform efforts to improve workplace culture and reach high-risk populations. This should be done using standardized language, definitions, and variables that include specific populations of employees by role, profession, and geographic area.
Incentivize students in the mental health professions with support for education and training through grants or low-interest and fixed-rate school loans. Expand existing Federal programs (e.g., VA programs such as the National Nursing Education Initiative, Employee Incentive Scholarship Program, and Education Debt Reduction Program) to include repayment of full or partial costs for schooling. Such an incentive could include a service-agreement component that includes two years of service for every one year of schooling, with services to be delivered to high-risk communities or communities with limited access to mental health care.

Provide incentives to organizations that have mental health and holistic wellness programs and benefits. Incentives could be in the form of tax relief for organizations that offer a superior level of programming and/or grants for the development of programs in organizations that need them.
Facilitate conversation among mental health professionals and employers about best practices to ensure that programs are developed to support those employees experiencing mental health challenges. Develop and share a database of studies and programs.
Continue to explore the impact of an EAP with respect to its overall usage, range of services provided, and perceived value by organization leadership in reducing absenteeism and presenteeism and improving overall organizational health.
Explore technology (e.g., messaging, mobile app, toolkits) to reach transient workers and work sites.

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs



## Chapter 6 Lethal Means Safety

## Background

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Each year, more than 800,000 people die by suicide globally, and 20 times more attempt suicide.<sup>190</sup> In recent decades, research has consistently found that reducing access to or improving the safety of various means of suicide reduces the number of suicides.<sup>191</sup> This makes increasing lethal means safety efforts an important strategy for reducing suicide risk. Understanding potential mechanisms of enhancing means safety is critical to developing an effective suicide prevention strategy.

Voluntarily reducing the accessibility of lethal means is a population-level, community-based intervention for suicide prevention that includes reducing access to firearms and to poisons or medications used for overdose, erecting barriers to keep people from jumping from lethal heights, and reducing access to any other lethal means. Means safety interventions attempt to make suicide methods more challenging to access with respect to time, distance, and usability, which, in turn, reduces the number of suicide deaths. Numerous research studies suggest that suicide can be impulsive and that the decision to attempt suicide can be fleeting. Most suicides are not planned months, weeks, or even days in advance — instead, the time between the decision to attempt suicide and acting on it is usually a few minutes to a few hours.<sup>192</sup>

By putting time and space between an at-risk individual and a means of suicide, an opportunity is created for the individual to change their mind or for someone to intervene. Furthermore, if one means of attempting suicide is not available, most people do not substitute a different method.<sup>193,194</sup> People who attempt suicide by less lethal means are more likely to survive.<sup>195</sup> Finally, of those who attempt suicide and survive, 90% do not later go on to die by suicide.<sup>196</sup> Taken together, this evidence suggests that strategies to delay suicide attempts by minutes or hours can prevent most suicides in both the short term and the long term.

Means safety interventions save lives. Research suggests that means safety interventions have significant potential for reducing the overall suicide rate, not just suicide deaths by the specific means being addressed.<sup>197</sup> Evaluations of means safety initiatives from around the world suggest that universal policies to limit the accessibility of lethal means have a significant impact on population suicide rates. One meta-analysis of 18 studies determined that limiting access to lethal means resulted in a marked reduction in suicide deaths.<sup>198</sup>

Though conducted outside the U.S., much of the research focused on improving means safety and suicide risk has shown promising results. Policies that limited access to analgesics, or painkillers, resulted in a 21% reduction in suicide deaths in the United Kingdom.<sup>199</sup> In addition, there was a reported 86% reduction in suicides at bridges and cliffs where barriers were put in place in countries like New Zealand, the United Kingdom, the U.S., and Switzerland.<sup>200</sup> When these barriers were removed in New Zealand, suicides increased fivefold. Once the barriers were reinstalled, suicides decreased again. The installation of safety fences at high-risk jump sites (e.g., the Empire State Building and the Eiffel Tower) has also led to a decrease in suicides.<sup>201,202</sup> Over the course of 10 years, the suicide rate at railway stations in Japan plummeted by 76% following the installation of physical barriers at railway stations.<sup>203</sup> Pesticides, coal gas, and herbicide restrictions have also resulted in marked declines in suicide rates in the United Kingdom (by 20%–30%), Korea (50% between 2011 and 2013), and Indonesia and Sri Lanka (70%) — leading to a decrease in overall suicide rates in these countries.<sup>204,205,206,207</sup> Of particular relevance to the Veteran and Service member population, some research on access to lethal means has shown that applying evidence-informed practices and policies may lead to a reduction in the number of suicides for vulnerable populations.<sup>208</sup>

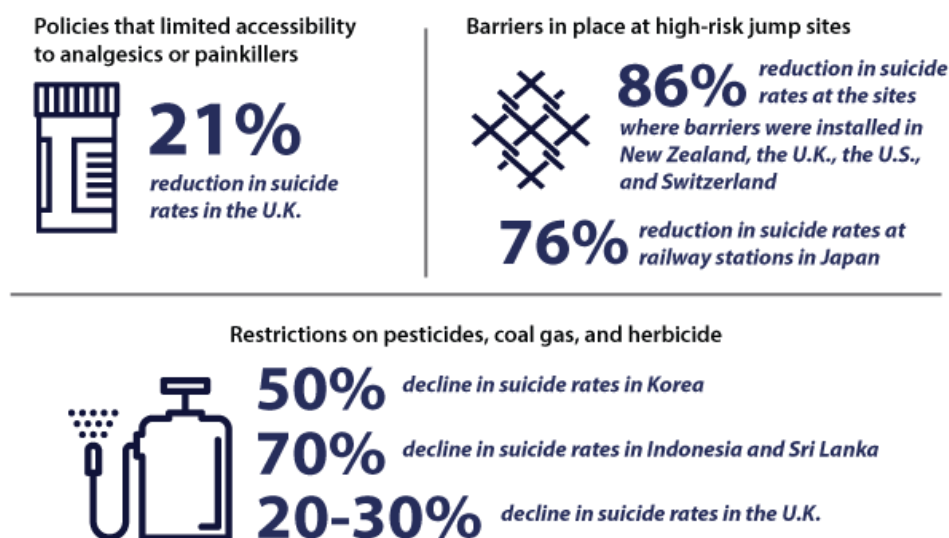


Figure 6-1

What can be learned from this body of research to prevent suicide across the military life cycle, as well as in other subpopulations in the United States? Among Veterans and Service members, 65% to 70% of suicides are completed by firearm, as are about 50% in the civilian population.<sup>209</sup> For Service members, the vast majority of firearm suicides are completed with a personal, not a service-issued, weapon. Applying research that incorporates these known facts can help guide the development of interventions to prevent suicide within specific populations.

Rates of suicide among civilians, Veterans, and Service members have increased during the past 15 years. While the cause of this sustained rise is multifactorial, one potential solution is increased lethal means safety education and related research.

Given the strong evidence that reduced access to lethal means can lower population suicide rates, suicide prevention experts in the U.S. have begun to develop materials and training for gatekeepers, health care providers, and other paraprofessional helpers to promote education and counseling about reducing access to and/or safe storage of lethal means among people at risk for suicide. Initial evidence suggests that lethal means safety counseling (LMSC) training improves both medical and nonmedical providers' knowledge about the relationship between access to lethal means and suicide and enhances their self-reported comfort with LMSC conversations.<sup>210</sup> Initial research indicates that counseling parents about safe storage of lethal means makes the home safer for everyone — including Veterans who live in the home — and leads to an increase in safe storage practices.<sup>211</sup> Additional evidence and evaluation are still needed to determine whether LMSC in other settings is effective in promoting safe storage of medication, firearms, and other lethal means in the home and ultimately in reducing suicides.

Lethal means safety is a sensitive topic for discussion in the U.S., just as the discussion of suicide and individual suicide risk is. For example, there are concerns that means safety may limit one's Second Amendment right to bear arms or other personal rights. The intent of this discussion of lethal means safety is to increase the time and space between someone's suicidal thoughts and actions by reducing accessibility of lethal means and/or increasing safety at times of elevated risk.

The intent is not to remove potential lethal means from the general U.S. population, Veteran population, military population, or other pertinent subpopulations within the nation but simply to underscore that safe and voluntary firearm storage practices, such as storing a firearm locked and unloaded when it is not in use, can decrease the risk for suicide by limiting access during times of distress. These simple practices can put crucial time and space between suicidal thoughts and seeking out a firearm.

Reducing access to the means that individuals use to attempt suicide, or improving the safety of those means, saves lives. Policy, legislation, and programs addressing safety with regard to firearms, medications, pesticides, and other lethal means may lower overall suicide rates. Suicides are preventable, and therefore national and international initiatives to limit accessibility of means for lethal self-harm should be considered. The goal of this chapter is to outline promising practices and opportunities concerning safety related to lethal means in order to develop an effective plan for the Nation.

## Approach and Goals

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In an effort to determine current promising practices and opportunities related to safety and access to suicide methods, the Lethal Means Safety Line of Effort (LOE) used a collaborative, multidisciplinary approach in eliciting thoughts, research, and concepts from key stakeholders — including Veterans and Veteran Service Organizations. This approach was used to further expand on and guide the development, implementation, and sustainment of key recommendations involving access to suicide methods.

Executive Order 13861 presents a unique opportunity to bring together industry leaders to identify and refine key safety concepts and plans to advance programs and practices that are applicable to the Nation, with the intention ultimately to reduce suicide and benefit Veterans and non-Veterans alike. The Executive Order builds on the existing Federal Means Safety Task Force, which is part of an ongoing collaboration between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). The task force coordinates resources across communities, nonprofits, and various government agencies while ensuring that new programming reflects previous successes in the area of access to methods of suicide.

Four primary topics are essential guideposts when discussing lethal means. These provided the foundation of this chapter:

1. **Clinical Interventions:** Implementing lethal means safety interventions in clinical settings.
2. **Policy:** Policies reducing the accessibility of lethal means and also increasing means safety — at the legislative, regulatory, system, and organizational level.
3. **Public Health Messaging and Education:** Identifying what kinds of information and methods of delivery are most effective in changing beliefs and behaviors concerning safe storage of and access to suicide methods.
4. **Community Coalitions:** Effective community coalitions to advance a shared objective, create opportunities to share resources, achieve mutual aims, and raise awareness with respect to lethal means safety.<sup>212</sup>

## 4 Guideposts of Effective Suicide Prevention



Figure 6-2

This section of the PREVENTS Roadmap is designed to advance the progress being made in limiting suicide method access and promoting safety with respect to time, distance, and usability. It details the current state of affairs, barriers, gaps, and key actionable and achievable recommendations — specifically focused on clinical interventions, policy, public health messaging and education, and community coalitions, with the ultimate intent of changing the conversation and culture when it comes to suicide, lethal means, and safe storage.

## Current State

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### Current State of Clinical Interventions

Access to lethal means, such as a ligature, toxic medication, or firearm, is necessary for suicide. Observational, ecological, and experimental studies have demonstrated that reducing accessibility of lethal means, even temporarily, prevents suicides. Recommending a voluntary reduction in the ability to access lethal means, particularly during acute suicidal crises, is a key component of effective suicide prevention. In fact, the effort to reduce access to lethal means of suicide is considered one of the most effective strategies for suicide prevention. The VA/DoD Clinical Practice Guidelines recommend promoting efforts to reduce access to lethal means for Veterans and Service members with elevated suicide risk.<sup>213</sup>



### **Clinical Interventions Intended To Affect Accessibility of Lethal Means**

Efforts to reduce accessibility of lethal means have proliferated within clinical settings over the past decade. Programs have largely consisted of various combinations of four main components:

1. Efforts to increase public and patient awareness regarding the risk of access to lethal means.
2. Developing training materials to equip health care workers with important communication and practical skills to make lethal means safety recommendations during clinical encounters.
3. Specific interventions embedded in clinical workflows that aim to facilitate lethal means safety among at-risk patients.
4. Health care system safety.

#### **Efforts To Increase Public and Patient Awareness Regarding the Risk of Access to Lethal Means**

Patient-facing materials have been developed by nonprofit entities, research collaborations, and health care systems, including the Veterans Health Administration (VHA) and DoD. These materials include brochures, flyers, public service announcements, podcasts, websites, and relevant messages promoted through social media (e.g., Twitter).<sup>214,215</sup> In some cases, materials have been developed to appeal to patients with elevated suicide risk based on specific suicide risk factors (e.g., dementia-specific materials). To date, most content has focused on firearm suicide prevention. Some materials have been developed to increase awareness regarding risk of medication overdose and methods to prevent it.<sup>216</sup> These materials have appeared simultaneously with increased social awareness of the risk of unintentional and intentional overdose due to opioid medications.

#### **Developing Training Materials to Equip Health Care Workers With Important Communication and Practical Skills for Making Lethal Means Safety Recommendations During Clinical Encounters**

Lethal means safety training curricula have been developed to provide health care students and providers with relevant knowledge about the importance of facilitating lethal means safety among those with elevated suicide risk. The content of that training and the extent to which it has been implemented across various learning environments and health care systems is unknown, as is the impact on patients' suicide behaviors or other important intermediate outcomes (e.g., firearm behaviors). Most materials appear to be focused on providing important background knowledge. For example, VA developed a lethal means safety lecture that has been delivered to more than 13,000 VA employees through in-person and online trainings. That training has also been made available to community providers through the TRAIN Learning Network.

A key limitation of this type of training is that it lacks in-depth instruction and practice of communication skills, such as motivational interviewing and shared decision-making, which may be beneficial in affecting behavior change among patients. An exception to this is Counseling on Access to Lethal Means (CALM), an online and in-person training curriculum offered by the Suicide Prevention Resource Center. Other important initiatives on clinician training are currently underway. Several pilot projects that aim to teach these skills to clinicians are being developed in clinical settings, such as by VHA and Kaiser Permanente.

In addition, a national work group (Priorities for Gun-Related Injury in Medical Education) is working to develop consensus guidelines for teaching health care students and providers about lethal means safety. To date, most training materials have heavily focused on affecting accessibility of firearms and toxic medications.

### **Specific Interventions Embedded in Clinical Workflows Intended To Facilitate Lethal Means Safety Among At-Risk Patients**

There are several mechanisms by which patients with elevated suicide risk may receive lethal means safety interventions. These include recommendations made by operators of crisis call lines, such as the Veterans and Military Crisis Line or National Suicide Prevention Lifeline; clinicians who complete safety planning procedures with patients at risk for suicide; and clinicians who include such recommendations within their routine practice.

#### *Firearm Interventions in Clinical Settings*

A broad variety of firearm-specific interventions have been incorporated into clinical settings. To date, most tested interventions have been developed with the goal of preventing pediatric firearm injuries rather than suicide among adult firearm owners. Interventions aimed at preventing adult suicides typically consist of screening for firearm access followed by patient-specific recommendations. Such interventions may be augmented by enhanced communication strategies (e.g., motivational interviewing) or by the distribution of firearm safety devices (e.g., firearm locks); these have been shown to increase intervention effectiveness within the context of pediatric injury prevention. Recent interventions have sought to affect firearm behaviors through brief safety recommendations in the absence of screening specifically for firearm ownership or by augmenting the process of decision-making by using firearm safety decision aids (e.g., Lock To Live).<sup>217</sup> To facilitate conversations within VA settings, VA's Office of Mental Health and Suicide Prevention has funded a program to provide clinicians with firearm safety devices that can be distributed to at-risk Veterans free of charge.<sup>218</sup>

#### *Medication Interventions*

Overdose-specific interventions have been designed largely to reduce available supplies of potentially lethal prescription and over-the-counter medications. Several health care systems have included on-site medication disposal bins similar to bins available in community settings. Within VA, the MEDSAFE program provides stamped, Federally approved envelopes that can be used to mail excess medications for disposal. Additionally, the DisposeRx program provides a convenient and environmentally friendly solution for disposing leftover medication to decrease the risk of drug diversion, accidental poisonings, overdoses, and death. For patients who are prescribed high-risk medications, clinicians may decide to limit the number of available pills per prescription (e.g., from a 90-day supply to a 30-day supply). Other options include blister packing potentially lethal medications to increase the time necessary to access a lethal quantity of those pills. The latter method stems from evidence showing that reductions in prescribed quantities of analgesic medications led to significant reductions in suicide in the United Kingdom.<sup>219</sup>

An important development in medication-related suicide prevention has been the increased awareness of the risk of opioid-class medications. Interest in preventing opioid-related overdose has led to overdose risk prediction tools (e.g., VHA's Stratification Tool for Opioid Risk Mitigation, or STORM), guidelines for limiting prescription of opioid medications to specific indications and quantities, and the broad and often cost-free provision of intramuscular and intranasal naloxone, an opioid overdose reversal agent.

### *Other Methods of Interventions*

There are few interventions aimed specifically at reducing access to other means of suicide, such as ligatures, sharp instruments, or toxic gases. In some cases, recommendations to limit access to such means are made during clinical encounters as part of routine lethal means safety counseling.

### **Health Care System Safety**

Clinics and hospitals are important locations for implementing lethal means safety, given that declines in mental or physical health may precipitate suicidal behavior. A variety of safety interventions are available for such settings. Exteriors, such as parking garages, can be fitted with jump barriers, crisis call boxes, and suicide prevention signage. Inpatient settings can be fitted to make ligatures (e.g., nurse call cords) unavailable or to reduce access to sharp instruments. Electronic medical record order sets are available to trigger the implementation of inpatient precautions for high-risk patients.

### **Current State of Lethal Means Safety Policy**

Policies limiting the availability of and access to lethal means — at the regulatory, systemic, and organizational levels — can prevent suicide. The PREVENTS Roadmap identifies five categories of policies:

1. Firearm policies that reduce access to firearms during periods of high suicide risk by promoting voluntary safe removal and safe storage.
2. Policies incentivizing voluntary safe storage of lethal means.
3. Policies requiring or incentivizing delivery of lethal means education, assessment, and/or counseling.
4. Policies limiting access to prescription and over-the-counter medications commonly used in suicide.
5. Built environment policies.

### **Firearm Policies That Reduce Access to Firearms During Periods of High Suicide Risk**

Key exemplary policies are summarized below and are included for context, not to suggest support for or opposition to these policies. The value of promoting voluntary safe removal and safe storage has been challenged in some research.<sup>220</sup>

#### *State Firearm Licensing Laws Are Associated With Lower Rates of Suicide*

Licensing laws require prospective firearm purchasers to obtain a license or permit from law enforcement before buying a firearm. Analyses of the effects of Connecticut's adoption and Missouri's repeal of permit-to-purchase laws provide strong evidence that this type of law is associated with reductions in suicide rates.<sup>221</sup>

The repeal of Missouri's permit-to-purchase law in 2007 was associated with a 16.1% increase in the state firearm suicide rate, and the implementation of Connecticut's permit-to-purchase law in 1995 was associated with a 15.4% reduction in the state firearm suicide rate.<sup>222</sup> However, these studies are limited by methodological constraints and cannot account for all possible covariates; they should therefore be interpreted with caution.

Research over an extended period of time that is better able to control for covariates is needed for the impact of these laws on firearm suicide to be fully understood. State licensing laws are one piece of the larger means safety approach; based on current research, these laws are not viewed as a primary mechanism with which to reduce national suicide rates.

Current U.S. State Licensing Laws: As of November 2019, 12 U.S. states (Connecticut, Hawaii, Iowa, Illinois, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New York, North Carolina, Rhode Island) and the District of Columbia have laws requiring prospective firearm purchasers to obtain a license or permit from law enforcement before buying firearms.<sup>223</sup>

#### *State Child Access Prevention (CAP) Laws Are Associated With Lower Rates of Adolescent Suicide*

Child access prevention (CAP) laws impose liability on adults who allow children to have unsupervised access to firearms. These laws can potentially create safer homes for everyone in the family, including Veterans who may be at risk for suicide. The details of CAP laws vary by state, with some imposing criminal liability on parents when a minor is likely to be able to access a firearm regardless of whether or not they actually gain access and others prohibiting parents or guardians from directly providing a firearm to a minor for unsupervised use. Evidence shows that state CAP laws reduce youth suicide rates.<sup>224,225</sup> A study published in the Journal of the American Medical Association found that state CAP laws were also associated with an 8% decrease in the number of overall suicides and an 11% decrease in the number of firearm suicides among adolescents ages 14 to 17.<sup>226</sup> Some of these studies are limited by the same methodological constraints noted above, but there is general consensus among experts that these laws are associated with lower rates of adolescent suicide.

#### *State Firearm Licensing and Universal Background Check Laws Should Include Provisions Allowing Temporary Firearm Transfer Specifically Intended for Prevention of Imminent Suicide*

Voluntary, temporary transfers of firearms to family members or friends during periods of suicidal ideation or crisis have the potential to temporarily separate high-risk individuals from lethal means and thereby prevent suicide. However, a 2017 publication in the Journal of the American Medical Association Internal Medicine notes a possible impediment. The article details how universal background check laws, which require a background check to be conducted on all firearm sales and transfers, may impede legal temporary transfers in the suicide prevention context.<sup>227</sup> All state licensing laws also require a background check as part of the licensing process; in states with licensing and/or universal background check laws, a firearm cannot be transferred until a background check has been conducted. This delays firearm transfer, a potential problem in cases of acute suicidal risk.

Current U.S. states with universal background check laws that allow exemptions for temporary transfers: Two states that require background checks prior to a transfer include exemptions that could facilitate transfer in cases of suicide risk. Based on a 2006 Court of Appeals ruling, Maryland exempts temporary exchanges or loans between two adults from background checks, and Colorado's universal background check law exempts transfers that are gifts or loans between immediate family members or among nonrelations if the transfer is temporary (72 hours or less). The effects of these types of exemptions on rates of firearm suicide has not yet been studied.

#### **Policies Should Avoid Linking Legal Firearm Access and Voluntary Mental Health Treatment**

Policies that restrict firearm access based on a diagnosis of or treatment for mental illness as a means safety strategy may have the unintended negative consequence of reducing mental health treatment seeking, though research on this topic is limited.

Current Federal and State Laws: Federal law prohibits firearm purchase and possession by people involuntarily committed to psychiatric care, people found incompetent to stand trial or acquitted because of serious mental illness, and people placed under legal conservatorship because of serious mental illness.<sup>228</sup> Involuntary commitment is predicated on a judicial finding that an individual poses a threat to themselves or others as a result of the symptoms of their mental illness. While the Federal mental health firearm restriction has been shown to have a small protective effect on interpersonal violence,<sup>229</sup> the limited available evidence suggests that prohibiting firearm purchase and possession based on the mental health-related criteria listed above does not reduce suicide rates.<sup>230</sup>

While most state laws mirror Federal law, some add criteria tying firearm restrictions to voluntary psychiatric treatment;<sup>231</sup> for example, Illinois law prohibits firearm purchase and possession by anyone who has been a patient in a mental institution within the past five years,<sup>232</sup> and a District of Columbia law prohibits firearm purchase and possession among individuals who, in the five-year period preceding the request for a firearm permit, have been voluntarily or involuntarily committed to any mental hospital or institution.<sup>233</sup> No studies have evaluated the degree to which laws tying firearm restrictions to voluntary treatment are implemented or the effects of such laws on suicide. However, experts in the field have expressed considerable concern about tying firearm prohibitions to voluntary mental health treatment, as this policy may make people less likely to seek needed mental health treatment. Such treatment plays a critical role in preventing suicide.<sup>234</sup>

#### **Policies Incentivizing Voluntary Safe Storage of Lethal Means**

Safe storage is important. Evidence suggests that risk for suicide is lower when firearms are safely stored (e.g., unloaded, locked, and/or separate from ammunition)<sup>235</sup> and that safe storage of medications (for example, in locked pill containers or automatic pill dispensers) can reduce access to medications that may be used to attempt suicide.

Current U.S. policies: The Bureau of Justice Assistance Firearm Locks Distribution and Safe Storage Program provides grants to organizations for promoting and distributing firearm locks to support safe firearm storage. This grant program, established in 2015, funded the National Shooting Sports Foundation/APCO Worldwide in distributing firearm locks and conducting safety education activities.<sup>236</sup> The National Shooting Sports Foundation implemented Project ChildSafe. From July 1, 2016, to December 31, 2018, the Project ChildSafe campaign formed 177 new community partnerships in their lock distribution and safety education network; distributed 628,903 gun locks; and fielded a public service campaign that garnered over 100,000 airings and views on television, radio, and social media.

#### **Policies Requiring or Incentivizing Delivery of Lethal Means Education, Assessment, and Counseling**

Lethal means education by firearm shop owners, firearm safety groups, or other entities, as well as education, assessment, and counseling by health care providers, is an important component of means safety. Policies that incentivize these groups to deliver evidence-informed interventions are a key tool for scale-up. Grants for Federally licensed firearm dealers and accreditation requirements for health care providers are examples of the types of policies that could require and/or incentivize delivery of lethal means education, assessment, and counseling.

Current Policies in the U.S.: While there is an increasing number of interventions in this category — for example, the Gun Shop Project,<sup>237</sup> which trains firearm retailers to identify potential customers at risk for suicide, provide lethal means education, and distribute suicide prevention materials, as well as the CALM lethal means counseling intervention for health care providers<sup>238</sup> — policies to support the widespread scale-up of these promising interventions are limited.

Some health care systems (for example, the Henry Ford Health System in Detroit), have adopted protocols for screening for suicide risk and assessing and counseling regarding lethal means among all behavioral health patients. The Henry Ford Health System saw a reduction in suicide rates of about 75% after it implemented its Zero Suicide initiative, which also included provider education and peer support services.<sup>239</sup> Key tenets of Henry Ford Health System's Zero Suicide model include the need to assess patients for risk for suicide at every encounter and understanding that modifying risks can lead to the prevention of suicide.

In 2017, the Commission on the Accreditation of Rehabilitation Facilities (CARF) released accreditation standards for behavioral health organizations wishing to be accredited as comprehensive suicide prevention programs. These standards require organizations to have protocols and programs in place for assessing and mitigating access to lethal means. In 2019, CARF required programs accredited under its Behavioral Health and Opioid Treatment Program manuals to conduct suicide risk screening for patients age 12 or older<sup>240</sup> but did not require programs to have protocols and programs in place for addressing access to lethal means. In July 2019, the Joint Commission's revised National Patient Safety Goal (NPSG) 15.01.01 on reducing risk for suicide was implemented for hospitals and behavioral health care organizations accredited by The Joint Commission. The revised NPSG.15.01.01 includes activities in environmental assessment, screening for suicide, assessments of patients who screen positive for suicide, staff training, and follow-up care but does not explicitly include means safety activities.<sup>241</sup>

#### **Policies Limiting Access to Prescription and Over-the Counter Medications Commonly Used in Suicide**

Policies limiting access to prescription medications commonly used in suicide attempts are an important component of lethal means safety. Prescription medications in the opioid, benzodiazepine, and stimulant classes are the leading types of medications used in suicide deaths. The over-the-counter medication acetaminophen is also commonly used in suicide.<sup>242</sup>

Current Policies in the U.S.: There is no Federal limit on the number of days' supply of controlled substance that can be prescribed in the U.S., though many states and insurance carriers limit controlled substance prescriptions to a maximum of 30 days.<sup>243</sup>

There is also no limit on the pack size of acetaminophen in the U.S. In the United Kingdom, a 1998 law that limited the pack size of acetaminophen (known as paracetamol in the United Kingdom) to 32 tablets for packs sold in pharmacies and 16 tablets for packs sold in nonpharmacy settings was associated with a reduction in the number of suicides involving acetaminophen.<sup>244</sup>

State laws designed to curb opioid overprescribing have the potential to reduce the degree to which opioids are involved in suicide attempts. All 50 states have passed laws establishing prescription drug monitoring program (PDMP) laws, which create a statewide database of opioid and other controlled prescriptions. Thirty-two states require prescribers to check their PDMP prior to prescribing an opioid. Eleven states have pill mill laws placing strict regulations on pain management clinics to ensure that they are issuing medically necessary opioid prescriptions.

Thirty-three states have opioid prescribing cap laws, which limit the dose and/or duration of opioid prescriptions; multiple insurers and health care systems also have similar types of prescribing cap policies.<sup>245,246</sup>

The research evidence on the effects of these laws on opioid prescribing patterns is mixed, with growing evidence showing that pill mill laws;<sup>247,248,249</sup> prescribing cap policies;<sup>243,250</sup> state laws requiring providers to check their PDMP prior to prescribing an opioid (but not voluntary PDMP laws) may reduce the overall volume of opioid prescribing.<sup>251,252,253,254,255,256,257,258</sup> However, the effects of these policies on suicide involving opioids has not been studied, and there is some concern among clinicians and patients that these policies may have the unintended negative consequence of adversely affecting chronic pain management.<sup>259,260,261,262,263,264</sup> As chronic pain can *increase* risk for suicide,<sup>265</sup> more research on this topic is needed.

### **Built Environment Policies**

Evidence shows that policies focused on redesigning the environment (for example, restricting access to the roofs of high buildings and putting barriers on bridges) can prevent suicide.<sup>67</sup>

**Current Policies:** Local ordinances and college and university-level policies have been enacted to change the built environment to reduce suicide risk.<sup>266</sup> Means Matter and the Suicide Prevention Resource Center recommend that college and university administrators consider policies including restricting access to high places; prohibiting firearms on campus; offering lockers for firearm owners to store their firearms; tracking, monitoring, and controlling access to toxic substances found in laboratories, pharmacies, and other departments that are accessible to students, staff, and faculty; and establishing guidelines about transporting an intoxicated or overdosed student to the hospital. No database or compilation of these policies exists, making the degree to which schools have adopted these policy recommendations unclear.

### **Current State of Public Health Messaging and Education**

An important and necessary step to take with the public to effectively message and educate about lethal means safety is to emphasize the importance of a holistic, public health approach to suicide prevention. The general assumption or popular opinion is that suicide is inextricably linked to mental illness and that suicide will cease to exist if mental health needs are addressed. Suicide prevention is more complex than this; educating the community about the public health approach to suicide prevention — including consideration of lethal means safety, peer support, financial and relationship issues, and safe messaging and reporting of suicide, among other things — is critical.

Not only will this help the public understand the many factors involved in suicide, it will increase the likelihood that the entire community, not solely mental health providers, can play a role in helping to prevent suicide.

Likewise, while suicide prevention interventions often focus on identification and management of individual risk (e.g., in clinical settings), attention to broader interventions is critical. Many of the effective clinical interventions for suicidal ideation and behaviors require people to self-identify as at-risk or to seek help; unfortunately, stigma and other barriers for care may prevent some individuals from receiving help from mental health providers.<sup>267</sup>



Public health approaches to educate and engage the community can affect cultural norms (e.g., related to help seeking and looking out for others) and behaviors. Specifically, efforts to encourage safe storage of potential means of suicide, including firearms and prescription medications, should focus on making those behaviors routine and universal.

As an example, routine storage of firearms locked and inaccessible to teenagers could help prevent teen suicide attempts and deaths. Public support for barriers on bridges could similarly prevent suicide by jumping. Facilitation of medication disposal or out-of-home firearm storage could help normalize those behaviors. While large-scale, bundled interventions take various forms, there is some evidence that mass media campaigns alone, when targeted and well-executed, can positively affect health beliefs, attitudes, and behaviors.<sup>268</sup>

A core component of any lethal means safety strategy — and, indeed, the larger PREVENTS effort — is attention to respectful, effective messaging for education of individuals and the larger public. This means identifying what kinds of information and manners of delivery are most effective in changing behavior concerning storage of and access to lethal means in times of suicide risk.<sup>269</sup> A relevant model from clinical and public health practice is cultural competence for populations as defined by ethnic heritage or other factors.<sup>270</sup> Cultural competence is a set of congruent behaviors, attitudes, and policies, which come together in a system, agency, or among professionals, that enables effective work in cross-cultural situations.<sup>271</sup> Fundamental components of cultural competence include respect for variation among cultures, awareness of one's own beliefs as distinct from another's beliefs and practices, interest in learning about other cultures and in developing skills to enhance cross-cultural communication, and acknowledgment that culturally competent practices support delivery of quality health care. In the United States, especially given the current contentious debate over gun control legislation, it is time to address cultural competence as related to counseling, education, and general messaging to prevent firearm suicide. This includes recognizing that there are multiple subpopulations of firearm owners whose perspectives and preferences may vary based on their reasons for owning firearms; this diversity in preference extends to the Veteran and Service member populations, as well.

Other organizations working in this realm include Hold My Guns, a new nonprofit organization attempting to encourage temporary firearm storage at participating retailers and ranges, including through provision of educational and financial resources for storage locations. Its tagline, “Freedom — Safety — Compassion,” refers to the notions of identity and trust mentioned above. Walk the Talk America aims to bridge the mental health and firearms communities through reciprocal education and, as mentioned above, inclusion of suicide prevention information in firearms packaging. Lock to Live is an online tool intended for individuals and their family members thinking through storage options for firearms, medications, and other potential hazards; it was developed by researchers at the University of Colorado Anschutz Medical Campus and is publicly available.<sup>272</sup>

The Educational Fund to Stop Gun Violence recently released a new website describing interventions along the spectrum of the social-ecological model, from individuals to society, with numerous links to existing programs.<sup>273</sup>

The primary message in lethal means safety is to take steps to ensure the individual at risk for suicide does not have access to lethal means during times of elevated risk.<sup>274</sup> In the case of firearms, for example, these safety steps are *voluntary* and *temporary* changes in firearm access.



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, although state laws for firearm transfers may affect what options are legal.<sup>275</sup> If out-of-home transfer is not feasible or acceptable, options include combinations of disabling weapons, removing ammunition, and locking firearms such that the person at risk for suicide cannot access them (i.e., does not have the key or code).

Current promising practices for messages about lethal means safety include drawing on concepts of cultural competence; as Marino et al. wrote, those encouraging voluntary and temporary changes in firearm access should frame these appeals using culturally appropriate language derived from a clear understanding of firearm owners' worldviews.<sup>276</sup> In another study, similar summary recommendations about framing (identity as a firearm owner; trust; voluntary and temporary storage; and context and motivation), specific content (preference for "firearm" over "gun"), and legal issues like background checks for transfers were found. Additional work has identified engaging Veterans in communication with other Veterans.<sup>277</sup>

Firearms are the key focus for lethal means safety strategies because 2 in 3 Veteran suicides are firearm-related (versus 1 in 2 in the general population), and nearly half of Veterans own a firearm.<sup>278,279</sup> Specifically, in 2017, 69.4% of Veteran suicide deaths were due to a self-inflicted firearm injury, while 48.1% of non-Veteran adult suicides resulted from a firearm injury. In the same year, 70.7% of male Veteran suicide deaths and 43.2% of female Veteran suicide deaths resulted from a firearm injury; the percentage of non-Veteran adult male suicide deaths that were by firearm injury was 53.5%, and that percentage was 31.3% among non-Veteran adult female suicide deaths.

Studies have shown that belief in the link between means access and risk for suicide death can affect firearm storage. Those who are aware of and believe in the association are more likely to store firearms securely. Yet this critical theory — that access to lethal means increases the risk of fatal suicide — has not yet been broadly disseminated. In a recent survey of the general population, only 6% of firearm owners agree that household firearms increase suicide risk.<sup>280</sup> A related survey among Veterans had the same findings, with only 6% agreeing that household firearms increase suicide risk. This study also found approximately 1 in 3 firearm owners store at least one firearm loaded and unlocked.<sup>193</sup>

Here, the focus is primarily on messages emphasizing voluntary and temporary actions. These fall into three general categories:

- Public engagement
- Storage and/or disposal of firearms/medication
- Information provided with lethal means

Lethal means safety messages and education are a key effort in the Department of Defense's efforts within the military community. For example, in the Air Force, lethal means safety efforts emphasize time-based prevention that focuses on the means most often used during (rather than the "why" of) completed suicides by Air Force personnel. Time-based prevention efforts are intended to eliminate the hazard of firearms being readily available during the first five minutes after an individual decides to perform a suicidal act — a decision that usually is irreversible when carried out, due to a firearm's lethality. These efforts are nested within a larger effort to enhance the safety of potential lethal means. Because properly stored firearms lower the risk of accidental firearm injuries, airmen are encouraged to exercise responsible firearm safety practices consistent with those exercised by the military community while on duty — "range safety is home safety."

It is important to note that time-based prevention efforts do not limit or prohibit individuals' legal ownership or use of firearms in any manner. In addition, the Air Force's "Ask — Care — Escort" model includes specific recommendations regarding means access. This model encourages airmen to directly ask their fellow wingman what is going on, to care for them by calmly listening and expressing concern, and finally to escort them to the nearest emergency room, chaplain, or mental health care facility.<sup>281</sup>

In another example, the Navy Suicide Prevention Program's "1 Small ACT" message was introduced in 2015 to encourage simple actions that can make a difference in others' lives. The Navy has developed and published a companion "1 Small ACT" toolkit. The toolkit contains graphics, talking points, event ideas, and other materials to refresh local engagement throughout fiscal 2020 in alignment with key focus areas such as means safety.<sup>282</sup> By using the resources and products in this toolkit, Suicide Prevention Coordinators, Health Promotion Coordinators, senior officers, providers, and anyone who wants to support Navy's suicide prevention efforts can:

- Promote safe discussion about psychological health and suicide.
- Recognize early warning signs of psychological health concerns in themselves and others and understand how to seek help and intervene.
- Identify sources for treatment and support and increase comfort in seeking those resources without fear of judgment or impact on their career or security clearance.
- Become familiar with lethal means safety precautions during periods of increased risk or stress.
- Become familiar with the Navy's resources, policies, and training that support stress navigation and suicide prevention.
- Practice simple ways to strengthen their physical, psychological, and emotional health and well-being.
- Make a difference in the lives of every sailor, every day.

The toolkit is updated annually, and the current "1 Small ACT" toolkit is [available for download](#).

Finally, an integral part of the Army's Suicide Prevention efforts is means safety messaging and education. The Army has established policies and consistently promotes efforts to increase Soldier, family member, and Army civilian awareness of means safety and proper storage of privately-owned weapons. This includes issuing weapon storage requirements on installations, encouraging Soldiers living off-post to store weapons on installations, promoting weapon safety and storage through partnerships with local gun shops, and issuing free gun safety locks Army-wide. These efforts help to place time and distance between at-risk individuals and lethal means.

The Army, along with all the military Services, is also collaborating with the Defense Suicide Prevention Office to develop means safety messaging. A Leader's Guide for Building Personal Readiness and Resilience and the Ready and Resilient Reference Guide, for leaders, were also developed to assist with efforts to increase their own resilience, as well as that of their Soldiers. These resources help Soldiers and leaders recognize warning signs of distress and understand actions they can take to help save lives. In addition, the "Ask — Care — Escort" suicide prevention training available to Soldiers, family members, and Army civilians develops awareness of risk factors, including access to weapons, warning signs, and resources available to prevent suicide. The Army also trains personnel to safely offer Soldiers ways in which they can temporarily surrender their weapons if they feel they will harm themselves or others. The Army encourages conversations about weapons safety with regard to self-harm to ensure that Soldiers and professionals feel comfortable and confident in having these tough conversations.

## Public Engagement

Messages in use or development have drawn on prior widespread, public-facing campaigns that contributed to shifts in cultural norms or perspectives. Perhaps the most widely cited education or messaging analogy is the “Friends don’t let friends drive drunk” ad campaign, which was launched in 1983 by the Ad Council.<sup>283</sup> The organization reports that, since that time, more than 68% of Americans have reported that they tried to prevent someone from driving after drinking. An analogous effort for suicide prevention would be encouraging friends, family members, and concerned contacts to take steps to reduce access to lethal means, such as firearms, for those at risk for suicide. A phrase used in one published qualitative study was “Hey, let me hold your guns for a while.”<sup>284</sup> Similarly, the Oregon Firearm Safety Coalition developed materials (online and in print) with the tagline “People who love guns, love you.”<sup>285</sup> The National Shooting Sports Foundation and American Foundation for Suicide Prevention partnership described below uses language like “Have a brave conversation” and “Trust your gut” when encouraging friends or family to engage.<sup>286</sup>

## Storage or Disposal

Additional efforts focusing on specific storage options also draw on prior public health interventions. An analogy for suicide prevention would be judgment-free, easy options for either storage or disposal (for firearms and/or medications). Indeed, the National Drug Take-Back Initiative is an example of such a program for medication disposal. These events are organized by the Drug Enforcement Administration and supported by the Controlled Substances Act. They enable development of a permanent process for safe and convenient disposal of unused or extra prescription drugs. The Safer Homes, Suicide Aware program, funded by the state of Washington, includes professional training and public-facing materials for both medication and firearm suicide prevention. As mentioned previously, firearm storage (including out-of-home storage and temporary transfers to individuals) is complicated due to variation in state laws. New efforts to facilitate firearm storage include the nonprofit organization Hold My Guns (more information on that nonprofit organization is below) and a multistate map showing locations of firearm outlets and law enforcement agencies willing at least to consider temporary storage.<sup>287,288</sup> To date, no data exists concerning the effect of these programs on firearm storage. However, a 2019 trial of Veterans exposed to an online firearm safety public service announcement did show improvement in beliefs concerning secure storage during stressful or emotional times.<sup>289</sup>

## Information Provided With Lethal Means

Providing information directly on products is another strategy with historical precedents. Warning labels on cigarettes have been required in the United States since 1966, although there has been opposition from tobacco manufacturers concerning labels and their size, graphics, and content. A 2009 review concluded that there is clear evidence that tobacco package health warnings increase consumers’ knowledge about the health consequences of tobacco use and that the warning messages contribute to changing consumers’ attitudes toward tobacco use as well as changing consumers’ behavior.<sup>290</sup> However, there is also evidence that communications about the severity of the threat (e.g., risk of fatal cancer from cigarette use) may be less effective than messages about susceptibility (e.g., risk of addiction or the risk of cancer overall from cigarette use); labels may not affect smokers who believe they can’t quit.<sup>291</sup> Medications already come with extensive lists of potential side effects, and there are numerous active campaigns about the potential addictiveness of opioid medications. The analogous firearm suicide prevention effort would be providing labels or information with firearms, firearm storage devices, or other firearm accessories.

These may take the form of information about suicide prevention (e.g., warning signs, resources for help, and supportive messages). Walk the Talk America is working with manufacturers to include suicide prevention information in the packaging of firearms, though no data exists on the effect of the program.<sup>292</sup>

The types of messages described above are being developed and disseminated, either alone or in combination, by many private and public organizations. The Gun Shop Project — collaborations between public health professionals and firearm retailers — originated in 2009 in New Hampshire after a local firearm retailer discovered a series of suicides within a week that all involved firearms purchased from his store.<sup>293</sup> The New Hampshire Firearm Safety Coalition was formed to explore how firearm retailers could have a role in preventing suicide. Coalition activities included distribution of educational material for display in retail outlets, along with optional training of retail or range staff members on suicide warning signs. Based on the promise of this initial effort, the National Action Alliance's 2012 National Strategy for Suicide Prevention called for health officials to engage in efforts to partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.<sup>10</sup> Numerous states have created similar partnerships using strategies of outreach, education, and engagement; these programs vary in scale, activities and complexity. In a recent review — despite significant diversity in origins, funding, and activities — common experiences included the importance of building community and of appropriate messaging.<sup>294</sup> Evaluation data on these projects' implementation and impact, however, are sparse. In an article assessing the impact and acceptability of program efforts in New Hampshire, it was found that roughly half of all surveyed firearms retailers promoted Gun Shop Project materials and accepted these techniques and materials, with others wanting more industry backing before joining.<sup>295</sup> A recent study in Washington State found similar results.<sup>296</sup> These represent some of the only sources of publicly reported evaluative data.

In 2016, the National Shooting Sports Foundation (NSSF) and the American Foundation for Suicide Prevention announced a new partnership at the national level, building on the local and state Gun Shop Project experiences.<sup>297</sup> They created a co-branded toolkit that was distributed to all NSSF members, who are independent firearm retailers across the United States. The toolkit included posters, brochures, online information, retailer training, and resources.<sup>298</sup> In 2019, the organizations extended their partnership to include VA, with the creation of a messaging toolkit with educational information and resources for development of community Gun Shop Project partnerships.

## Current State of Community Coalitions

Creating positive connections across a community has been shown to have universal effects tailored to suicide prevention.<sup>299</sup> Community coalitions and partnerships can create the positive social influence necessary to steer behavior away from accessing lethal means when in crisis. To be effective, community coalitions must advance a shared objective, create opportunities to share resources, achieve mutual aims, and raise awareness.<sup>300</sup>

Community coalitions or partnerships are particularly important when considering the subpopulation of Veterans. While Veterans are a diverse group, many share common values and norms that are relevant to the topics of lethal means safety and suicide.

Veteran culture promotes taking responsibility for oneself and stresses the importance of in-group cohesion, which are values that may be leveraged in making positive changes in behavior to prevent accessing lethal means of self-harm when in crisis.

There have been insufficient efforts to raise awareness of suicide as a major public health issue that can be mitigated by voluntarily limiting access to and safely storing lethal means.

Much suicide prevention education that is available to communities often omits the critical action steps of limiting access to lethal means in saving lives. Clinical interventions, such as safety planning, often do not emphasize specific actions to limit access to lethal means. That said, there are several existing coalitions and key stakeholders across the nation that can be leveraged to improve this situation.

Effective lethal means safety initiatives require a holistic community-based approach. Those in crisis, peers, family members, employers, faith-based leaders, civic leaders, health care professionals, workplaces, and private industries (including the firearm and pharmaceutical industries) can all play a role in reducing the likelihood of someone accessing lethal means during times of crisis. This guidepost aims to prompt specific actions of individuals, groups, local community organizations, and broad societal entities in promoting awareness and action in the area of lethal means safety at critical moments.

**Current State and Initiatives:** There are robust coalitions focused on the general Veteran community; there are also coalitions and key stakeholders focused specifically on reducing access and/or increasing safety with respect to lethal means for any individual who may be in crisis.

Veteran community coalitions can be leveraged to support messaging and awareness:

1. Designated national Veterans Service Organizations (VSOs) that focus on subpopulations of Veterans (e.g., Veterans of Foreign Wars; Team Red, White, and Blue)
2. Successful independent regional Veteran groups (e.g., Greater Boston Veterans Collaborative, Los Angeles Veterans Collaborative)
3. VA-supported Community Veterans Engagement Boards that exist across the country to provide a consistent “Voice of the Veteran” in VA clinical and community care operations

Similarly to the anti-drunk driving motto, “friends don’t let friends drive drunk,”<sup>301</sup> these Veterans coalitions may positively advocate for the expectation that Veterans “don’t allow” their fellow Veterans to put themselves at risk during times of crisis; this can be replicated across all populations, among Veterans and non-Veterans alike. Veterans coalitions can also share messaging with the Veteran community at large, families, and other key stakeholders.

There are also coalitions and key stakeholders that focus on lethal means safety and suicide prevention for all community members or specific subgroups (which may include Veterans and non-Veterans). Such stakeholders may include suicide loss survivors, firearm shop and shooting range owners, firearm distributors, and bridge safety coalition members. Here are examples of partnerships and key stakeholders:

- Diverse stakeholder groups or coalitions of community members (e.g., Washington State’s Safer Homes, Suicide Aware) are coming together to put local actions into place concerning suicide prevention with a focus on temporarily and voluntarily limiting access to lethal means during times of suicidal crisis. These groups prompt a wide range of recommendations about firearm and pharmaceutical storage (e.g., discourage use of traditional medicine cabinets, advocate replacing them with locked cabinetry), and the development of effective messaging designed to change storage and safety practices. The Project ChildSafe program, created by NSSF, promotes safe storage of firearms to prevent accidents. Although such programs focus more on avoiding accidental firearm injuries and providing online guides to where a free firearm safety kit could be accessed or where a firearm could be stored, they offer valuable resources to spread through lethal means safety coalitions.

- Firearm shop and shooting range owners participate in projects (e.g., New Hampshire Firearm Safety Coalition, California Gun Shop Project) focused on raising awareness of suicide as a firearms safety issue and what every firearm owner should know. These projects usually focus on disseminating educational/awareness materials and sharing guidelines on avoiding the sale of firearms to distressed individuals.
- Stakeholder groups (e.g., Alliance of Hope, Friends for Survival, Tragedy Assistance Program for Survivors) representing suicide loss survivors (individuals who have lost a loved one to suicide) can share their powerful story of the impact of suicide to help others.
- The International Parking Institute published a document focused on organizations that design, manage, and operate parking garages. The publication outlined the suicide risk posed by parking structures and various methods of prevention; it also discusses postvention. Following this lead, several community and governmental agencies have organized around improving the safety of parking structures (e.g., Ann Arbor Downtown Development Authority, the VA health care system serving Indiana, Michigan, and Ohio).
- Similarly, coalitions exist (e.g., Golden Gate Bridge District, Natchez Trace Bridge Barrier Coalition) that focus on devising systems to deter suicide on bridges. Like the parking garage efforts, bridge safety coalitions typically focus on making structural changes to the bridge design to discourage jumps, reduce the likelihood of injury, and raise awareness and supporting funds.
- The Global Railway Alliance for Suicide Prevention is an international collaboration of the U.S. Department of Transportation's Volpe Center and the Association of American Railroads.<sup>302</sup> The coalition has met twice yearly for the last seven years and promotes information about best practices in the area of railway safety and reducing access to tracks in hot spot areas with known higher rates of suicide.
- A coalition in Washington State trains pharmacists on suicide awareness and the creation of a pharmacy environment in which working with patients to lock and limit access to medications is standard. This group is also examining legislative changes that will limit access to large quantities of prescription medications, reduce quantities of over-the-counter pain relief medications, encourage the use of blister packaging, and encourage drug take-back practices.

## Gaps and Barriers

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Overall, based on the current state of the Nation, it is clear that the implementation of lethal means safety interventions in the future will require formal evaluations to help determine potential refinements and to optimize the use of limited prevention resources. There are gaps in the literature, and only a few lethal means safety interventions have been studied in detail. The results from some evaluations are still debated. Many studies have been conducted outside the United States. Furthermore, Veterans represent a distinct cultural group, and few existing studies were conducted with Veterans.<sup>277</sup> Therefore, while lethal means safety represents a key strategy for any national suicide prevention plan, new initiatives should include evaluation plans from inception. All guideposts listed in the following sections address this gap.

### Clinical Interventions

There are several challenges to implementing lethal means safety interventions in clinical settings. These challenges were identified through review of published literature and discussion with suicide prevention and lethal means safety subject matter experts.



- There is no model intervention for promoting lethal means safety. Numerous interventions have been implemented and/or tested across a variety of settings, using different messengers, and targeting different behaviors and various risk populations. To date, most interventions have focused on preventing firearm injuries among children and adolescents. While the evidence showing that lethal means safety is important for preventing suicide is strong, little is known about how to promote those behaviors. Appropriate messengers, communication strategies, settings, and best practices for augmentation of these interventions (e.g., storage devices, storage aids) are unknown.
- A key question is the acceptability of firearm-related interventions among adult firearm owners. While evidence is mounting that adults, including firearm owners and Veterans, believe that health care systems and clinicians have a role in preventing firearm-related suicides, little is known about the recommendations or messaging that those individuals find most acceptable. For example, the bulk of the empirical evidence supporting firearm-related lethal means safety suggests that removing firearms from the household will protect others in the household from suicide. There is little evidence to suggest that increasing the safety of household firearms protects firearm owners themselves. Whether firearm owners believe that firearm access increases suicide risk may also limit motivation for individuals to change firearm storage behaviors.
- Implementing clinical interventions will require a large training investment for employers and their staffs.

The challenges described above are compounded by, and are in part a result of, challenges in measurement. Suicide is difficult to assess, especially in relation to changes in individual-level behaviors. Other important intermediate outcomes (e.g., changes in firearm behaviors) are at risk of several measurement biases. Measuring suicide outcomes related to overdose is challenging because of the frequent mis-categorization of events as intentional or unintentional.

A key issue affecting health care provider abilities to effect change in firearm behaviors is mistrust from their patients. Evidence suggest that many firearm owners are concerned about seeking mental health care or disclosing their firearm ownership out of fear of losing firearm rights. Trust appears to be a critical prerequisite to enable firearm-related discussions.

Thus, providers that deliver lethal means safety interventions only for those at acute risk for suicide (e.g., in the emergency department during a crisis) may have difficulty affecting behaviors, because lethal means safety counseling conducted in these scenarios frequently occurs in the absence of preexisting patient-clinician relationships.

A large proportion of the population at risk for suicide has not been identified as such by health care systems. Therefore, interventions tailored to patients at high or acute risk for suicide are likely to miss a substantial proportion of those most at risk for suicide.

Lack of experience with firearms and discomfort in discussing firearms with patients also represent barriers to the broad implementation of lethal means safety interventions.

Efforts to develop basic competence regarding firearm knowledge (e.g., types of firearms), specific aspects of lethal means safety behavior (e.g., how to use a cable lock with various types of firearms), and the cultural lens through which various firearm owners view their firearms (e.g., a tool for safety in case of home invasion) may prove challenging.

Several state and Federal laws limit the ease with which at-risk patients may temporarily transfer firearms to another individual or entity, including during suicidal crises.

## Policy

The current lethal means safety policy landscape summarized earlier suggests several key gaps and barriers:

- Firearm policies: State firearm licensing and child access prevention laws are associated with reduced risk for suicide. These laws exist in some but not all states and require state legislatures to introduce and pass legislation. Only two states that require a background check before transferring a firearm (Maryland and Colorado) have exceptions in their law for temporary transfers, which aids those at risk and seeking to temporarily give their firearms to a trusted individual.
- Medication policies: Requirements are inconsistent for education for all prescribers concerning lethality of medications and medication combinations used in self-harm behavior.
- Environmental structure policies: There is inconsistency in consideration, review, and safeguards for barriers (e.g., bridge nets) of existing and new sites and structures.
- Voluntary safe storage policies: Safe firearm storage initiatives exist, including those educating about safe firearm storage and distribution of gun locks, but are not reaching all firearm owners in the U.S.; the scope of these initiatives (for example, the Bureau of Justice grant program) could be expanded. There is a lack of Federal grant programs aimed at supporting non-firearm-based lethal means safety — for example, efforts focused on safe storage of prescription drugs, the most frequently used means in suicide attempts.
- Training requirements for key stakeholders — including health professionals, firearms shop owners, and social service providers — about the identification of medication users and potential firearm purchasers who might be at risk for suicide.
- Suicide prevention education: No current policies require licensed health care providers, social service providers, or staff members of firearm shops or ranges to provide suicide prevention education materials to patients/clients/customers.
- Lethal means counseling policies: The health system lacks policies supporting clinicians' delivery of evidence-informed lethal means counseling interventions, like Counseling on Access to Lethal Means. These lethal means counseling interventions should focus on all lethal means, including firearms.
- Firearm storage: Additional policy-related questions relate to the liability of retailers or law enforcement agencies that store weapons. Such concerns relate to avoiding damage to or theft of weapons during storage as well as return of weapons after storage (e.g., liability if the person who retrieves a weapon then uses it in a suicide attempt).<sup>303,304</sup> For at-home storage, data suggest that most Veterans (and other firearm owners) prefer lock boxes or other quick-access locking devices to cable locks.<sup>275</sup> Yet many firearm safety and suicide prevention campaigns include provision of free cable locks, and prior work suggests that inclusion of a locking device with counseling may result in more significant behavior change. A better understanding of whether or how such programs affect home storage will be important.<sup>305</sup>
- Confidentiality: Matters concerning confidentiality, discouragement in seeking mental health care, and other complexities warrant robust dialogue and research. The community voice is needed on this matter.
- Smart technology: This holds promise for increasing firearm safety but is not proven to prevent suicide (aside from teenage suicide). Barriers exist, such as unproven technology, resistance to widespread dissemination from firearm rights advocates, and attitudes and opinions of firearm owners who do not trust the premise.<sup>306</sup>



- Pharmaceuticals: Dispensing small numbers of medications has cost, logistical, clinical workflow, and time-burden complications that must be factored into any routine change in practices in this area.

## Public Health Messaging and Education

Current knowledge gaps and challenges for the public health messaging and education guideposts fall into four main categories, including message, messengers, audience, and metrics.

1. **Message:** Development of a best, consistent message is a fundamental and critical challenge. Naming the topic itself is important; “firearm safety” (which might suggest trigger discipline and other tenets of firearm handling) versus “firearm safe storage” is one such debate. The phrase “lethal means safety” likely has little significance for the general public, but an agreed-upon alternative has yet to emerge. There is a movement away from “lethal means restriction” (the term previously used), based on research findings that the term “restriction” was less preferred.<sup>307</sup> Identifying how to shorten or simplify the overall goal — “have a conversation about suicide method reduction” — will be a critical first step in broader messaging efforts. Strategies to engage with law enforcement are needed.
2. **Messenger:** Identifying and engaging the best, most credible messengers remains an ongoing effort. Development of the Gun Shop Project has been an important move forward in building trust and collaboration with the firearms community. To date, the involvement of the larger national chains has been limited in large part because projects often arise at the local or state level, and store managers must align with national directives. Identification of messengers has not historically been as widespread as the recommendations below envision. Attention must also be focused on specific at-risk groups, including Veterans and Service members broadly, as well as specific demographic groups (e.g., Native Americans and LGBTQ populations).<sup>308</sup>
3. **Audience:** As discussed above, messaging and intervention needs have not historically occurred across the spectrum. One end of the spectrum is “upstream,” general population campaigns promoting universal, routine secure storage and recognition of suicide warning signs. The other end of the spectrum is “downstream,” effective intervention and counseling with individuals with active suicide risk — for example, in clinical settings. While the specific content may vary depending on the audience and medium (e.g., video public service announcement for dissemination through social media versus in-person, one-on-one counseling), consistent messages and content do not currently exist to promote uptake, retention, and behavior change.
4. **Lack of Metrics:** To date, there are no data on whether or how the public-facing messaging, Gun Shop Project, or other programs affect behavior, storage, or suicide attempts or deaths. Small studies have identified that counseling of parents of at-risk teens may prompt changes in storage of home firearms and medications; and lethal means safety has been effective at the population level, mostly through policy- or environment-based interventions (e.g., regulation of cooking gas, barriers on bridges).<sup>309</sup>

## Community Coalitions

Most broad community change initiatives can be logistically and financially challenging to start, spread, and sustain. The lethal means safety recommendations found in this document represent changing both widespread cultural awareness and behavior (promoting the idea that suicide prevention, and means safety, is everyone’s business), as well as similar endeavors that are focal and industry-specific (e.g., parking-lot safety).

Therefore, a current gap is a detailed operational plan for what broad and specific coalitions are needed and how those entities would be funded, launched, and sustained effectively on a national scale.

There is much potential in Veterans coalitions' being a positive force in bringing about culture change. Firearms are woven into the fabric of many Veterans' lives and community groups. But some Veterans may misinterpret or misunderstand lethal means safety efforts as a veiled approach at "gun control" and, thus, may mistrust them. Coalitions may exist that run counter to the effort at addressing lethal means safety in any fashion.

There are many firearm safety courses available through state and national education entities (e.g., Kalkomey); however, there are no national standards or coalitions that guide this education. Local coalitions may not consider providing firearm education as part of their suicide prevention efforts. Roughly two-thirds of U.S. firearm owners do not receive any firearm training at all. Research suggests that only 1 in 7 of those educated reportedly receives information on suicide.<sup>310</sup> A gap exists in leveraging this educational opportunity to focus on lethal means safety and suicide.

Law enforcement and other professions in which firearms are required as part of duty are common career fields for Veterans. Normative change is needed in terms of how the country communicates about use of firearms and storage in such cases. Regardless, this is an added variable that may complicate efforts to reduce access to lethal means for some Veterans at higher risk for suicide.

## Recommendations

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The PREVENTS Office created 22 specific and detailed recommendations meant to close the gaps and overcome the barriers discussed above. Each recommendation and its corresponding action have been aligned to the following two overarching recommendations:

1. Increase awareness of lethal means safety by developing and implementing a multifaceted national communications campaign focused on educating all sectors of the population.
2. Increase program implementation about lethal means safety, including voluntarily reducing accessibility of lethal means for individuals in crisis, increasing free/inexpensive and easy safe storage options for applicable lethal means, and encouraging a culture of openness that supports discussions about suicide and suicide prevention.

Each of the 22 specific and detailed recommendations align with the four guideposts of clinical interventions, policy, public health messaging and education, and community coalitions.

*Table 6-1*

Recommendations
Identify ways to incorporate evidence-informed lethal means safety interventions into existing Federal prevention efforts.
Convene a group of behavior change experts to study and recommend policies to incentivize safe storage behavior.

Recommendations
Develop and promote lethal means safety counseling training materials and lethal means safety education into suicide prevention efforts to highlight that suicide is not just the result of mental illness.
Conduct a review of Veterans Health Administration facilities to determine those that have yet to adopt evidence-informed medication and environmental precautions and then provide support to ensure that facilities have what they need to implement these programs.
Put in place health care accreditation standards requiring organizations to deliver lethal means assessment and evidence-informed counseling interventions (e.g., Counseling on Access to Lethal Means) across health care settings, including primary care, behavioral health, and emergency departments.
Research funding designed to actively support and expand the development and evaluation of novel lethal means safety programs, while ensuring that research funding criteria explicitly prohibit grants to organizations that lobby for or against gun control restrictions.
Access financing mechanisms that allow health care providers to be reimbursed for delivering evidence-informed lethal means counseling.
Encourage all U.S. medical and nursing schools to train students in evidence-informed lethal means counseling.
Incentivize key community stakeholders (e.g., health care and social service providers, firearm shop and firearm range staff members) to complete lethal means safety training.
Expand, elevate, and create key partnerships between: <ul style="list-style-type: none"> <li>• Suicide prevention organization, government, and pharmaceutical industry stakeholders to promote proper pharmaceutical disposal practices.</li> <li>• Health care professional organizations and hospital associations to promote the early identification of suicide risk, safety planning interventions, and lethal means safety follow-up.</li> <li>• Lethal means safety groups and general violence prevention groups (e.g., domestic/intimate partner violence prevention, workplace violence prevention).</li> <li>• Existing coalitions that focus on occupations that are commonly held by Veterans and have access to lethal means (e.g., police, military contractors, construction).</li> <li>• The Global Railway Alliance for Suicide Prevention, the coalition of the Department of Transportation and the Association of American Railroads.</li> </ul>
Expand current VA and DoD firearm lock distribution programs.
Establish a national coalition of lethal means stakeholders to drive implementation of sustained change.

Recommendations
Develop programs that facilitate community interventions to support voluntary reduction of access to lethal means (e.g., medication disposal sites and free community storage lockers for firearms).
Support implementation of a publicly available and easily accessible online map for out-of-home firearm storage and medication disposal in all 50 states.
In the future, explore grants to public and private nonprofit entities to create/expand community coalitions focused on lethal means safety, while ensuring that funding criteria explicitly prohibit grants to organizations that lobby for or against gun control restrictions.
Define and showcase effective models and practices of community partnership/engagement specific to lethal means safety that are based on existing strong practices.
Explore partnerships within and outside the government to provide financial and logistical support for the distribution of naloxone.
Form a program evaluation board that reviews whole-population initiatives (e.g., policies, universal interventions) using methods such as natural experiments, regression discontinuity designs, and interrupted time series designs to test whole-population lethal means safety initiatives.
Expand the scope of coalition work focused on the design, management, and operation of parking garages and other structures that may pose suicide risk of falls by creating an evaluation method to assess suicide risk in existing structures.
Expand programs that facilitate the easy distribution of medication return envelopes (e.g., the VA Center for Medication Safety, known as VA MedSAFE) and expand pharmacy programs for enforcing use of blister packaging and limiting prescribed quantities of potentially lethal medications.
Research the effectiveness of in-home safe firearm and safe prescription storage in suicide prevention.
Seek support and voluntary funding from lethal means manufacturers (e.g. firearms, pharmaceuticals) to support various coalitions.
To eliminate barriers to seeking care, develop messaging to remove misconceptions about the connection between mental health care/reporting and access to firearms.

# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs



## Chapter 7 Examples of High-Risk Groups

## Examples of High-Risk Groups

While suicide has no single cause and no single solution, there are factors that can either increase one's suicide risk or serve as protective factors against suicide risk.



Figure 7-1

Suicide is a complex problem, affecting not just Veterans, but people from all walks of life and of all ages. This chapter examines the data available for high risk populations and the Veterans and Service members within these groups. It is not an exhaustive review. In fact, many of these sections overlap and reflect the voices of Veterans and Service members, parents, colleagues, and children. Woven between sections on different populations are four case studies that provide an in-depth look at first responders and public safety professionals, homeless individuals, children, and those affected by suicide loss.

## Active Component Service Members

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Suicide rates of the U.S. Armed Services are roughly equivalent to the rates of the U.S. general population after adjusting for age and sex, with the exception of the National Guard.<sup>311</sup> However, from 2013 to 2018, the suicide rate for the Active Component (AC) increased from 18.5 to 24.8 suicides per 100,000 Service members.<sup>311</sup> AC Service members who died by suicide were primarily enlisted, less than 30 years of age, and male; primarily, they died by firearm.<sup>311</sup>

In addition, according to the Department of Defense's Health Related Behaviors Survey,<sup>312</sup> "almost one-fifth (18.1 percent; CI: 16.7–19.4) of Service members reported thinking about trying to kill themselves at some point in their lives, and 12.3 percent (CI: 11.2–13.5) reported thinking about doing so since joining the military; 5.1 percent (CI: 4.3–5.9) reported at least one suicide attempt in their lifetime." One subgroup "more likely...to report depression, non-suicidal self-injury, [and] suicide ideation or attempts" was the 6.1% of people in the U.S. military who self-identified on the survey as lesbian, gay, bisexual, or transgender.<sup>313</sup> Among individuals who identify as lesbian, gay, or bisexual, the attempted suicide rate is three to four times higher than the general population and is up to 10 times higher for transgender adults.<sup>314</sup> The need to support and protect the health of Service members remains essential to the readiness and resilience of the U.S. Armed Services. A variety of risk factors exist at the individual, relationship, and community levels (e.g., access to lethal means, trauma, relationship or financial stress, mental health diagnoses and substance misuse). While many of these risk factors are also applicable to the civilian population, combined with AC Service member sociodemographic factors and a unique military culture and environment, they represent distinct challenges facing AC Service member populations.

Military cultural values can serve as both protective factors against suicide risk and as suicide risk factors. Unit cohesion, devotion to duty and mission, and stoicism are integral to military success but can also cause fear of repercussions. Recognizing and enhancing protective factors, such as strong social connections, problem solving, and coping skills, can reduce the risk for suicide. Efforts are underway to help young and enlisted AC Service members develop and enhance foundational skills to deal with life stressors early in their military career as well as recognize and respond to suicide warning signs in places such as social media platforms used frequently by their peers. Resources, such as Rational Thinking-Emotion Regulation-Problem-Solving (REPS) training and Resources Exist and Can Help (REACH) training, are currently being piloted with the goal of fostering adaptive and strategic skills and addressing the most prevalent help-seeking concerns of AC Service members. The Department of Defense is implementing additional suicide prevention initiatives and resources to educate and foster awareness, connections, peer engagement, and communication, including an effort to embed mental health and counseling professionals in military units.<sup>315,316</sup> One of these initiatives, the "This Is My Squad" program created and led by the Sergeant Major of the Army, aims to empower noncommissioned officers to take care of their soldiers and build cohesive teams. By engaging with fellow soldiers, squad leaders can instill trust and confidence, encouraging soldiers to come forward with challenges, while also better positioning themselves to detect personal dilemmas and crises. Resources such as the Veterans/Military Crisis Line and Military OneSource also provide avenues for confidential counseling and support. All of these are focused on improving safe communication and reporting, increasing help-seeking behaviors, and reducing barriers to care.



## American Indian/Alaska Native

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American Indians/Alaska Natives serve the military in a greater proportion than any other ethnic group. In addition, American Indians/Alaska Natives (AI/AN) communities have the highest rates of suicide of any racial or ethnic group in the United States.<sup>317</sup> Many of the most critical risk factors for suicide disproportionately affect AI/AN communities, who rank lowest on almost every indicator of social, physical, and economic well-being.<sup>318</sup> AI/AN communities have the highest poverty rate and lowest life expectancy of any racial or ethnic group, have unemployment rates that are double the national rate, and have a higher likelihood than other ethnic groups of experiencing difficulties related to health, substance misuse, and lower education levels.<sup>319,320,321,322</sup> AI/AN Veterans overall have a higher income than AI/AN non-Veterans but have lower personal incomes than Veterans of other races.<sup>323</sup> AI/AN families and communities are significantly affected by high rates of adverse childhood experiences, mental health issues, physical violence, and sexual abuse, and they are twice as likely as members of the general population to experience posttraumatic stress.<sup>324,325,326</sup>

While the risk for suicide in the general population typically increases with age, the opposite is seen in AI/AN communities, in which the highest rates of suicide are found among adolescents.<sup>327</sup> Data strongly indicate a particularly high risk for suicide among youths with a friend or family member who attempted or completed suicide. Given that AI/AN communities are often tightly knit and highly concentrated, the alarmingly high rates of suicide among AI/AN adolescents and young adults have created heightened concerns about the risk for suicide clustering in AI/AN communities.<sup>324</sup> Many AI/AN communities are geographically isolated, which can limit economic and transportation opportunities, thereby reducing both financial and physical access to mental health care and other services and presenting additional risks for suicide. AI/AN Veterans are more likely to lack health insurance and have a service-connected disability than Veterans of other races.<sup>328</sup> Other challenges include limited internet access, lack of specialists, distrust of providers, and lack of culturally aware or competent care.<sup>329,330</sup> Among AI/AN youths, beliefs about mental health and help seeking were more commonly reported as reasons for not seeking care than structural or financial barriers were.<sup>331</sup>

Historically, many of the best practices to do with community capacity building have shown relatively little application for meeting the unique needs and cultural realities of AI/AN people.<sup>332</sup> AI/AN communities need to be empowered to develop their own community capacity-building frameworks and programs that use the underlying concepts of public health. This requires moving beyond cultural competence and cultural sensitivity to a deeper awareness of the various social, historical, cultural, and environmental factors that influence the health behaviors of AI/AN people. Moreover, many AI/AN communities have become disconnected from the cultural values and traditions that may have otherwise served as protective factors and sources of strength during times of hardship, such as extended family, a shared sense of collective community responsibility, indigenous generational knowledge or wisdom, traditional healers and medicine, and community pride. For Veterans, previous research has advocated for a holistic approach that takes into account the mind, body, and spirit as a way to improve culturally competent care for AI/AN Veterans.<sup>333</sup> For AI/AN youths, upstream life skills interventions that promote connectedness to culture and traditions have shown efficacy in fostering resilience and promoting purpose and value of life.<sup>334</sup>

Improved cooperation and connection with tribal communities on the Federal, state, and local levels is also critical to ensuring that a safety net of interconnected programming is available to these communities. For example, AI/AN people have the highest rates of military service among all racial or ethnic groups.<sup>335</sup>



AI/AN Veterans are also more concentrated in rural areas than Veterans of other races or ethnicities are, with roughly 39% residing in rural, isolated, and geographically dispersed tribal communities and trust lands.<sup>336</sup> Initiatives within the Department of Veterans Affairs (VA) and other Federal departments have focused on improving programming and outreach efforts with tribal communities to ensure that AI/AN Veterans are aware of the services available to them and that population-specific barriers to receiving them are minimal. Innovative solutions to the complex challenges facing AI/AN communities in general, and AI/AN Veterans in particular, are needed to empower these individuals and prevent suicide.

## Caregivers

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On the roughly 44,000 flights that traditionally cross the United States each day, 2.7 million people will be reminded to secure their own oxygen mask before assisting others. This universal safety instruction acknowledges the fact that, while individuals tend to prioritize their loved ones' well-being over their own, effectively caring for someone else starts with caring for oneself. It also demonstrates the importance of broad and repeated messaging, even when the risk of an emergency is relatively low.

Far less consideration has been paid to encouraging self-care among the 40 million Americans who are currently serving as unpaid family caregivers to a loved one.<sup>337</sup> One study reported that only 32% of family caregivers said they had ever been asked by a health care provider about what they needed to care for their family member and that only 16% had been asked what they needed to care for themselves.<sup>338</sup>

Historically, there has been little focus on the specific needs of caregivers of Veterans and Service members. Indeed, many of these individuals come from a culture where they are even less likely to focus on self-care or ask for help.

Veteran and military caregivers are a diverse group that includes the parents, spouses, neighbors, friends, and children of Veterans and Service members; according to recent estimates, approximately 25% of family caregivers are millennials.<sup>338</sup> Compared with pre-9/11 military caregivers, post-9/11 military caregivers are more likely to be caring for a younger person with a behavioral health concern and to be nonwhite, a Veteran, employed, and not connected to a support network.<sup>339</sup>

Time spent caregiving can reduce income, employment, and overall well-being, which may affect a caregiver's ability to fulfill their caregiving role.<sup>340</sup> A growing body of literature finds that caregivers are at greater risk of experiencing depression and anxiety, suicidal ideation, alcohol and substance misuse, and a range of other health complications that can negatively affect their physical and mental well-being.<sup>341,342,343,344</sup> For example, a 2017 survey found that approximately half of unpaid U.S. caregivers reported symptoms of depression (53%) and sleep disturbance (46%).<sup>345</sup> Further, the impact of caregiving varies across conditions and populations. Veteran and military caregivers have twice the rate of depression that nonmilitary caregivers have, which correlates to the time spent providing care and helping the care recipient cope with behavioral health concerns.<sup>346</sup> Moreover, caring for someone with dementia, traumatic brain injury (TBI), or posttraumatic stress disorder has been associated with particularly heightened risk for depression.<sup>347,348,349</sup>

The act of caregiving itself does not cause depression. In fact, caregiving often creates a strong sense of purpose and may enhance an individual's problem-solving and coping skills.

Rather, it is the fact that meeting the time and resource demands associated with caregiving often requires family caregivers to make considerable personal sacrifices across multiple life domains (resulting in, e.g., marital strain and workplace challenges), which can lead to feelings of anger, hopelessness, isolation, and exhaustion.<sup>350</sup> The financial burden of caregiving cannot be ignored, either; according to recent estimates, caregivers pay nearly \$7,000 per year in out-of-pocket expenses related to their caregiving.<sup>351</sup> Among post-9/11 military caregivers, the estimated cost of lost productivity is \$5.9 billion (in 2011 dollars).<sup>352</sup>

To decrease the potential negative consequences of caregiving, health care providers can be trained to recognize signs of caregiver burnout — through screening and mental health check-ins for family caregivers as part of their beneficiary's appointment — and to provide support. Experts contend that improving education, training, and resources to better prepare caregivers for the responsibilities of the role is also critical, as a significant contributor to caregiver anxiety stems from a lack of knowledge and experience.<sup>353</sup> For example, Congress recently mandated the development of a curriculum to support the needs of military caregivers of patients with TBI.<sup>354</sup> Also, organizations such as the Elizabeth Dole Foundation and VA's Caregiver Support Program are seeking solutions for the challenges caregivers face and providing resources for their long-term needs. Studies show that, on an interpersonal and community level, a strong social support network (e.g., family and friends, community resources, religious affiliation) and respite care are two particularly important protective factors for caregivers.<sup>355</sup> Enhancing opportunities for building social supports — as through online communities and peer networks that offer connection, hope, support, and education — are important for normalizing experiences and promoting self-care. One such online program, the Red Cross' Military and Veteran Caregiver Network, indicated a reduction in social isolation with participation. Respite care — which includes assistance provided by family members, friends, or volunteers; day care or nursing home services; and in-home assistance — is critical for providing caregivers with the opportunity to engage in self-care.

Programs and services to support caregivers should be affordable and accessible, which may require more telehealth options and trained health professionals to increase the availability of convenient appointment times and locations. Finally, while society seems to acknowledge how noble the role of caregiving is, it rarely recognizes caregiving as having monetary value. Policies that allow family caregivers to retain and earn income, such as the Family and Medical Leave Act and VA's Program of Comprehensive Assistance for Family Caregivers, are important to address barriers and mitigate any long-term negative impacts of caregiving.

## First Responders/Public Safety Professionals

### Key Facts:

- First responders and public safety professionals are at higher risk for suicide than other civilian populations.
- Helping first responders and public safety professionals feel comfortable talking about risk factors and suicidality is critically important. Public safety leadership must create a cultural shift to change the mindset that one should be able to “handle” trauma.
- To effectively protect our communities, it is imperative that first responders and public safety professionals have access to adequate mental health care.

### Risk Factors



Public safety is crucial to the well-being and success of a community. First responders and public safety professionals (PSPs) include law enforcement officers, firefighters, emergency medical personnel, corrections officers, telecommunicators, and coroners. These men and women are tasked with responding to traumatic and often high-risk situations yet choose to serve their communities despite the toll it can take on their personal well-being. According to the Police Executive Research Forum, the risk for suicide among law enforcement officers is 54% greater than among all other professions. Law enforcement officers and firefighters are more likely to die by suicide than in the line of duty. In 2017, there were 103 reported firefighter or EMS suicides, compared with 93 line-of-duty deaths. The same year, there were 129 law enforcement line-of-duty deaths and 140 reported law enforcement suicides.<sup>356</sup>

Although it is difficult to track, the Department of Labor estimated that in 2014 Veterans made up roughly 25% of law enforcement, 18% of firefighters, and 10% of EMS workers.<sup>357</sup> Many Veterans choose a career in public safety to continue their service to others. Public safety entities are often structured as paramilitary organizations with missions of protecting the communities they serve. Many Veterans find this structure assists with the transition from active duty to civilian life.

In addition to daily exposure to traumatic events, other risk factors include shift work, proximity or access to lethal means (weapons, narcotics, medications), and a culture that promotes the expectation that one should be able to “handle” high-risk or traumatic situations. This same culture often encourages a “suck it up” or “tough it out” attitude that discourages help-seeking behavior.

### Barriers and Promising Practices

Most public safety entities are locally run organizations and are, therefore, forced to rely on their own limited resources when implementing programs.

This means that they may have to make difficult choices — such as whether to increase pay for officers and staff members or to implement a mental health or peer support program.

There are many nonprofit and national organizations that assist PSPs in need; however, many PSPs are not aware of these programs.

The stigma surrounding mental health treatment is another barrier, as PSPs are often reluctant to appear ill-equipped to handle the stressors of their profession. In recent years, local and national leaders have pushed to change this culture; however, more work is needed. In 2019, the Fairfax County (Virginia) Police Department, with the assistance of the U.S. Marshals Service Behavioral Analysis Unit, conducted a survey throughout Virginia to identify risks and protective factors related to the public safety professions.<sup>358</sup> Twenty-six public safety agencies responded with significant PSP participation. Of the 5,000 participants, 7.8% reported having suicidal thoughts. The survey found that 4.4% of police, 8% of fire and rescue, and 10.3% of public safety communications professionals reported having suicidal thoughts within the last year. Rates of suicidal thoughts among police officers were lower than among their fire and safety communications counterparts. However, the survey noted that it is difficult to determine whether police officers were simply less likely to report suicidal thoughts. Another significant finding was the relationship between time in the profession and reports of depression. While 12.5% of PSPs reported work-caused depression in the first five years of service, the number drastically increases to 24.6% in PSPs with six to 10 years of service and slightly increases further with additional years on the job. This drastic increase between the first five years of service and the remaining years of service indicates a need for mental health support throughout the public safety professional's career. The Virginia public safety leadership obtained an important snapshot of the state of their PSPs. Thanks to the success of this survey, the Fairfax County Police Department is expanding the survey nationwide.

A cultural shift is particularly relevant when discussing the impact of access to lethal means for those who are struggling emotionally and may be suicidal. In law enforcement, firearms are a required tool of the profession that may be confiscated if department leadership believes officers are a threat to themselves. Law enforcement officers often fear that they will be removed from their position if they are struggling emotionally. Despite the good intentions and precautionary measures of agency leadership, an officer forced to turn in a weapon and their badge ends up suffering another significant stressor — the loss of their identity. Leaders in the New York Police Department (NYPD) recognized this as being a barrier for officers seeking help and implemented a new policy. When an officer's weapon is taken for nondisciplinary matters, he is allowed to keep his badge. This simple step reminds the officer that he is still part of the law enforcement family and provides a tangible reminder that he can return to the job he loves.

Many jurisdictions around the country have introduced mental health and wellness initiatives. Peer-to-peer counseling is a common approach used by agencies to provide mental health support to individual PSPs. These programs provide specialized training in peer counseling. This type of support may take the form of facilitating conversations with those affected after a critical incident, accumulated trauma, or personal trauma.

These trained "peers" have information on resources available to assist the first responder should further professional help be useful or necessary.

Some states, including South Carolina, Georgia, North Carolina, Ohio, Arizona, Tennessee, and Virginia, often have a team leader who can coordinate meetings after a critical incident and ensure the trained peers are accessible to PSPs throughout the entire state. In these jurisdictions, peer support programs periodically host a conference that PSPs and their spouses can attend after a critical incident or accumulated trauma. Peer teams from surrounding states are often invited, and participants are given the contact information of all peer team members. It is not uncommon for a peer to provide support to a public safety professional or public safety professional's spouse from another agency or state.

Many departments recognize that mental health professionals serving PSPs must be trained to address the specific trauma related to each profession. Within VA, the Law Enforcement Training Center, in conjunction with VHA clinical leaders, developed community training to bolster suicide prevention initiatives. The training provides guidance on identifying individuals who may be at risk for suicide and identifies prevention measures that can be implemented. The collaborative training emphasizes recognition of the warning signs of suicide and encourages individuals to assist in bringing at-risk individuals to VA facilities for care before they reach a point of crisis. PSPs are exposed to traumatic events at a higher rate than many of their civilian counterparts and to kinds of trauma that are different from those experienced by the general public. In addition, many PSPs are concerned about the professional consequences of seeking mental health assistance. They may be reluctant to ask for help or acknowledge that they are struggling. Properly training and preparing mental health professionals to assist PSPs is key to building rapport between the PSPs and the mental health professionals. The Fairfax County Police Department employs mental health providers at the agency and has implemented mandatory annual checkups for their officers. Onsite mental health professionals help build rapport and can assist outside health care professionals with understanding the agency's culture. Another successful method is using specifically trained mental health professionals from the community to provide services at a designated location. The First Responder Support Team in Charleston, South Carolina, was created after nine firefighters were killed battling a warehouse fire in 2007. This team of mental health professionals are trained to assist PSPs at a discreet location separate from the mental health clinic. The program has support from public safety leaders and is used by PSPs.

Some agencies provide specific instruction on developing healthy coping skills and general well-being to help their PSPs address the challenges they face. The goal of such efforts is to educate PSPs on early recognition of mental health issues and provide a pathway to appropriate intervention. Many of these programs focus on a holistic approach and encourage the use of a variety of healthy coping skills, such as exercise, spiritual guidance, sports, and other hobbies, as well as traditional counseling. These programs may also teach PSPs to recognize warning signs in peers. In 2019, New Jersey became the first state to require all state, county, and municipal police agencies to appoint a "resiliency officer." This officer oversees training on how to better handle the stressors associated with the challenges of being in law enforcement. This initiative also requires all law enforcement officers in the state to complete a two-day course on coping and resiliency skills. The appointed resiliency officers serve as peer support resources and have access to programs for officers in need. Several agencies nationwide have implemented similar programs.

The Charleston County (South Carolina) Sheriff's Office includes family members in its initial resiliency training for recruits, in which it provides essential phone numbers and resources to all participants.

Ultimately, it is incumbent on the leaders of public safety organizations to address the importance of mental wellness within the ranks.

Whether an agency creates a unit specifically tasked with PSPs wellness (e.g., NYPD's Employee Assistance Unit) or collaborative teams (e.g., the Lowcountry Firefighter Support Team in South Carolina) consisting of peers, chaplains, and mental health professionals, leaders must ensure that they are fostering an environment that supports PSPs seeking help when they are struggling emotionally, regardless of the source of their challenge.

## People With Chronic Health Conditions

Approximately half of the U.S. population is diagnosed with at least one chronic health condition (CHC); Veterans have much higher rates of chronic health conditions than the general U.S. population has.<sup>359</sup> Nearly 1 in 5 Veterans between the ages of 45 and 54 report at least two chronic health conditions, compared with less than 15% of non-Veterans.<sup>360</sup> Managing a CHC can be time-consuming and costly; it often requires significant adjustments to one's lifestyle, aspirations, and employment.<sup>361</sup> Individuals with a CHC may experience loss of identity, feelings of hopelessness, relationship challenges, employment difficulties, and financial strain. As a result, they are at a significantly increased risk of experiencing depression and suicidal ideation.<sup>362</sup> The presence of CHCs can increase suicide risk to up to four times that of a person without these challenges, and this is particularly true for Veterans who are already at an increased risk for suicide. There is a particularly strong and specific link between CHCs and suicide in young people, as well as in individuals with multiple or specific CHC types, including multiple sclerosis, Parkinson's disease, stroke, and TBI.<sup>363,364,365,366</sup> For example, individuals with TBI are reported to have a risk for suicide that is nine times that of the general population's risk. Additionally, TBI is common among some groups of Veterans, with as many as 23% of Veterans who served in the Iraq and Afghanistan wars experiencing the condition.<sup>367</sup>

There are numerous challenges associated with diagnosing and treating depression and suicidal ideation resulting from a CHC. It can sometimes be difficult to identify the cause of changes in mood and reasoning. It can be the CHC itself, an underlying mood disorder, or a combination of the two. This difficulty can inhibit finding the best methods for identifying those at risk, for intervening, and for developing a course of treatment. Further, depression can negatively affect disease progression through multiple mechanisms, such as a lack of compliance with treatment recommendations and a propensity to engage in unhealthy behaviors.<sup>368</sup> In addition, these factors related to chronic health conditions may affect the Veteran population, which is subject to higher rates of comorbid conditions like TBI and PTSD, differently than it affects others.

Guidelines for managing CHCs emphasize the importance of self-management knowledge and skills while promoting the highest possible levels of independence and autonomy.<sup>369</sup> Self-management is influenced by a multitude of individual, interpersonal, and health care system factors.

At the individual level, efforts that promote positive adjustment and address commonly cited barriers to self-management and treatment compliance (e.g., treating mental health concerns, minimizing burnout related to managing complex regimens) have shown a positive impact on both condition-specific health outcomes and emotional well-being.<sup>370,371,372</sup> For example, patients who receive treatment for depression show an overall improvement in their medical condition, have better adherence to treatment plans, and have a higher quality of life.<sup>373</sup>

At the interpersonal level, greater adjustment and treatment adherence are consistently linked with high levels of social support from family and peers.<sup>374</sup>

Interventions that consider the impact of CHCs on families, especially those of Veterans who have already experienced the stress of supporting family members during deployment or long periods away from home, are also important; the burden of managing a CHC often falls on parents and siblings and is associated with higher levels of family conflict.<sup>375</sup> Characteristics of the communities where individuals live and work (e.g., access to grocery stores, walkability, safety, and street lighting) can have a direct impact on self-management by influencing access to programs that support healthful behaviors (e.g., physical activity); healthy eating; and access to health services, community-based programs, and resources (e.g., educational interventions, support groups, nutrition classes, housing programs, and work programs).<sup>376</sup> Schools play a critical role in promoting autonomy and a sense of belonging for young people with CHCs before they join the military or take other career paths. For example, the School Climate Transformation Grant program, in collaboration with the Technical Assistance Center on Positive Behavioral Intervention and Supports, provides some support through social-emotional learning programs. Demonstrated to support better academic, social, behavioral, and mental health outcomes in students and other factors offer a framework for managing emotions, achieving positive goals, developing empathy, maintaining positive relationships, and making responsible decisions. Adolescents with chronic conditions have more disease-related school absences, which can lead to lower academic performance, poorer integration, and greater isolation or social exclusion. Isolation, in turn, can have long-term negative effects on both physical and mental health outcomes.<sup>377</sup>

Some studies have found that organizational factors such as appointment length, continuity of care, and patient-provider communication have a stronger impact on adherence and self-management than socio-demographic factors.<sup>378</sup> In fact, these elements were commonly mentioned by individuals who responded to the PREVENTS Request for Information (RFI). A common RFI theme was that individuals, many of whom were Veterans, felt their concerns and desires for help were not always recognized, captured, communicated, or appropriately acted upon by health care personnel and other institutional representatives. High-quality patient-provider communication leads to greater involvement in, motivation for, and satisfaction with health care; such communication can be the simplest and most cost-effective strategy for improving self-management. For many individuals, physical illnesses take precedence in medical appointments; little time is devoted to addressing potential mental health concerns. Continuing education for health care providers is important and should address best practices for engaging with patients, including Veteran-specific cultural training, screening, early intervention, and crisis intervention.

Finally, the burden of CHCs is inextricably linked to social determinants of health. Low socioeconomic status, poverty, illiteracy, low education level, lack of social support, unstable housing, and medication costs create barriers to effective self-management and treatment.<sup>379</sup> An example of a peer support program to manage chronic disease is the Chronic Disease Self-Management Education program, which has been rolled out in at least 25 state health departments across the country.



Policies directed at health care organizations and insurance companies can promote effective delivery of care and increase access to necessary medications and services, thereby potentially reducing the rate of suicide in this population.

## People of Color

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“People of color” and “communities of color” refer to people of racial and ethnic minority backgrounds residing in the United States, including Asian Americans, African Americans, Hispanic or Latino Americans, and Pacific Islander Americans. American Indians/Alaska Natives are not included in this section, as they were discussed earlier in this chapter. Of these populations, African American and Hispanic or Latino American suicide rates have increased significantly in recent years. While the suicide rate of minority Veterans tends to be lower than of nonminority Veterans, the number of minority Veterans is expected to increase, making the issue of minority Veteran suicide important to address.<sup>380</sup>

In assessing other suicide-related risk factors for people of color, it is important to acknowledge and address culturally relevant beliefs and attitudes about life, death, and suicide. Specific factors vary between ethnic groups, but cultural differences present opportunities to identify and support meaningful protective factors, such as community, education, faith, and work ethic. Similarly, the study of cultural relevance and sensitivity is critical with respect to suicide and people of color. Assessments of risk and protective factors as well as interventions based on white-majority samples are not necessarily generalizable to people of color. Instead, it is imperative that people and communities of color are directly involved and represented in the research, design, and practice implementation associated with their own communities.

Data on suicide rates and risk factors among people of color, including African Americans and Hispanics or Latinos, remains incomplete. Historically, studies have shown that suicide rates among African American and Hispanic or Latino Americans are lower than suicide rates among white populations. Yet recent research shows that reported suicide rates for these minority populations may not be accurate due to misattribution and incorrect data reporting. Moreover, the volume, scale, and scope of research on risk factors for suicide among people of color is significantly less than suicide research in general or predominantly white studies of suicide; much of the research on risk factors in people of color has only been conducted in the last 20 years.

Existing studies show that communities of color share some common social determinants or risk factors for suicide. These include alienation, substance misuse, history of childhood abuse, limited healthy family/social support, mental health challenges, a family history of suicide, joblessness, and poverty. At the same time, each community of color — African American, Hispanic or Latino American, Asian American, Native American, and others — has particular risk factors for suicide informed by unique experiences, behaviors, cultural attitudes, and familial structures. More work needs to be done to expand the scope of research on communities of people of color and, in turn, improve the quality of care through culturally sensitive programs, policies, and health care providers. As existing research indicates, people who do not receive culturally relevant care are more likely to discontinue treatment.



## Homelessness



While homelessness and suicide have many of the same risk factors — such as poverty, adverse childhood experiences, mental illness, and substance misuse — homelessness has also been found to be a particularly strong and independent risk factor for suicide.<sup>381,382</sup> Veterans who experienced homelessness were nearly eight times as likely as Veterans without a history of homelessness to have attempted suicide, even after adjusting for demographics and mental health. Similar findings are reported among non-Veterans, with those having a history of homelessness being four times as likely to attempt suicide as those without a history of being homeless.

The experience of homelessness often increases exposure to many traumatic, dangerous, and stressful situations that can exacerbate risk factors for suicide. Rates of suicide in homeless populations are reported to be nine times as high as those found in the general population.<sup>383</sup>

Programming that increases access to stable housing and employment represents a critical opportunity to improve overall mental health and well-being for individuals experiencing homelessness. While many communities offer shelter services, especially in the winter months, there remains wide variation in the quality and quantity of shelters, and it is not uncommon for homeless individuals to choose the streets or encampments over shelters.<sup>384</sup> Therefore, street and mobile outreach services that can reach individuals who are disconnected from mainstream services and supports to address untreated mental health concerns and substance use problems remain critical. Likewise, it is important to ensure outreach and engagement efforts are coordinated across service providers; law enforcement personnel, prisons, and jails; hospitals; libraries; and job centers to proactively seek Veterans in need of assistance with housing.

In addition, it is important to train outreach workers and service providers who work with the homeless community in suicide prevention, with a particular focus on prevention efforts oriented towards homeless individuals.<sup>385</sup> Approximately 70% of the homeless population is classified as individuals. These people may be at higher risk for suicide because they face multiple challenges.<sup>386</sup> Homeless individuals are more likely to be socially isolated than those who have family members with them.

Significant progress has been made in preventing and ending Veteran homelessness. The number of Veterans experiencing homelessness in the United States declined by nearly half since 2010. The most recent HUD Point-in-Time (PIT) Count estimated that, on a single night in January 2019, 37,085 Veterans were experiencing homelessness; a record low and a 2% reduction from the 37,878 reported in January 2018.

Since 2010, more than 800,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness through HUD's targeted housing vouchers and VA's homelessness programs.

In addition to the national snapshot provided by the 2019 PIT Count, as of Dec. 4, 2019, 81 communities — including three states — have effectively ended Veteran homelessness, based on criteria established by VA, HUD, and the U.S. Interagency Council on Homelessness.

This progress illustrates what can be achieved when government agencies work with citizens and community leaders to tailor the delivery of services in a manner that meets the needs and expectations of the community.

## Older Adults

Annually, more than 12,000 adults over age 50 die by suicide in the United States.<sup>387</sup> “Older adults” generally refers to those who are age 65 or older, and a significant portion of the American Veteran population is reaching this age, including Veterans from World War II, the Korean War, and Vietnam.<sup>388</sup> This group has one of the highest risks for suicide death in the United States.<sup>389</sup> Older adults have a suicide rate of 15.9 per 100,000, compared with 10.9 per 100,000 for the general population. Among Veterans, individuals ages 55–74 accounted for 38% of all Veteran suicide deaths in 2017. These numbers are expected to increase significantly as the baby boomers, those born between 1946 and 1964 and the second largest living generation, enter retirement age.<sup>390</sup>

Researchers believe that older adults have high suicide rates in part because they become isolated and suffer the loss of meaning and purpose in their lives. While Veterans do share many commonalities with their nonmilitary counterparts, aging Veterans face additional military-specific risk factors, such as military-related trauma and PTSD, which further contribute to feelings of loneliness and social isolation.<sup>391</sup> In addition, older adults tend to experience physical and cognitive challenges leading to decreased mobility, financial stress, and social isolation. Periods of transition may leave individuals feeling that they are a burden to society, especially if they have become reliant on a caregiver. Approximately 20% of older adults experience mental health issues that can place them at greater risk for suicide.<sup>392</sup> While the rate of older adults with depressive symptoms tends to increase with age, depression is treatable. Encouraging health care providers to regularly screen for depression and suicide risk among older adults can increase early identification and allow for early intervention.

To help prevent feelings of hopelessness, social isolation, and sense of being an inconvenience to loved ones, communities can develop broad public health interventions that address these issues for older adults. One example of a community intervention to help foster social engagement for older adults was developed by the AARP Foundation. The Connect2Affect program encourages a deeper understanding of the impact that loneliness and isolation can have on seniors, with the goal of ending social isolation. Some programs focus on mealtimes as an opportunity to increase social connection. An evaluation of the Department of Health and Human Services Administration for Community Living’s nutrition program, which provides meals to older adults, found that 93% of participants who receive meals in group settings, such as senior centers, were socially active and satisfied with their opportunities to spend time with other people. The typical group meal participant did not report loneliness, and only 7% of group meal participants in this study screened positive for depression. In addition, researchers in Japan used community outreach to prevent suicide in older adults. These researchers implemented techniques such as frequent mental health presentations, depression screenings, and mental health outreach over a 10-year period. Due to these interventions, there was a greater than 70% decrease in the suicide rate for both men and women over the age of 65. Interventions like these may be especially helpful as attention is turned toward at-risk aging Veterans.

A study in Italy adapted a community intervention to prevent suicide in older adults; it found that the use of a telephone and distress support program was successful in preventing older adult suicide deaths. The system enabled the user in crisis to press a button, which notified a response network (“TeleHelp”) and then prompted the delivery of telephonic support to the individual in distress twice a week (“TeleCheck”). This system not only provided immediate access to services but also notified a physician in the response network. Such swift access to help and support can be extremely effective in preventing suicide deaths.

The reasons older adults may be at an elevated risk for suicide include mental or physical health difficulties and lack of social connections. However, these risks can be mitigated through successful implementation of interventions, as in the aforementioned examples. Educating the general public about the normalcy of aging and an increased likelihood of depression and loss of hope is key to preventing suicide. Increased outreach, screening, and quick access to resources may have a significant impact on this age group as they transition into a new stage of life.

### Children and Youths

#### Key Facts:

- Rates of mental health disorders and suicide are increasing among people ages 10–24.
- Although there are strengths associated with military families and children, there are also unique stressors and challenges.
- It is important to continue broad messaging to families that care is available and that it is OK to seek out help when it is needed.
- Helping caregivers feel comfortable talking about mental health disorders and suicidality with children is critically important, as is dispelling the myth that talking to children about suicide increases the risk for suicide.

#### Risk Factors



Suicide is the second leading cause of death in the United States for people ages 10–24, with data indicating a 56% increase in the rate of suicide in this population between 2007 and 2017. The average Service member joins the military while still considered to be a youth; a person as young as 17 can enlist in the military. While certain populations seem to be at increased risk for suicide, there is no single risk factor that is necessary or sufficient to cause suicide. Rather, a complex interaction of biological, social, and psychological factors (e.g., substance misuse, mental illness, bullying, family stress, poverty, and physical or sexual abuse) contribute to young people’s risk profile, and the relationships between these factors are multifaceted, wide ranging, and sometimes unexpected. For example, interpersonal factors, such as family relationships, appear to be better predictors of suicide risk for black American adolescents than for their white counterparts.

Approximately 40% of Service members have children.<sup>393</sup> When thinking about military children and youth, the conversation often surrounds the balance between the strengths and stressors that military life and culture bring.

Military culture offers numerous protective factors, programs, and supports for military families, and the dynamic of military life can cultivate strengths that allow families to grow in ways that civilian families may not. Even so, military families face unique stressors and challenges related to movements, separations, deployment, and transitions into civilian life. Relocation, for example, can result in families being separated from the larger community and create disruptions in social support and connectedness, as well as a loss of resources or services for some families and children. Parent mental health issues or physical injury related to the deployment may play a role in child mental health.<sup>394</sup> There is also evidence of higher rates of use of mental health services among spouses related to deployment.<sup>395</sup> However, part of the challenge in understanding suicide behavior and risk in military children compared with civilian children is an overall paucity of data. Indeed, while some studies indicate higher rates of suicidal attempts among adolescents in military families,<sup>396</sup> other data indicate that the prevalence of suicide among military families was equivalent to or less than that of the general population.<sup>397</sup> Thus, while the physical injuries and mental health issues that can result from combat, deployment, separation, and relocation may be associated with increased risks for suicidal ideation in military children, this has not been studied in detail.

For all children, access and exposure to lethal means presents an important risk factor, especially given data showing that suicide attempts among youth are often impulsive acts. Across all families, securing firearms, medication, and other lethal means needs to be emphasized as a part of parental awareness and tracking, especially if a child or adolescent is at risk.

While downstream suicide prevention strategies (e.g., screening, counseling, clinical intervention, and reducing access to lethal means) for high-risk youth have demonstrated some efficacy on an individual level, they have shown little impact on population-level suicide rates.<sup>398,399</sup> One possible explanation for this is that prevention strategies tend to be reactive, focusing more on preventing the suicidal act than on preventing suicidal ideation from occurring in the first place. Given the complexity of suicide's underlying risk factors, distinct targets for prevention can be hard to pinpoint. Therefore, identifying underlying risk factors that commonly present in the general population may provide the strongest basis for population-level suicide prevention efforts. One such factor may be exposure to adverse childhood experiences (ACEs).

ACEs include a variety of potentially traumatic events that occur to people younger than 18. These include abuse (emotional, physical, or sexual), household challenges (domestic violence, substance misuse in the household, mental illness in the household, parental separation or divorce, or an incarcerated family member), and neglect (emotional or physical).<sup>400</sup> ACEs are commonly measured using a 10-item survey, with the total ACE score (1–10) representing the number of categories of adverse experiences that an individual experienced in childhood. It is important to note that the ACE score is not a reflection of the frequency or severity of experiences in each individual category. Since the original ACEs study in 1998, a growing body of research has demonstrated that ACEs are common in the general population (the majority has at least one ACE), often co-occur and cluster, and have a graded dose-response relationship (e.g., the higher the ACE score, the higher the risk) to an expansive list of diseases and negative health and well-being outcomes.

More importantly, although an individual's relative risk increases with each additional ACE, a score of 4 or more is associated with an exponential increase in the risk for each negative health outcome. Thus, the distribution of ACEs in the population appears to be positively skewed, with the majority of individuals at low risk and a relatively small proportion of individuals at particularly high risk.

ACEs may be particularly relevant for suicide, as a strong corollary relationship has been shown with both suicide attempts and many of the associated risk factors for suicide (e.g., depression, substance use). Moreover, recent neurobiological studies have shown that ACEs appear to disrupt normal brain development and can have long-term effects on cognitive functioning. This theory aligns well with some of the predominant theories of suicidality, which posit that early stressful events trigger a biological vulnerability to emotional dysregulation that reduces the ability to cope with future events. The cumulative impact of these early stressors and reduced coping abilities can result in prolonged or unrelenting emotional pain and suffering. The likelihood of suicide attempts among youths with an ACE score of 7 or higher was shown to be 51 times as high.<sup>401</sup>

ACEs may have additional relevance for military families, as research has found that men and women who serve in the military report more ACEs than civilians.<sup>402</sup> One key explanation for this finding is that, although many individuals enlist in the military for primarily positive reasons such as altruism and patriotism, enlistment may also serve as an escape for individuals experiencing high levels of adversity. Moreover, higher ACE scores among military populations have been considered a potential factor in the high rates of suicide among military personnel that have never been deployed.<sup>403,404</sup> In addition, a recent study reported that adolescents in military families similarly reported higher exposure to ACEs than their nonmilitary peers did.<sup>397</sup> Deployment, for example, does result in one critical ACE related to the loss or absence of a parent; two other key ACEs, child exposure to domestic violence and parent substance abuse issues, have been found in high rates among military families.<sup>405,406</sup>

### **Barriers and Promising Practices To Overcome Them**

The perception of mental health challenges as a weakness and the negative perceptions that surround mental health issues in general are key barriers to suicide prevention strategies for children and youths. Individuals will often go to great lengths to avoid or deny mental health issues to others and even to themselves. Improved understanding of mental health in general and earlier conversations about mental health within the family can help minimize a child or adolescent's tendency to keep these issues hidden. This needs to be supported by ongoing messaging that normalizes help-seeking and conversations about emotional pain. Moreover, those at greatest risk are often the hardest to reach and are outside of the typical safety net.

Increased access to resources and programs focused on facilitating overall mental health and well-being is needed. Our goal should be not only to increase the number of mental health providers but also to develop a tiered approach for collaborative and coordinated services for children through a combination of school-based, family-based, and peer-based interventions.

Early childhood interventions that promote connectedness and healthy relationships and enhance social-emotional learning and stress management skills are associated with longitudinal decreases in suicidality among very young children. Within the Department of Education, the Office of Elementary and Secondary Education provides resources (i.e., webinars or trainings) on social-emotional and other mental health needs specific to children of military families. Such strategies may be particularly important for the military and Veteran communities.

At the same time, studies have reported that individuals who serve in the military demonstrate greater resiliency and efficacy than do those who have not served; these characteristics can be enhanced to mitigate the unique risk factors that may affect military families.<sup>407,408</sup> ADAPT (After Deployment, Adaptive Parenting Tools) and FOCUS (Families OverComing Under Stress) are two promising evidence-informed prevention programs that aim to foster and develop protective processes within military families. FOCUS provides strength-based resilience training to military children, families, and couples to promote communication, problem solving, and developing a shared narrative, especially around critical issues such as separation and integration. ADAPT, while similar to FOCUS, places a larger emphasis on improving parenting practices. A key strength of these programs is that implementation grew primarily from word of mouth within the military community, demonstrating that engagement and interest is often higher when military families endorse a program as valuable and can choose to participate for the sake of their family wellness. The “Military Child Education Coalition” is another key effort focused on suicide prevention that aims to ensure inclusive, quality educational opportunities for military children affected by relocation, transition, deployments, and separation. There are also programs within organizations like the National Child Traumatic Stress Network that have strong interest in bringing their trauma-informed suicide prevention interventions into new settings such as military clinics and schools.

Given that stressors within the home — such as family conflict, parental mental health problems, violence, and the death of a loved one — can all increase children and adolescents’ suicide risk, parenting interventions that are capable of wide-scale implementation also represent a potential population-based suicide prevention and health-enhancing strategy for children. The Positive Parenting Program (Triple P) is an example of an evidence-informed public health approach to parenting with proven effectiveness in enhancing parental competence, promoting positive relationships and appropriate management of child misbehavior, and reducing family risk factors for child abuse and neglect across different cultures and socioeconomic groups.<sup>409</sup> Findings suggest that programs such as Triple P could prevent suicide through improving parenting skills, reducing coercive family processes, and decreasing parenting stress and anxiety, all of which are significantly associated with reductions in child maltreatment and suicidality.

There is also evidence for an intergenerational impact of ACEs, with higher ACE scores among parents associated with more behavioral health problems in their children.<sup>410</sup> In turn, children with more behavioral health problems are shown to have an increased risk for suicide or likelihood of engaging in risky behaviors that may increase their overall risk for suicide. These results indicate that parental ACE scores should help target parental interventions and programming for families at increased risk.

Finally, building community capacity (i.e., the quantity, quality, and accessibility of a variety of resources and supports available within a community that can be leveraged to improve or maintain the well-being of its residents) may serve as an effective broad-based approach for reducing ACEs and preventing suicide. A recent study that aimed to reduce ACEs by building community capacities that help to align suicide prevention resources and social support networks indicated that the prevalence of overall ACEs and high ACE scores (3 and above) among young adults was lower in communities with higher ratings of community capacity than in communities with low capacity.<sup>411</sup> Similar evidence on the significance of increasing social connection at the community level can also be found in suicide prevention literature.<sup>412</sup> Thus, this type of approach would address high-risk individuals by targeting low-capacity communities.

## National Guard and Reserve Members

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Together, National Guard and Reserve (NGR) members have demonstrated a sustained, higher combined suicide rate than their Active Component counterpart in previous years. Among NGR members, the National Guard had a higher suicide rate (30.6 per 100,000) than Reserve (22.9 per 100,000) in 2018.<sup>413</sup> As is true across all groups and populations, there is no single risk factor responsible for suicide among NGR members, yet these individuals and families face unique individual, relationship, community, and societal challenges (e.g., financial and relationship stressors related to geographic distance, significant time between drill activities minimizing the protective factor of unit cohesion, potentially complex health care eligibility and access) that contribute to their overall suicide risk profile.

A 2007 study, based on Department of Defense (DoD) health assessments of U.S. Soldiers conducted immediately after deployment and again at three and six months after deployment to Iraq, shows that, at height of the Iraq war, NGR members reported higher rates of mental health and general health problems than their active component counterparts.<sup>414</sup> Furthermore, NGR rates of many mental health disorders increase significantly from three to 12 months after combat, whereas the active component mental health disorder diagnosis rate does not change. This may be related to NGR-specific factors, such as readjusting to civilian life, obtaining civilian employment, and access to health care.<sup>415</sup> Current efforts by NGR leadership and by organizations working with these communities are focused on a variety of efforts to educate and engage NGR members and their families to increase early identification and improve access to care.

To improve the likelihood that NGR members receive the care that they need, military culture change regarding the negative impact of mental health diagnoses and treatment use on the career of members of the NGR is critical. In a study, Service members who screened positive for mental health problems were more likely than those who did not to report fears about being perceived as weak and about being treated differently and to report not believing treatment is effective. The study also showed that these Service members did not believe treatment for mental health concerns was effective.<sup>416</sup> Interestingly, further studies have revealed that negative beliefs about the effectiveness of mental health treatment predict service use, while negative beliefs about being perceived as weak or being treated differently diminish use of services. Considering these findings, it is important to demonstrate that mental health treatment is effective through public health messaging.



Given the stressors among NGR members on and off duty, NGR leaders are leveraging partnerships at the local, state, and Federal level to enhance readiness and improve overall health, develop strong community collaborations, promote improved family education and involvement, implement awareness campaigns about available resources, ensure positive peer influences, and garner leadership support to encourage help-seeking behavior and increase access to care. For example, the National Guard Bureau recently teamed up with VA to increase behavioral health support through mobile Vet Centers during drill weekends. Between May and October 2019, over 1,200 Army National Guard soldiers were referred to the Vet Center program for services.

## Rural Communities

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Of the 1 in 5 Americans living in rural areas,<sup>417</sup> approximately 5 million are Veterans.<sup>418</sup> From 1999 to 2015, suicide rates among people living in rural counties were 25% higher than those in large metropolitan counties (17.32 per 100,000 people in rural counties, 11.92 per 100,000 people in large metropolitan counties).<sup>419</sup> The increased risk within rural populations is even more pronounced among rural Veterans, with suicide rates 22% higher than among their civilian counterparts.<sup>420</sup> While there are many aspects of rural life (e.g., geographic and social isolation, cultural ideals, and social or economic distress) that can contribute to an increased suicide risk among residents of rural communities, there are additional risk factors that are specific to Veterans. Lowering suicide risk in rural areas for Veterans and the general population requires developing solutions that leverage existing resiliency within these communities and address prominent barriers in rural parts of the country, such as geographic isolation, potential lack of economic opportunity, and limited access to resources and health care.

Currently, nearly 70% of the areas with a mental health professional shortage are rural or partially rural. Moreover, there is lower mental health service use in rural areas than in urban.<sup>421,422</sup> Within the Department of Education, the Office of Elementary and Secondary Education gives preference to applicants that place mental health providers in rural communities. Furthermore, there are approximately only 16 psychologists for every 100,000 rural residents.<sup>423</sup> Within the Veterans Health Administration (VHA) system, approximately 35% of all VHA patients live in rural areas.<sup>424</sup> While there are significant mental health staffing shortages across the U.S., organizations such as VA are working to leverage resources such as telehealth and satellite community-based resources to address these gaps. One example is Veterans Rural Health Resources Centers (VRHRCs), which serve as field-based satellite offices across five states. Under the Congressional mandate 38 USC 7308, VRHRCs focus on improving national understanding of challenges faced by Veterans living in rural areas, identifying health disparities rural Veterans face, developing best practices to improve access to care for rural Veterans, and creating and implementing specific practices and products in rural communities to improve Veterans' health and well-being. It is essential for VA resources such as VRHRCs to understand issues from national to local levels that affect the health and well-being of rural Americans.

In addition to barriers to care, economic and social issues specific to rural communities can be potentially harmful to rural America's mental health. Currently, the overall population of rural areas is decreasing, especially the working-age population, with fewer rural residents than urban residents reporting optimism about the future of jobs in their community.<sup>425</sup> Similarly, economic crises can affect a person's overall suicide risk profile in rural communities, which may be particularly relevant when considering the impact of agricultural crises such as drought, fluctuations in global trade, and competition with industrial farming.<sup>426</sup>



While the U.S. Department of Agriculture has many programs to support rural Americans in the food and agricultural sector, they also prioritize hiring Veterans and providing specific programs to help them return to or start a new career in the farming industry. These resources focus on sustaining and growing rural America by supporting Veterans in these communities.

Within rural and farming communities, values such as hard work, self-reliance, and independence are typically highly valued.<sup>424</sup> These cultural ideals, which mirror core values within the military, can mediate the relationship between traditional suicide risk factors (e.g., relational, social, work, or financial loss; mental health disorder diagnosis; substance misuse) and suicidal ideation. Cultural ideals in rural communities can reinforce a lifestyle that includes strong work ethic, religion and spirituality, and the value of knowing one's neighbor.<sup>427,428</sup> However, in some rural communities, mental health disorders may be perceived as a personal weakness, which can prevent people from seeking and engaging with treatment.<sup>429,430,431</sup> In addition, the prevalence of firearms and poisons such as pesticides may increase access to lethal means and therefore suicide risk.<sup>432</sup> Considering these findings, any proposed intervention must be culturally sensitive to reflect the values, beliefs, and ideals of a particular rural community.

To decrease the risk factors for people living in rural communities and improve overall health, culturally appropriate interventions must be community-driven and:

- Capitalize on protective characteristics (e.g., tight-knit communities, strong faith ties).
- Train primary care providers to screen for suicide risk.
- Improve recruitment and retention of rural mental health professionals.
- Strengthen local partnerships to allow help to come from within the community whenever possible.<sup>433</sup>

## People With Serious Mental Illness

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The National Institute of Mental Health defines serious mental illness (SMI) as a mental, behavioral, or emotional disorder resulting in functional impairment substantially affecting life activities. In 2017, 11.2 million individuals, or 4.5% of all U.S. adults, were estimated to be living with SMI. Types of SMI include bipolar disorder, major depressive disorder, and schizophrenia.<sup>434</sup> Individuals with SMI have a lifetime suicide rate ranging from 4% to 8%, compared with a rate of 1% in the general population, and suicide is a leading cause of death.<sup>435</sup> In fiscal 2016, the VA National Psychosis Registry recorded 110,013 Veterans with bipolar disorder, 2.8% of whom attempted suicide; 82,292 Veterans with schizophrenia, 1.4% of whom attempted suicide; and 22,079 with other psychoses, 2.5% of whom attempted suicide.<sup>436</sup>

An example of the impact of increased suicide risk in those with SMI can be found in those diagnosed with schizophrenia. It is estimated that up to 15% of individuals with schizophrenia will die by suicide, and up to 40% will attempt suicide.<sup>437</sup> Almost half of those with schizophrenia who completed suicide had made a previous attempt, and those who attempted suicide were likely to make subsequent suicide attempts. Individuals with schizophrenia have periods of psychotic behavior often accompanied by hallucinations of auditory commands.<sup>437</sup> Periods of psychotic behavior alone do not increase the risk for suicide, but the period afterwards when the individual frequently feels guilt or embarrassment for their actions is when the individual is at the highest risk for suicide. Veteran statistics mirror these rates; data show that Veterans with bipolar disorder and schizophrenia, particular women Veterans receiving VHA care, are at a higher risk for suicide.<sup>438</sup>

In addition to general suicide risk factors (e.g., prior attempts, relationship challenges), people with SMI also have unique acute and chronic risk factors. Specifically, SMI acute risk factors include severe hopelessness, economic instability, impulsivity, unrest or instability, and aggression; SMI chronic risk factors include ongoing psychiatric symptoms, lack of cognitive or coping skills, maladaptive personality traits, and the SMI diagnosis itself. Due to the unique risk factors associated with SMI, identifying and diagnosing SMI is an important first step in reducing suicide risk in this population. However, fewer than 40% of people with a psychiatric diagnosis receive adequate care.<sup>439</sup>

One way to lower suicide risk among this group is to ensure that people with serious mental illness are identified early and engaged by their community — so that they receive proper care and support. One study found that 55% of people who died by suicide had an undiagnosed mental illness.<sup>440</sup> Because mental illnesses may develop later in life, an individual's illness may be missed completely or misdiagnosed as a result of conflicting symptoms between diagnoses (e.g., symptoms of bipolar disorder versus symptoms of major depressive disorder), lack of awareness of symptoms of mental illness in adults,<sup>441</sup> and lack of access to care due to demographic and socioeconomic status. Early diagnosis and appropriate clinical treatment can lower the risk for suicide in these individuals.<sup>437</sup> In 2017, 3.4% of Veterans with schizophrenia and bipolar disorder had a gap in VHA services lasting for more than one year, further increasing their risk for suicide. Through VA's SMI Re-Engage program, local Recovery Coordinators provided outreach, which led to a return to VHA care for more than 1,700 Veterans between 2012 and 2017.<sup>442</sup> Because mental health disorders may develop without warning signs and can be difficult to detect, primary care providers should incorporate mental health screening into their routine office visits with patients to increase early identification, diagnosis, and treatment and educate patients about recognizing early signs of SMI.

For patients with diagnosed SMI who do receive care, appropriate and expedited clinical treatment may significantly reduce the risk for suicide.<sup>443</sup> For example, individuals receiving antipsychotic medication and cognitive behavioral therapy (CBT) had a lower suicide risk.<sup>443</sup> Antipsychotic medications can reduce the frequency of psychotic episodes,<sup>444</sup> thus reducing the number of post-psychotic periods and overall suicide risk. CBT can help mitigate suicide risk as well by teaching individuals problem-solving and coping skills. Individuals with SMI who are prescribed medications may not take them as directed, for a variety of reasons including homelessness, substance use disorder, financial difficulties, lack of caregiver or family support, and the negative perception of impact of medication on symptoms. Caregivers should ensure medication directions are followed to limit negative outcomes (e.g., return of symptoms, negative side effects) and should curb access to lethal doses of medication in the home. More research is needed to develop effective treatments with fewer side effects.

Given the increased risk for suicide among people with SMI, special attention should be given to preventing suicide in this population. Prevention techniques such as caregiver education on medication adherence, public education about SMI, engagement and re-engagement into SMI care, and standardized screening tools for primary care can be incorporated at little or no cost to the provider and individual. As suicide rates continue to climb in the U.S.,<sup>445</sup> it is crucial to implement effective suicide prevention techniques for this high-risk group.

## People With Substance Use Disorders

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One in 12 American adults are estimated to have a substance use disorder (SUD), which is associated with a high risk of suicidal ideation, attempts, and death.<sup>446,447</sup> SUD occurs when an individual cannot control consumption of an illegal or legal substance, i.e., alcohol and/or drugs.<sup>448,449,450</sup> More than 10% of Veterans are estimated to have SUD, and 16% of these are not treated.<sup>451</sup> Male Veterans ages 18–25 are more likely to have SUD than their male non-Veteran counterparts.<sup>35</sup> Risk factors for SUD are similar to those for suicide and include depression, impulsivity, and thrill-seeking or life-threatening behaviors. SUD can further increase suicide risk by exacerbating negative effects on physical and mental health, emotional well-being, interpersonal relationships, and socioeconomic factors. Collaboration between the SUD and suicide prevention community is necessary to best address the co-occurrence of SUD and suicide and to meet the challenges of reducing rates of suicidal behaviors and improving overall health.

Suicide is a leading cause of death among people who misuse alcohol or drugs.<sup>452</sup> Between 20% to 33% of people who die by suicide have alcohol in their system at the time of death, and studies have indicated that alcohol misuse is the second highest risk factor for suicide.<sup>453,454,455</sup> Blood alcohol content and age of suicide are associated, with younger suicide decedents more likely than older decedents to have alcohol in their system.<sup>456</sup> Less is known about the link between opioids and suicide risk; however, nonmedical prescription opioid users have a greater likelihood of suicidal ideation than those who have never misused prescription opioids, and the number of suicides through opioid overdose nearly doubled between 1999 and 2014.<sup>457,458</sup> People who reported past-year opioid misuse were more likely to have attempted suicide in that year than those who misused other substances.<sup>459</sup> Particularly relevant to Veterans, 63% of Operation Enduring Freedom/Operation Iraqi Freedom Veterans who meet criteria for SUD also meet criteria for posttraumatic stress disorders.<sup>460</sup> To work toward care integration, VA has attempted to integrate treatment by funding PTSD/SUD specialist positions and research efforts aimed at identifying efficacious evidence-informed PTSD/SUD treatments. While integrated care shows promise, further research is needed.<sup>461</sup>

Comprehensive strategies that meet a person with SUD in all aspects of life can reduce lifetime suicide risk. For example, strategies that target adolescents through community education about suicide and related behavioral issues, including alcohol and substance misuse, have reduced the rate of suicide attempts.<sup>462</sup> Encouraging employers to educate employees about warning signs of SUD can significantly decrease suicide risk. Further, the use of employee assistance programs can be an effective tool for employee support so that employees can use and seek treatment for their substance use disorder without fear of retaliation.

## Female Veterans

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The rate of suicide among female Veterans was 2.2 times as high as than the rate among women non-Veterans (16.8 per 100,000 female Veterans, 7.6 per 100,000 female non-Veterans) in 2017.<sup>463</sup> While there is some literature regarding suicide in women Veterans, much Veteran mental health and suicide research has been focused on men, creating a knowledge gap regarding the unique needs of female Veterans.<sup>464,465</sup> Current research shows that, compared with non-Veteran women, women Veterans have unique individual and environmental factors (e.g., higher prevalence of adverse childhood experiences, greater exposure to trauma, higher likelihood of posttraumatic stress disorder, and greater access to and experience with lethal means) that can individually or collectively influence their suicide risk profile.<sup>466,467,468,469,470</sup>

Lowering suicide risk in women Veterans requires solutions tailored to the unique challenges of their situation. Women Veterans have higher rates of exposure to trauma — both physical and psychological — than non-Veteran women have; this exposure is associated with a higher level of mental health concerns, sleep disturbances, and chronic pain, all of which can increase suicide risk.<sup>471,472,473,474</sup> In addition, women Veterans have a higher prevalence of ACEs such as childhood abuse, sexual contact, and exposure to domestic violence, which also increase adult suicide risk.<sup>475,476</sup> ACEs also negatively affect coping skills as an adult<sup>477,478</sup> and may affect how a woman Veteran responds to other types of trauma.

Tailored strategies that meet the needs of women Veterans through education, risk identification, treatment, and support are necessary to reduce suicide risk. Widespread education and messaging for women Veterans, who may not self-identify as Veterans or acknowledge being at risk for suicide, is needed so that they understand why they may be at risk and what they can do to lower their risk. Education to get health care providers to recognize key suicide risk factors in women Veterans (e.g., the experience of trauma while in the military and the greater likelihood of ACEs) allows for early identification and intervention in a culturally responsive manner. In treatment, a trauma-informed approach that integrates primary care, mental health, and pain management may more effectively address the complex health needs of women Veterans.<sup>479</sup> Finally, community programs that build supportive relationships, support leadership opportunities, and increase access to community resources help ensure women Veterans' health, safety, and well-being.<sup>480</sup>

### Postvention as a Suicide Prevention Strategy: State of the Science

Suicide bereavement support (also known as postvention) efforts are an important component of a comprehensive suicide prevention strategy. It is important to understand the effectiveness of these strategies, which are frequently used.



The VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide<sup>481</sup> provides the most widely recognized authoritative standards for putting research into practice with Veteran and military populations. The Suicide Risk CPG Work Group assessed the strength of each assessment or management recommendation based on its confidence in the quality of evidence for that recommendation, the difference in magnitude between benefits and harms of the intervention, patient and provider values and preferences, research use, feasibility, and other factors. CPG work groups typically use the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system to assess the quality of the evidence and assign a strength for each recommendation.<sup>98</sup>

The CPG GRADE recommendations are presented as part of a continuum with five possible ratings along four domains. CPG positive recommendations are either “strong for” or “weak for.”

A “strong for” recommendation is defined by the CPG as one backed by “high confidence in the quality of the available scientific evidence” and showing “a clear difference in magnitude between the benefits and harms of an intervention” — by implication a candidate for implementation.

A “weak for” recommendation is defined by the CPG as one backed by “less confidence” and where additional evidence may change the recommendation. By this definition, a “weak for” recommendation is analogous to “promising” research with enough rigor and preliminary evidence to track and monitor for future progress but not yet enough to support full implementation.

CPG negative recommendations are either “strong against” or “weak against.” A “weak against” rating generally indicates a suggestion not to offer this strategy. A “strong against” indicates a recommendation against offering the option. In some reviews, the Suicide Risk CPG Work Group determined there is insufficient evidence to make a recommendation for or against a particular intervention or preventive strategy. This occurs when there is an absence of research studies in the area of interest that met the inclusionary criteria for review, when the available evidence provides conflicting results, or when findings are inconclusive. In these instances, no recommendation for or against is made (or “there is insufficient evidence ...”). Comprehensive suicide postvention programs were assessed, and the VA/DoD Suicide Risk CPG Work Group determined that there is “insufficient evidence for or against postvention in regard to suicide outcomes.” The Suicide Risk CPG Work Group concluded that postvention programming is an untested endeavor that has potential for both harm as well as for healing and health promotion.

The postvention program Tragedy Assistance Program for Survivors (TAPS) was reviewed in the 2019 Suicide Risk CPG. TAPS was described as offering a comprehensive suicide prevention program providing support for over 9,000 family members of military suicide decedents over the past 10 years. The Suicide Risk CPG Work Group determined there is “insufficient evidence for or against the therapeutic principles used in this program in regard to suicide outcomes.” While the suicide prevention community continues to engage in postvention, more research is needed to instill confidence that postvention programming is effective.

Because the latest VA/DoD Suicide Risk CPG is based on information available through April 2018, a literature search was conducted for the time between April 2018 to November 2019 to assess any new research findings in the area of postvention. This search resulted in the identification of a 2019 systematic review of suicide bereavement. Andriessen and colleagues (2019) conducted a systematic review to assess the effectiveness of postvention interventions and to evaluate the quality of the research in this area. Consistent with previous reviews of the literature, the authors found that in general the quality of postvention studies was weak. They highlighted the need for more high-quality studies on suicide postvention programs.

Potentially promising postvention interventions emerging after the April 2018 cut-off date for the VA/DoD Suicide Risk CPG reviews should be evaluated using the same standards as in the CPG review and only be deemed ready for implementation if interventions meet requirements for the equivalent of a weak or strong “for” recommendation.

However, no new, well-designed interventions meeting “strong for” criteria have been identified, and thus, for all postvention interventions, there is insufficient evidence to support full implementation.

In an area such as suicide prevention, with very little in the way of empirically validated interventions, there is an ethical obligation to help others in distress, which may appropriately allow us to implement interventions with less evidence than required for problems with established and effective interventions. When promising postvention strategies are identified as ready for adaptation and implementation, it is recommended that outcomes be collected and scientifically evaluated to further aid in the evaluation of the effectiveness of these practices.<sup>98,482</sup>

One such promising intervention is DoD's Suicide Postvention Toolkit, a comprehensive, evidence-informed resource guide for DoD postvention providers (e.g., commanding officers, chaplains, casualty assistance officers, Suicide Prevention Program Managers, military first responders, mental health professionals) regarding best practices for delivery of bereavement and postvention services to unit members and next of kin who survive a military suicide loss. The toolkit was developed after the DoD completed a study that assessed the postvention needs of military Service members and families. Results indicated that, when a suicide death occurred, some Service members and families reported experiencing shame, stigma, and dissatisfaction with the quality of care received. The toolkit is scheduled for release in 2020.



## Learn More

### *National Guard Flyer*



# Warrior Resilience & Fitness Division

The National Guard Bureau (NGB) established the Warrior Resilience & Fitness (WRF) Division to synchronize Air and Army National Guard well-being, resilience, and suicide prevention efforts across the 54 states, territories, and DC. The goals are to: 1) align, promote, and enhance wellness and prevention best practices; and, 2) provide strategic oversight for outreach, innovation pilots, and data analysis of these efforts across the National Guard (NG).

### **Unique Challenges**

NG Service members face unique challenges in comparison to their Active Duty counterparts, including: geographic dispersion, significant time between drill activities, healthcare eligibility, and accessing resources across the 54 states, territories, and DC. A deeper understanding of these challenges is required to build targeted solutions that mitigate risk and promote evidence-based prevention strategies.

### **Uniquely Positioned**

WRF was established in July 2019 within NGB's Manpower and Personnel Directorate (J-1). From its position within the Joint Staff, WRF aligns Air and Army National Guard programs through a holistic approach that leverages the Department of Defense's Total Force Fitness framework. WRF is organized into two branches: 1) Resilience, Risk Reduction, and Suicide Prevention; and, 2) Innovation and Outreach.

NOVEMBER 2019





# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs






## Recommendations

## Legend









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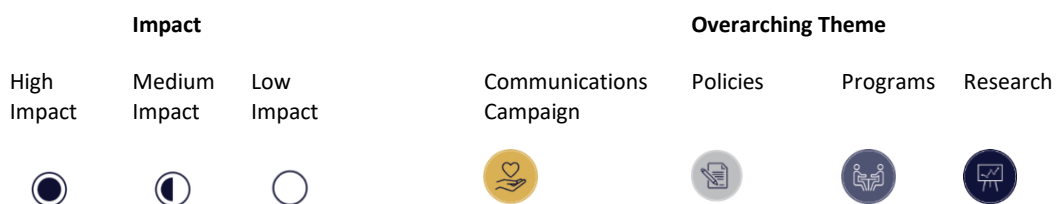
Overarching Theme	
Communications Campaign	
Policies	
Programs	
Research	









Impact		Feasibility
High Impact		High Feasibility
Medium Impact		Medium Feasibility
Low Impact		Low Feasibility

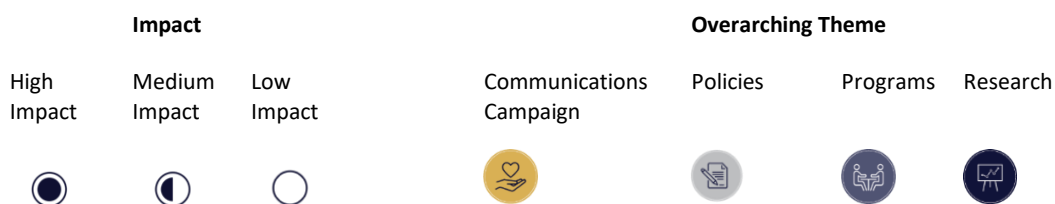
## Overarching Recommendations





The following overarching recommendations are intentionally broad and serve as an umbrella for the specific recommendations. A range of subject matter experts were consulted to make an educated estimation of the impact and feasibility. As the implementation process begins, the PREVENTS Office will make adjustments on these ratings.

Overarching Theme	Area of Strategic Focus	Recommendation Number	Recommendation	Impact
	Communication	1	Create and implement a national public health campaign focused on suicide prevention for Veterans and all Americans.	
	Research Policies	2	Identify and prioritize suicide research that focuses on a Veteran's unique combination of individual, social, and societal factors to deliver the most effective intervention(s) tailored to meet their needs and circumstances.	
	Research Policies	3	Promote foundational changes to the way research is conducted — including improving the speed and accuracy with which research is translated into practice, improving efficiency through data sharing and data curation practices, and using innovative funding techniques to drive team science and reproducibility.	
	Programs Communication	4	Develop effective partnerships across government agencies and nongovernment entities and organizations to increase capacity and impact of programs and research to empower Veterans and prevent suicide.	





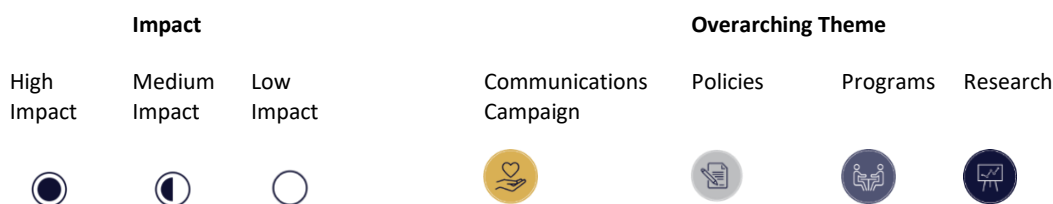
Overarching Theme	Area of Strategic Focus	Recommendation Number	Recommendation	Impact
	Programs Policies Research Communication	5	Encourage employers and academic institutions to provide and integrate comprehensive mental health and wellness practices and policies into their culture and systems.	
	Programs	6	Provide and promote comprehensive suicide prevention trainings across professions.	
	Programs Research Communication	7	Identify, evaluate, and promote community-based models that are effectively implementing evidence-informed mental health and suicide prevention programs across the country. In doing so, they should leverage relationships with community-based efforts, non-profit organizations, faith-based communities, VSOs, and MSOs focused on saving the lives of Veterans.	
	Programs Communication	8	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).	









Overarching Theme	Area of Strategic Focus	Recommendation Number	Recommendation	Impact
	Policy Programs	9	Develop a coordinated, interagency Federal funding mechanism to support, provide resources for, and facilitate the implementation of successful evidence-informed mental health and suicide prevention programs focused on Veterans and their communities at the state and local levels.	
	Policy Programs	10	Streamline access to innovative suicide prevention programs and interventions by expanding the network of qualified health care providers.	



## Non-Task Force Originated Recommendations

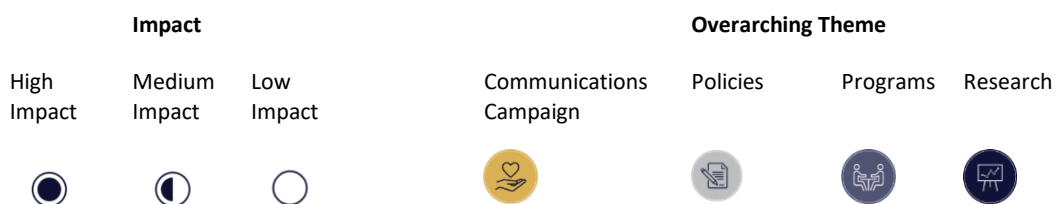
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	11	Create interagency, public/private work group to assess and ensure appropriate funding and infrastructure for the National Suicide Prevention and Mental Health Hotline, with a new national suicide prevention hotline number (988). The work group should address implementation practices such as guidelines for response to callers, accessibility of community-based resources that will receive and place referrals, and public education to ensure proper use of service.		High











Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	12	Establish an effective coordinated approach with VA and the Veterans Crisis Line (VCL) to ensure the successful launch and use of the proposed National Suicide Prevention and Mental Health Hotline (988). The approach should maintain the continuity and current level of VCL service for Veterans, Service members, and families.		High
	13	Raise awareness and develop strategies focused on those most vulnerable to economic strain and crisis.		High
	14	Develop state reciprocity agreements that allow for the transport or commitment of a patient to a facility in a neighboring state that honor jurisdiction across state lines.		High

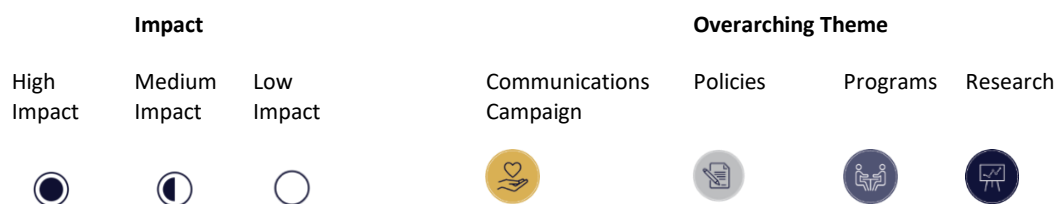
## Communications









Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	15	Use the Behavioral Risk Factor Surveillance System to evaluate the effectiveness of the PREVENTS public health message campaign.		High

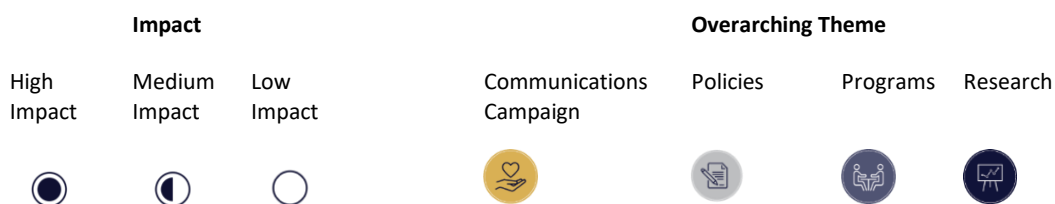


## Partnerships

Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	16	Expand and support the U.S. Chamber of Commerce/Hiring Our Heroes' Employers Challenge to develop and implement best practices in the workplace for strengthening mental wellness and preventing suicide.		High
	17	Develop partnerships and coalitions at the local level designed for Veterans, including those who are unemployed, retirees, students, homeless, incarcerated, disabled, or in residential settings.		Medium
	18	Encourage and support partnerships with and among community organizations, VSOs, faith-based and academic institutions, government, aging and disability service organizations, tribal communities, and others to implement best practices. Facilitate collaboration among these partners to address the social determinants of health identified as risk factors for suicide, such as financial stress, food insecurity, and social isolation.		Medium
	19	Ensure state resources are integrated with national suicide prevention strategies and are disseminated and implemented through local organizations and communities.		Medium









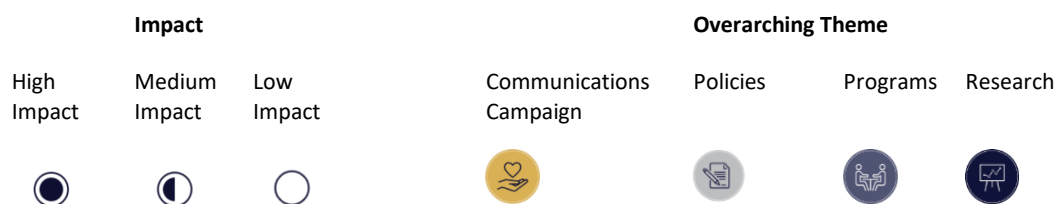
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	20	Create a PREVENTS partnership database that would house best practices for building business partnerships and share opportunities for companies to find and create partnerships based on their needs and desired outcomes. The database also could collect valuable mental health resources and suicide prevention training for employers and employees.		Medium
	21	Develop a community partnership that develops best practice guidelines for building peer support networks for Veterans, first responders, or other professions and populations at high risk.		High
	22	Establish local Veterans treatment courts, supported by VA and law enforcement, to provide services including mentoring, and mental health and/or substance use treatment for Veterans involved in the criminal justice system.		Medium
	23	Provide wellness and suicide prevention resources — including information on Veterans' benefits for Veterans — during typical business and community engagements such as the closing of a mortgage or the signing of a rental agreement.		High













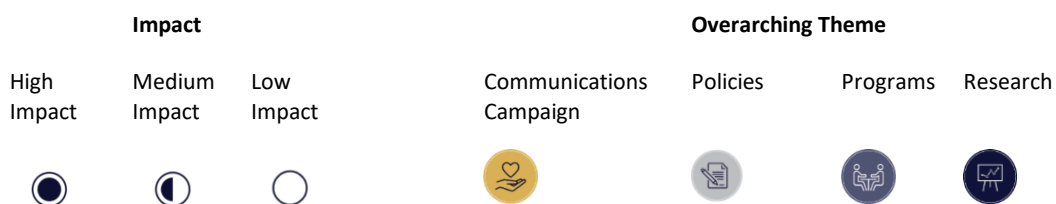










## Research Strategies

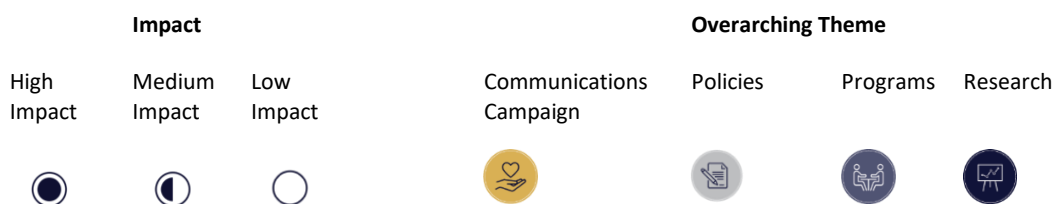
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	24	Identify the critical components of interventions to reduce negative attitudes and perceptions about mental health and how they can lead to more help seeking and reductions in suicide attempts and deaths.		Medium
	25	Develop an educational campaign to make the public aware of the system and its objectives, educate researchers on the value of ethical data sharing, and allow stakeholders to contribute data to the virtual data enclaves and be involved in decisions about data uses. Specifically, this will include the following: (1) Veterans will be allowed to opt-in so as to share their personal data. (2) Researchers sharing data will not require public awareness, but they will need to adhere to data-sharing rules in order to maintain funding. (3) Data will not be public-facing to avoid contagion risks but will include functionality to obtain data from private companies.		Medium
	26	Explore the benefits of declaring suicide a public health priority to enhance coordination and access to resources, including data.		High

















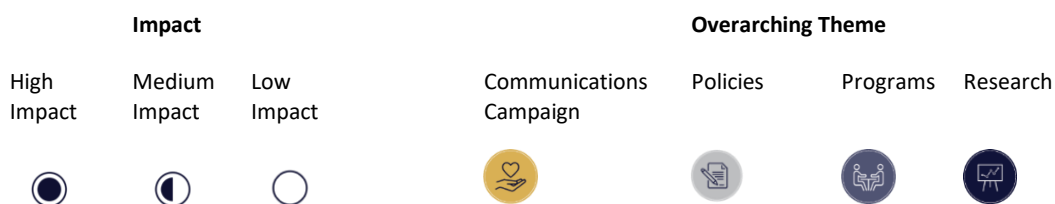
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	27	Include military service (current or ever-served) for Active Component, Reserve Component (National Guard and Reserve), and Coast Guard within the National Violent Death Reporting System (NVDRS), with appropriate data integration strategies to ensure data is compared with existing DoD, VA, and DHS data.		Medium
	28	Include Veteran status within the HHS, Indian Health Service (IHS), electronic health record, and datasets.		Medium
	29	Develop clear guidelines and protections for those who safely (consistent with legal and ethical standards of practice) make data actionable and enforce accountability for those who unnecessarily perpetuate data sharing bottlenecks to enhance support for data holders' effective data sharing.		Medium
	30	Develop a standard for acceptable interpretations of ethical and legal policies so as to avoid inconsistent decision-making and communication about best practices and appropriate uses of data.		Medium
	31	Develop a Suicide Prevention Data Sharing and Ethical Use Toolkit with policy guidance, case studies, and digital tools.		Medium















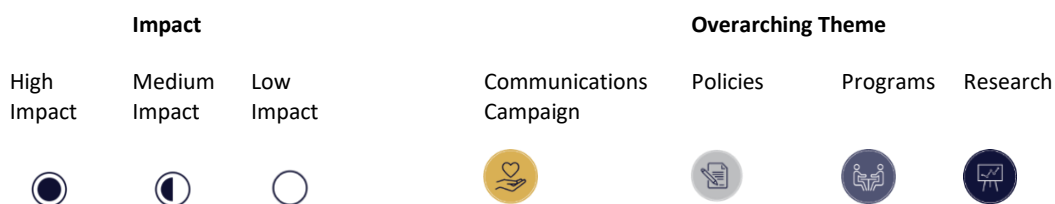
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	32	Develop a team of specialists to identify an interagency process to generate, implement, and execute a PREVENTS NRS work plan, leveraging best practices and lessons learned from other similar efforts, and identifying how the work plan may overlap with existing interagency collaborative efforts.		High
	33	Develop an interagency leadership group to improve coordination and cooperation between Federal agencies.		Medium
	34	Create an independent body to objectively assess the new data infrastructure and its policies and practices, coordinate stakeholder input, and establish and conduct investigations or decision reviews through a streamlined adjudication process.		Medium
	35	Identify interagency processes that will be used to ensure coordination of the Federal research portfolio to: <ul style="list-style-type: none"> <li>Identify all Federally funded research on suicide and brain health.</li> <li>Create program management tools to support gap-driven investment.</li> <li>Enable interagency coordination of research processes and funding.</li> <li>Enable complementary policy and portfolio management.</li> </ul>		Medium















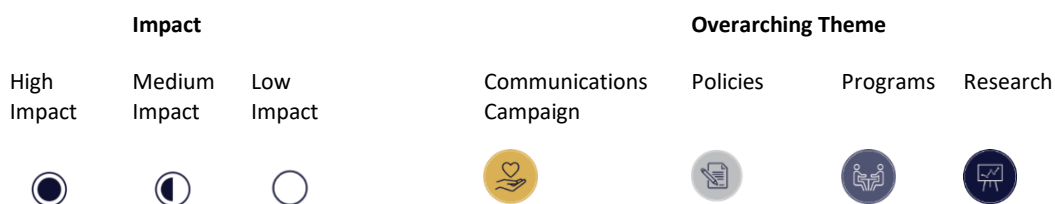
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	36	Develop partnerships between the Federal government and non-VHA health systems and hospitals to encourage and facilitate wider screening for suicide risk, especially universal screening in emergency departments.		Medium
	37	Develop additional partnerships to better identify at-risk Veterans not receiving VHA care.		Low
	38	Develop and test the effectiveness of enhanced interventions for Veterans within and across successive risk strata.		High
	39	Test telehealth in different health care settings.		High
	40	Recommend process for evaluating recommendations that emerge in the years between VA/DoD clinical practice guidelines releases.		High
	41	Develop a centralized clearinghouse consistent with current work in open data and open science to improve the discoverability of ongoing research and existing data assets.		High
	42	Link VHA patient care data with Veterans Benefits Administration disability program data to improve coordination of services.		High









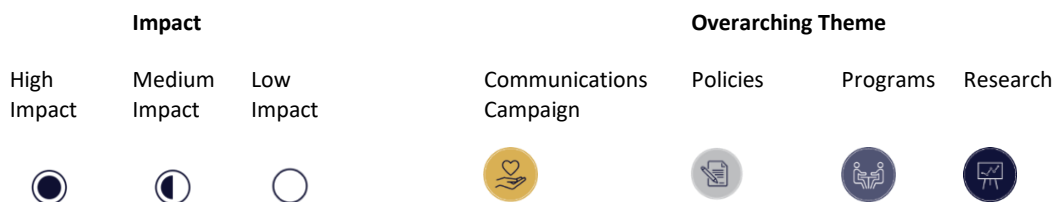
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	43	Prioritize prevention/intervention studies that build on type I predictive analytics to test effectiveness of type II predictive analytics.		High
	44	Evaluate existing Federal funding models for novel mechanisms that promote expedited funding and/or shared costs.		High
	45	Evaluate ways to modify public and private incentives, including professional societies, nonprofit, and for-profit stakeholders, to promote team science, open science principles, sharing of well-curated datasets and expertise, and communication of unpublished or negative results.		High
	46	Evaluate the funding, information technology, policy, and legal mechanisms of data surveillance systems to inform administrative and scientific gaps.		High
	47	Evaluate mechanisms to promote adoption of a team science or systems approach that identifies needed studies, focuses on mentorship of principal investigators, and establishes core expertise (including data scientists) on interagency or interorganizational teams.		Medium
	48	Invest in type I predictive analytics to enhance understanding of risk profiles of individuals.		Medium









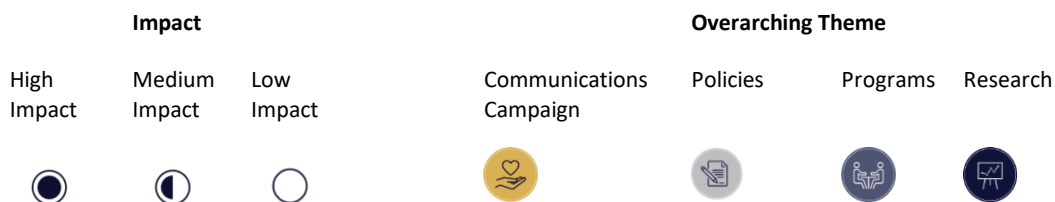
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	49	Identify formal processes that accelerate timely translation of science. Include mechanisms as appropriate that evaluate results for translation into policy, clinical guidance, or future research.		Medium
	50	Evaluate how to coordinate with public, private, and nonprofit entities regarding data sharing and integration to accelerate discovery in the research portfolio.		Medium
	51	Evaluate ways to incentivize desired outcomes within the public-private research ecosystem with funding incentives to increase participation of private industry.		Medium
	52	Study the time course of suicide risk across the military life cycle, including military service time, deployments, and transitions.		Medium
	53	Understand better the trajectories of Veteran and Service member suicide risk (e.g., think, then plan, then attempt).		Medium
	54	Evaluate the role of using electronic health record data to contribute to targeted approaches in suicide prevention.		Medium













Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	55	Develop virtual data enclaves where researchers can perform data analytics without requiring data to be transferred and limiting the need for data extraction to promote security.		Medium
	56	<p>Understand better who is at risk, when, and why. Important considerations for risk include:</p> <ul style="list-style-type: none"> <li>• Discharge following psychiatric hospitalization and other settings.</li> <li>• Transition out of active military service.</li> <li>• Veterans outside of VHA.</li> <li>• Special occupational groups (such as female Veterans).</li> <li>• Individuals who experience suicidal ideation, posttraumatic stress disorder, traumatic brain injury, current psychiatric conditions or symptoms and aspects of personality.</li> <li>• Individuals who have not sought behavioral health care.</li> <li>• Genetic risk.</li> <li>• Risk related to propagation in social media.</li> <li>• Family violence.</li> <li>• Legal issues.</li> </ul>		Medium
	57	Test interventions that address suicide risk factors among Veterans in community settings such as drug courts, prisons, American Indian reservations, and tribal communities.		Medium

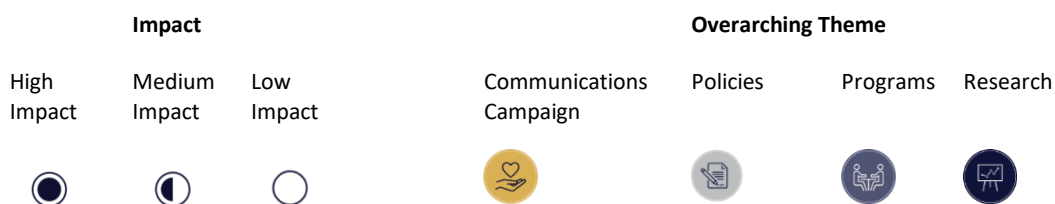














Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	58	Link VA patient care data to information on all-cause mortality from the Social Security Administration's full Death Master File, and on cause/manner of death from the CDC's NDI, and allow access for non-VA researchers as well.		Medium
	59	Create mechanisms for generating or collecting data about Veterans and families under the new framework, with appropriate consent mechanisms, potentially including new ways of: <ul style="list-style-type: none"> <li>Identifying Veteran status in datasets/collection where it is not typically tracked.</li> <li>Identifying and using information and measurable indicators for social determinants of health identified as risk factors for suicide and other suicide risk factors.</li> <li>Collecting and improving data to identify and learn about deaths of despair among Veterans.</li> <li>Linking the NVDRS, IHS, and VHA datasets to determine Veteran status.</li> </ul>		Medium
	60	Pursue research investigating the role of synthetic data or semisynthetic data to enhance data sharing, improve data analytics, and drive progress in research.		Medium

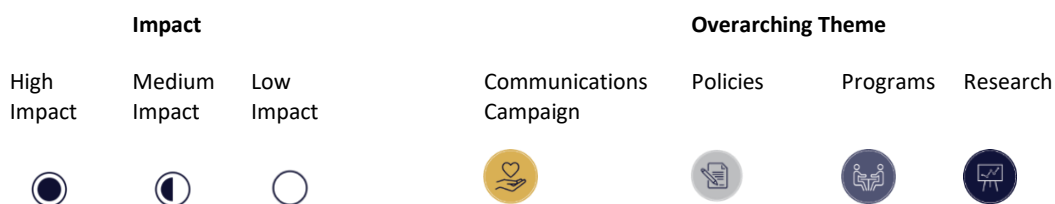










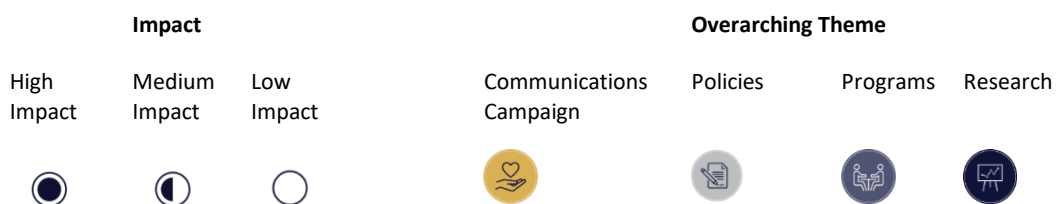
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	61	Evaluate the need for a U.S. government Health Data Sharing Consortium to mitigate legal risks and liability concerns.		Medium
	62	Evaluate the maturity of the Federal research portfolio on biomarkers to establish better targeted medicine predictors of suicidal behaviors.		Medium
	63	Evaluate the feasibility of a consolidated research data system that is supported by shared access to data science expertise and equipped with supercomputing capabilities to maximize the power of Federally funded data and empower existing investigators to draw on shared resources.		Medium
	64	Evaluate the feasibility of building a living systematic review and generating living clinical guidelines as a mechanism for knowledge translation and return on investment within the Federal research portfolio.		Medium
	65	Evaluate the benefit of Federal support for learning collaboratives to help communities share ideas and resources while facilitating determination of effective interventions.		Medium









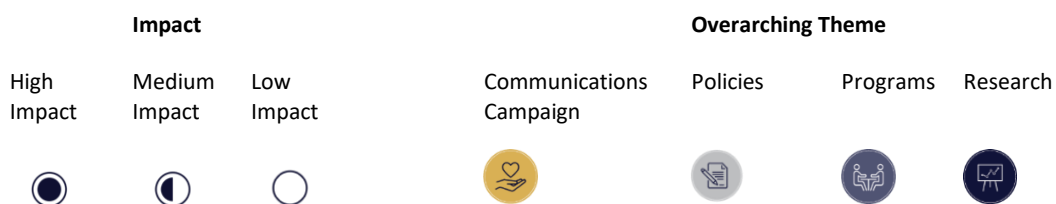
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	66	Expand the implementation science portfolio to eliminate the gaps in knowledge about the effectiveness of interventions, particularly those in the community or public health settings.		Medium
	67	Ensure research budgets reflect the true value of quality data, including budgeting for secure data infrastructure and advanced data science expertise.		Medium
	68	Create a process to oversee the development and operational management including evaluating applications for data and data-tier access, monitoring, and assessing outcomes of data use, developing, and implementing standardized data governance documents, and providing continual oversight and accountability.		Medium
	69	Make full information available for research purposes without compromising data security.		Medium
	70	Research the most effective way to track, record, and integrate information about social determinants of health.		Medium
	71	Develop a mechanism for identification of, and communication with, Veterans outside VHA that can support research on all Veterans, not just those accessing services at VHA.		Medium















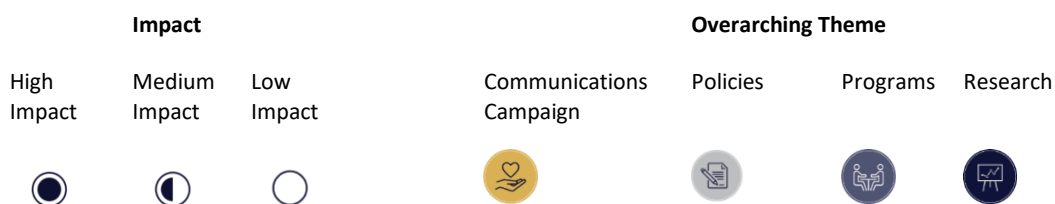
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	72	Leverage a gap-driven research portfolio to evaluate the role of community resiliency and strengthen community infrastructure to prevent Veteran suicide.		Medium
	73	Develop predictive models of suicide risk, through Federal agencies' combining or sharing databases and research teams and focused especially on the association between experiences during military service, and suicide risk in the period soon after separation from military service (e.g., within one to three years).		Medium
	74	Establish a mechanism whereby prevention and intervention strategies that are delivered (both consistent with current evidence and outside of it) track and publicly report outcomes to allow for future research as well as adaptation and tailoring of content to subpopulations, including those at risk for suicide after discharge from the emergency department (ED).		Low















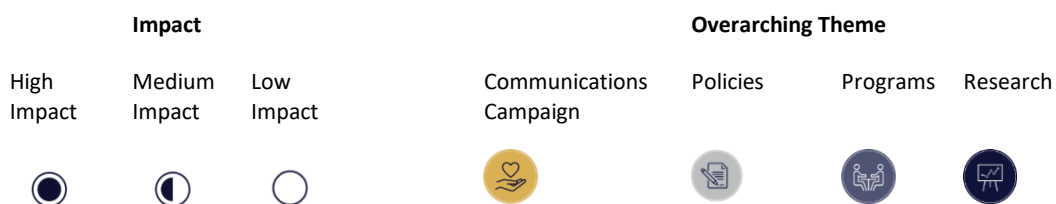
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	75	Mandate at the state level (and monitor for completeness) external cause reporting within ED data. States with hospital coding systems for external injuries (mostly used in EDs) are a model to monitor ED-based detection of suicide behavior injuries, as well as monitoring disposition. Uniform coding systems could be broadly developed nationwide from best models available.		Low
	76	Deploy data technologies supporting secure data transfer, storage, anonymization, and enhanced protection of sensitive information during processing to streamline data sharing, access, and analytics processes.		Low
	77	Design and institute mandatory standardized data collection and aggregation protocols through: <ul style="list-style-type: none"> <li>• Unique patient identifiers to aid the linkage of individual-level data across multiple data assets.</li> <li>• Universally unique dataset identifiers to identify each unique dataset/asset.</li> <li>• Common data elements as standards for research.</li> </ul>		Low















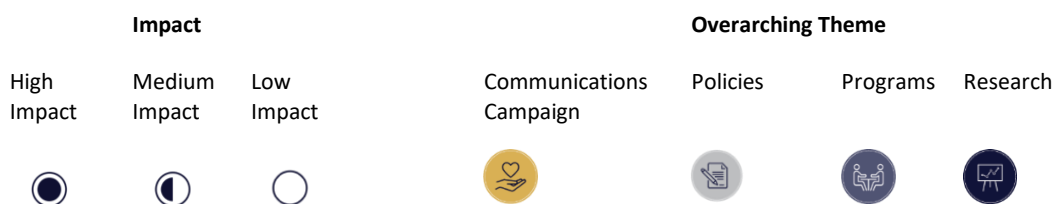
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	78	Perform a comprehensive assessment of existing data assets relevant to suicide prevention, public health, and social determinants of health, including identification of the current data sharing and access policies and procedures governing each data asset. This process should also include assignment of unique digital identifiers, leading to implementation of the data impact factor.		Low
	79	Link research data on individuals with private/commercial health insurance to Veteran data and mortality data, which may be achieved through the use of global unique identifiers.		Low
	80	Call and extract data on-demand from disparate sources using application programming interfaces.		Low
	81	Inform and empower IRBs and other governance bodies to ensure consistent, timely, and effective oversight of data-driven and technology-enabled research.		Medium
	82	Incentivize collaboration and responsible data sharing in the face of cultural barriers (e.g., academic institutions versus private industry).		High
	83	Enhance the research ecosystem to eliminate data hurdles that are specific to policy and culture change challenges.		Medium







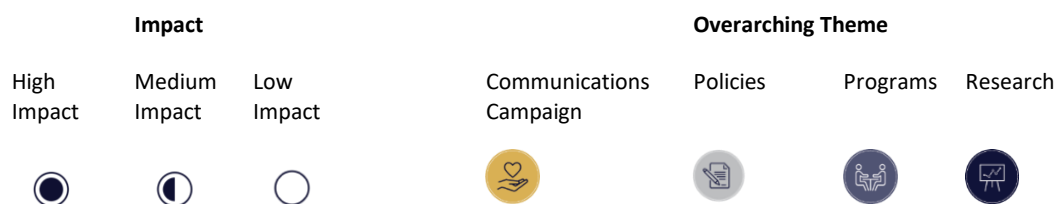
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	84	Ensure systems like VA and non-VA hospital settings are operating under evidence-informed structures and make changes to those systems that are not.		Low
	85	Build on existing resources to establish a national learning health care network across the Federal government, linking studies on suicide prevention across VA and non-VA health care settings to standardize measures, measure results, implement improvements in services, and answer new research and care questions.		Medium
	86	Increase the number of opportunities for the federal government to collaborate to examine suicide risk in the population of Veterans who participate in programs such as Medicare and/or Medicaid.		High
	87	Further test “caring communications” approaches through multiple delivery methods and with peers.		High
	88	Develop a new, quantitative metric, the “data impact factor,” to help assess and communicate the use and impact of individual data assets, particularly those used in research.		High
	89	Test collaborative care models with a suicide prevention component in civilian and VHA primary care settings.		Medium



Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	90	Develop and test family- and peer-support programs or components of larger programs for suicide prevention in both health care and community settings.		Medium
	91	Study how suicide contagion operates via social networks; test models that make individuals more resistant to contagion and decrease their overall suicide risk.		Medium
	92	Test ways to maximize community interventions by combining surveillance and prevention efforts.		Medium
	93	Support research to further investigate the roles of social connectedness and social isolation in suicide.		Medium
	94	Test combinations of rapid-acting interventions and more durable evidence-informed psychosocial treatments to facilitate the recovery process in acute care settings.		Low
	95	Rigorously develop and evaluate community program metrics in the way that hospital metrics were developed and evaluated to identify optimal patterns of care and use of appropriate level of care.		Low









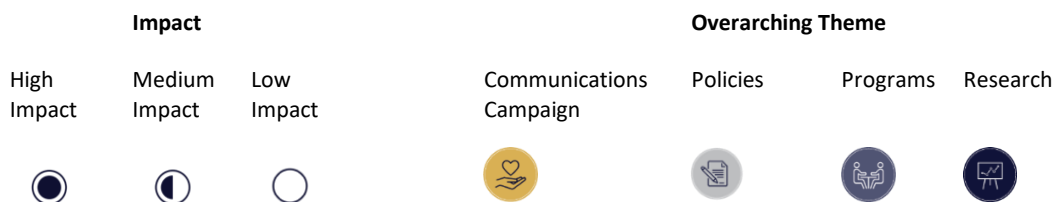
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	96	Develop a data framework for tier-level assignment and tier-level access based upon data type, sensitivity, use case, and user; broadly, tiers could include restricted access data, access defined by stipulations of data use agreement, and nonsensitive, open data, and open science.		Low
	97	Establish a personally identifiable information data security clearance process similar to the security clearance process used by the government for access to classified data to grant access to tiered data.		Low









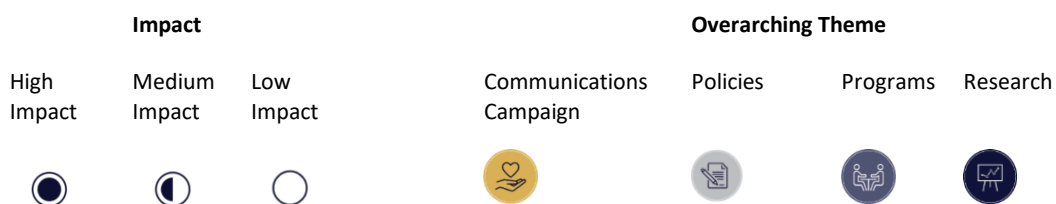










## State, Local, and Community Action

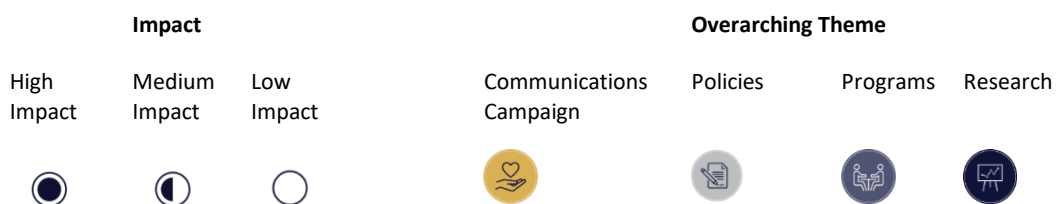
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	98	<p>Establish a grant-making program that:</p> <ul style="list-style-type: none"> <li>Is supported through coordination between Federal, state, local, tribal, and territory entities.</li> <li>Funds programmatic and innovative approaches at the community level (e.g., through faith-based, private, and nonprofit organizations), including the use of philanthropic matching funds to help empower individual Veterans.</li> <li>Helps to prevent Veterans from becoming suicidal and ensures that Veterans in suicidal crisis receive high-quality care, regardless of where in the community they might be encountered.</li> </ul>		High
	99	Provide comprehensive and high-quality technical assistance to both grant applicants and grant awardees.		Medium
	100	Establish a Federal interdepartmental evaluating team, initially within the PREVENTS Office, to create a structure in which grant data are assessed and reported on an annual basis and where progress in reducing the numbers of Veteran suicides, suicide attempts, and Veterans seriously considering suicide can be assessed at the national level.		High











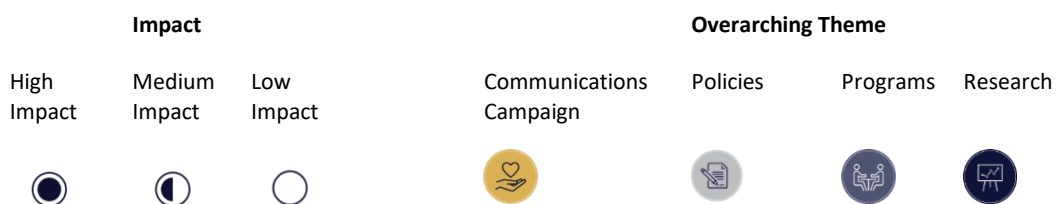
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	101	Ensure an annual review across Federal departments of suicide-related data and surveillance with analysis of implications of current data for suicide prevention. Include this as a component of the Federal Working Group on Suicide Prevention's annual report.		High
	102	Establish a sustainable funding mechanism for supporting care coordination (including telephonic follow-up) for Veterans who are in contact with community crisis and emergency systems.		High
	103	Improve data systems that track Veteran status. For example, increase access to and use of National Survey on Drug Use and Health data on Veterans, including Veteran suicidal ideation, plans, and attempts; update annually the latest VA state summaries; encourage updating of the Census Bureau's State Veteran profiles; and encourage existing surveillance systems that do not include Veteran status, such as hospital discharge data, emergency department data, and syndromic surveillance, to add Veteran status.		Medium















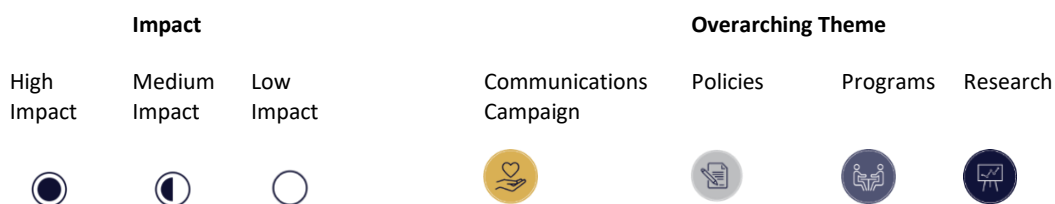
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	104	Require all Federally provided grants and programs that focus on suicide prevention to include, where appropriate, outreach to military and Veteran populations within the areas they plan to serve.		Medium
	105	Work to increase government-collected data on minority Veterans groups and tailor programming to those groups through annual review by the PREVENTS Office.		Medium
	106	Enhance state suicide prevention infrastructure.  Provide funding to states that need an SPC and require engagement with Veteran suicide prevention. For states that have an SPC, fund a plan for public health approaches that will require further infrastructure development for sustainable suicide prevention and Veteran and military integrated strategies and programs and to ensure that Veterans receive a follow-up contact at 24, 48, and 72 hours after initial counseling.*		Medium
	107	Increase the use of suicide risk screening and safety planning in community emergency departments along with appropriate referral and follow-up to VHA or community care.		Medium













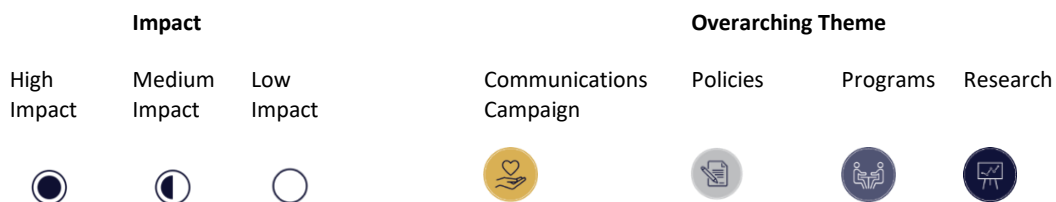
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	108	Incorporate a family education and support component in grant-supported Veterans' programs, unless the Veteran does not consent or it is an emergency.		Medium
	109	Fund an additional SPC (40-hour or full-time equivalent) for each state who will serve as a military and Veteran expert. This individual would coordinate with the existing state SPC and connect with the VHA and DoD/National Guard Bureau SPCs and the community-based suicide prevention/local coalitions. They would be responsible for integrating Service member- and Veteran-specific content into the state suicide prevention plan annually. They would also coordinate policy and projects to advance statewide coordination of military and Veteran behavioral health and suicide prevention initiatives and identify service gaps for Veterans at risk for suicide.*		Low
	110	Develop community-based programs that identify and build resources for the National Guard and Reserve.		High
	111	Expand military culture and suicide prevention training for state- and community-level agencies and local organizations, such as faith-based communities, to enhance culturally competent and accessible health and behavioral health care access for Service members and Veterans.		High













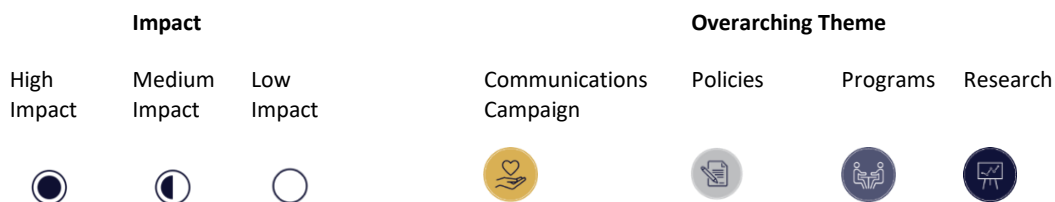
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	112	Create an interdepartmental Federal monitoring team within the PREVENTS Office focused on the management of government resources designed to serve Veterans and Service members to ensure effective and efficient use of funds and integration of ongoing state and Federal suicide prevention efforts.		High
	113	Ensure continued progress and implementation of recommendations from Executive Order 13822, Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life, focused on the period of transition from active duty to Veteran status.		High
	114	Encourage faith-based organizations to develop specific Service member- and Veteran-focused ministries.		Medium
	115	Encourage faith- and community-based educational programs and support services focused on strengthening families.		Medium
	116	Identify and strengthen faith-based and community programs that focus on empowering Service members, Veterans, and their families.		Medium
	117	Expand Department of Housing and Urban Development – Veterans Affairs Supportive Housing vouchers and promote eviction prevention programs.*		Medium











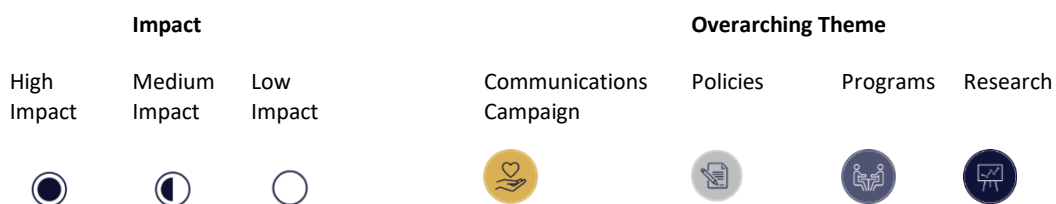
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	118	Encourage the designation of SPCs in community mental health centers to serve as liaisons with VA SPCs to ensure care coordination as well as support adherence to the requirements and recommendations of the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.		Medium
	119	Increase the outreach that crisis lines make to Veterans' families, friends, and co-workers and ensure family member input.		Medium
	120	Identify, train, and recruit more "nonclinical" community partners, such as veterinarian offices, faith-based communities, and animal shelters or motel owners and operators, who can serve to identify and assist people in crisis or stress who may be suicidal.		Medium
	121	Develop an online clearinghouse that includes resources and guidance, to be hosted on the PREVENTS and/or partner websites.		Medium
	122	Increase access to peer and family support networks in community settings for Veterans and their families and explore evaluation of "caring contacts" projects to decrease risk after hospitalization and increase access to follow-on treatment.		Medium



Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	123	Enhance training in military culture and awareness of Veterans and military resources by community-based crisis centers and increase collaboration with the Veterans Crisis Line. Maximize use by Veterans through alternatives such as chat and text.		Medium
	124	Increase training for homeless and housing agencies, employment and financial services agencies, and faith-based communities on suicide warning signs and how to effectively refer Veterans to needed health care and other services.		Medium
	125	Develop local VHA SPCs to help with outreach and training among community stakeholders, including faith-based leaders, to help provide public health leadership and coordination in their communities, including identification of service gaps.*		Medium
	126	Identify and support faith-based organizations' efforts to engage in Veteran homelessness initiatives and other methods to support homeless Veterans.		Medium
	127	Adapt existing frameworks and coalition toolkits to be culturally competent and tailored to Service members and Veterans.		Medium









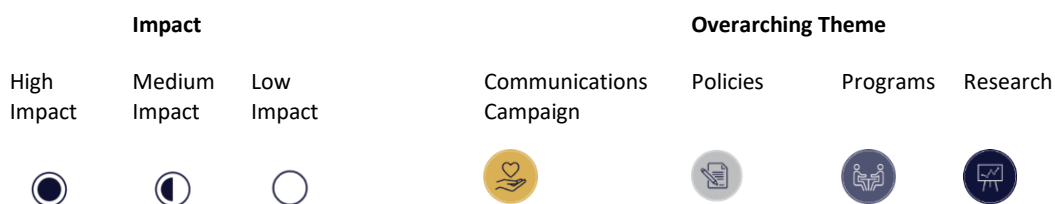
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	128	Develop more tools for state leadership that include Service member- and Veteran-specific components to advance public health suicide prevention models.		Medium
	129	Encourage the development and posting of annual statewide coalition reports on a publicly accessible, web-based platform that would also house resources and offer opportunities to share promising efforts and best practices.		Medium
	130	Provide additional staffing support for the Federal Working Group on Suicide Prevention — a part of the National Action Alliance for Suicide Prevention — through the PREVENTS Office or other means — and require annual reports on the status of suicide prevention efforts, including those for Veterans, and recommendations for needed improvements.		Medium
	131	Create a comprehensive catalog of Federal resources, tied to the CDC's Preventing Suicide: A Technical Package of Policies, Programs, and Practices, that is available for a review of gaps and shared with states and communities.		Medium







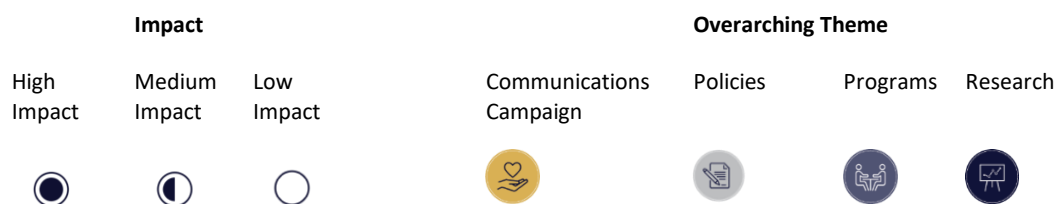








## Workforce and Professional Development

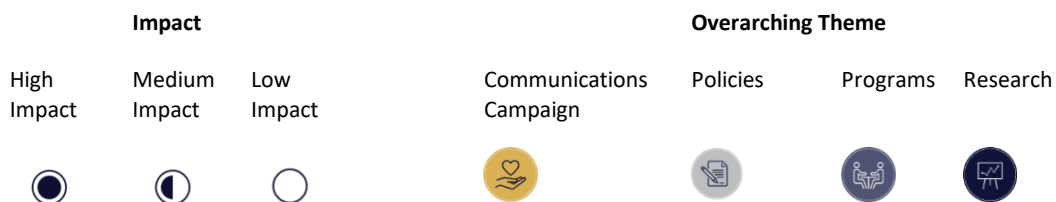
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	132	Develop and evaluation peer support services for the workplace, focusing on clinical and other high-risk occupations to inform best practices.		Low
	133	Working in collaboration with thought leaders in workplace mental health, develop a toolkit focused on workplace mental wellness and suicide prevention efforts. Toolkits could be supported by available resources used within the Federal government (including a current toolkit from the Department of Labor, Office of Disability Employment Policy); they may include self-assessment resources, implementation recommendations, use of technology solutions, and use of digital media and other communications strategies to socialize best practices.		High
	134	Develop a standardized suicide prevention course to be offered for high-risk professions to include mental health and well-being, social connectedness, and suicide prevention, intervention, and postvention.		Low







Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	135	Develop, implement, and measure longitudinal impact and cost-benefit of employee training programs focused on mental health and suicide prevention, such as Mental Health First Aid, S.A.V.E., bystander intervention, and other broad, public-facing education on suicide prevention.		Medium
	136	Develop clear guidance on the data to be collected, measured, analyzed, and reported across the public, private, nonprofit, and academic sectors to inform efforts to improve workplace culture and reach high-risk populations. This should be done using standardized language, definitions, and variables that include specific populations of employees by role, profession, and geographic area.		Medium









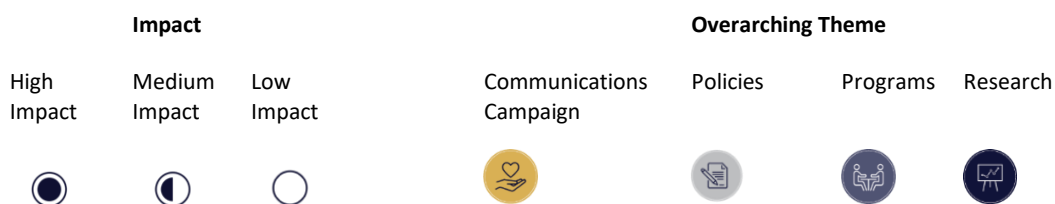
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	137	Incentivize students in the mental health professions with support for education and training through grants or low-interest and fixed-rate school loans. Expand existing Federal programs (e.g., VA programs such as the National Nursing Education Initiative, Employee Incentive Scholarship Program, and Education Debt Reduction Program) to include repayment of full or partial costs for schooling. Such an incentive could include a service-agreement component that includes two years of service for every one year of schooling, with services to be delivered to high-risk communities or communities with limited access to mental health care.		Low
	138	Provide incentives to organizations that have mental health and holistic wellness programs and benefits. Incentives could be in the form of tax relief for organizations that offer a superior level of programming and/or grants for the development of programs in organizations that need them.		Low
	139	Facilitate conversation among mental health professionals and employers about best practices to ensure that programs are developed to support those employees experiencing mental health challenges. Develop and share a database of studies and programs.		Medium













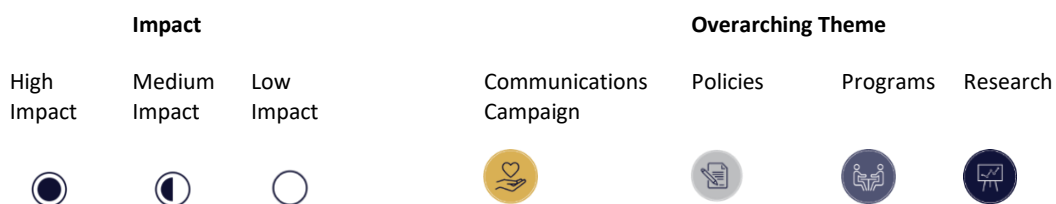
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	140	Continue to explore the impact of an EAP with respect to its overall usage, range of services provided, and perceived value by organization leadership in reducing absenteeism and presenteeism and improving overall organizational health.		High
	141	Explore technology (e.g., messaging, mobile app, toolkits) to reach transient workers and worksites		Medium







## Lethal Means Safety

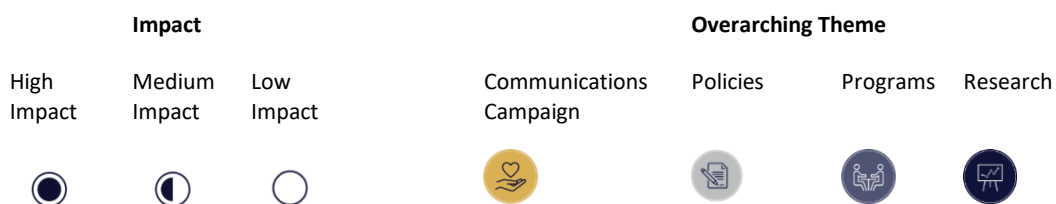
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	142	Identify ways to incorporate evidence-informed lethal means safety interventions into existing Federal prevention efforts.		High
	143	Convene a group of behavior change experts to study and recommend policies to incentivize safe storage behavior.		High
	144	Develop and promote lethal means safety counseling training materials and lethal means safety education into suicide prevention efforts to highlight that suicide is not just the result of mental illness.		High



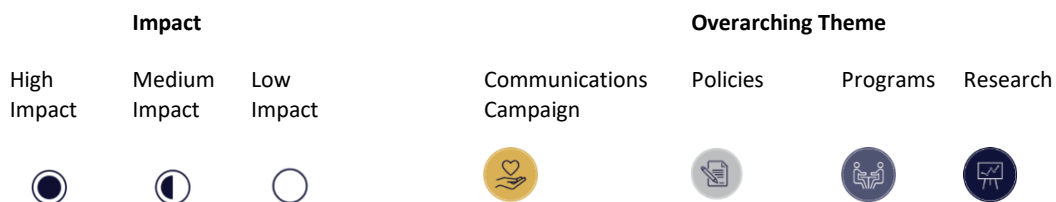
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	145	Conduct a review of Veterans Health Administration facilities to determine those that have yet to adopt evidence-informed medication and environmental precautions and then provide support to ensure that facilities have what they need to implement these programs.		High
	146	Put in place health care accreditation standards requiring organizations to deliver lethal means assessment and evidence-informed counseling interventions (e.g., Counseling on Access to Lethal Means) across health care settings, including primary care, behavioral health, and emergency departments.		Medium
	147	Research funding designed to actively support and expand the development and evaluation of novel lethal means safety programs, while ensuring that research funding criteria explicitly prohibit grants to organizations that lobby for or against gun control restrictions.		Medium
	148	Access financing mechanisms that allow health care providers to be reimbursed for delivering evidence-informed lethal means counseling.		Medium
	149	Encourage all U.S. medical and nursing schools to train students in evidence-informed lethal means counseling.		Medium















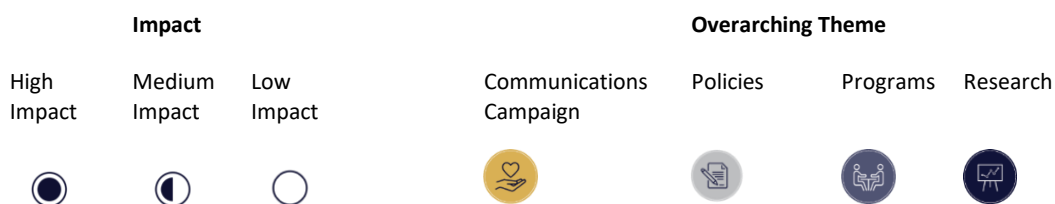
Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	150	Incentivize key community stakeholders (e.g., health care and social service providers, firearm shop and firearm range staff members) to complete lethal means safety training.		Medium
	151	Expand, elevate, and create key partnerships between: <ul style="list-style-type: none"> <li>• Suicide prevention organization, government, and pharmaceutical industry stakeholders to promote proper pharmaceutical disposal practices.</li> <li>• Health care professional organizations and hospital associations to promote the early identification of suicide risk, safety planning interventions, and lethal means safety follow-up.</li> <li>• Lethal means safety groups and general violence prevention groups (e.g., domestic/intimate partner violence prevention, workplace violence prevention).</li> <li>• Existing coalitions that focus on occupations that are commonly held by Veterans and have access to lethal means (e.g., police, military contractors, construction).</li> <li>• The Global Railway Alliance for Suicide Prevention, the coalition of the Department of Transportation and the Association of American Railroads.</li> </ul>		High
	152	Expand current VA and DoD firearm lock distribution programs.		High



Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	153	To eliminate barriers to seeking care, develop messaging to remove misconceptions about the connection between mental health care/reporting and access to firearms.		Medium
	154	Establish a national coalition of lethal means stakeholders to drive implementation of sustained change.		Medium
	155	Develop programs that facilitate community interventions to support voluntary reduction of access to lethal means (e.g., medication disposal sites and free community storage lockers for firearms).		Medium
	156	Support implementation of a publicly available and easily accessible online map for out-of-home firearm storage and medication disposal in all 50 states.		Medium
	157	In the future, explore grants to public and private nonprofit entities to create/expand community coalitions focused on lethal means safety, while ensuring that funding criteria explicitly prohibit grants to organizations that lobby for or against gun control restrictions.		Medium
	158	Define and showcase effective models and practices of community partnership/engagement specific to lethal means safety that are based on existing strong practices.		Medium



Overarching Theme	Recommendation Number	Recommendation	Impact	Feasibility
	159	Explore partnerships within and outside the government to provide financial and logistical support for the distribution of naloxone.		Medium
	160	Form a program evaluation board that reviews whole-population initiatives (e.g., policies, universal interventions) using methods such as natural experiments, regression discontinuity designs, and interrupted time series designs to test whole-population lethal means safety initiatives.		Medium
	161	Expand the scope of coalition work focused on the design, management, and operation of parking garages and other structures that may pose suicide risk of falls by creating an evaluation method to assess suicide risk in existing structures.		Medium
	162	Expand programs that facilitate the easy distribution of medication return envelopes (e.g., the VA Center for Medication Safety, known as VA MedSAFE) and expand pharmacy programs for enforcing use of blister packaging and limiting prescribed quantities of potentially lethal medications.		Medium
	163	Research the effectiveness of in-home safe firearm and safe prescription storage in suicide prevention.		High
	164	Seek support and voluntary funding from lethal means manufacturers (e.g. firearms, pharmaceuticals) to support various coalitions.		Medium





# PREVENTS

The President's Roadmap to Empower Veterans  
and End a National Tragedy of Suicide



**VA**



U.S. Department  
of Veterans Affairs

## Appendix

## A Strategic Focus on Suicide Prevention

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### Overview of Strategic Frameworks

In 2001, Surgeon General David Satcher released the first National Strategy for Suicide Prevention (NSSP). This landmark document launched an organized effort to prevent suicide in the United States; it was the first national strategic framework that laid out a public health approach to suicide prevention. In 2012, the NSSP was revised to reflect major advancements in suicide prevention, research, and practice. The 2012 NSSP revision has been used as the basis for all comparisons in the PREVENTS Roadmap.

Following the recommendations of a 2010 congressionally mandated task force on military suicides, the Department of Defense (DoD) created the Defense Suicide Prevention Office (DSPO) to address suicide among Service members using a public health approach. As a result, DSPO led the creation of the Defense Strategy for Suicide Prevention (DSSP); the DSSP was published in 2015 and was based on the framework laid out in the NSSP.

The Department of Veterans Affairs (VA) played a key role in the creation of the 2001 and 2012 NSSP and the work of the 2010 task force on military suicides. In 2018, VA released a National Strategy for Preventing Veteran Suicide (NSPVS). This strategic document reflects the framework outlined in the NSSP; it adapts the public health approach to suicide prevention for the Veteran population. The NSPVS is also closely aligned with the DSSP; it recognizes that Service members eventually become Veterans and that there is a need for concerted efforts between the two departments' suicide prevention programs.

Two recently signed Executive Orders focus on preventing suicide among Veterans. The first, Executive Order 13822, was signed on Jan. 9, 2018; it addressed the needs of Veterans who are in the process of transitioning from military life to civilian life to ensure that they have access to suicide prevention resources and continuity of mental health care. The Joint Action Plan, created as a result of this Executive Order, includes outreach efforts to educate Veterans about suicide prevention and to inform them about resources for which they may be eligible. It also aims to ensure that a Service member who received mental health care in the military is transitioned to a provider of their choice within the Veterans Health Administration or the community upon discharge. Executive Order 13822 spurred the VA Solid Start initiative, which provides early, consistent, caring contact to transitioning Service members for one year after military separation through prescribed proactive and personal interactions that center on their needs.

After implementing Executive Order 13822, VA and DoD established a joint agency effort designed to better connect Service members, Veterans, and their families with comprehensive support starting 365 days pre-separation through 365 days post-separation and beyond. This framework, referred to as the Military to Civilian Readiness Pathway (M2C Ready), is a comprehensive, integrated program which assists Service members during transition from service and leverages Federal agencies, partnerships, VA benefits and services, Veterans Service Organizations, and other existing community resources to provide a smooth transition back to civilian life.

Additionally, VA's Veterans Benefits Administration (VBA) and DoD's Office of Force Resiliency are leading the effort to connect Service members and Veterans to the services and benefits they have earned at the earliest possible point.

M2C Ready efforts will help to identify gaps or failure points in the transition process and will develop an approach to conduct a warm handoff to VA's services and programs before a Service member leaves the military.

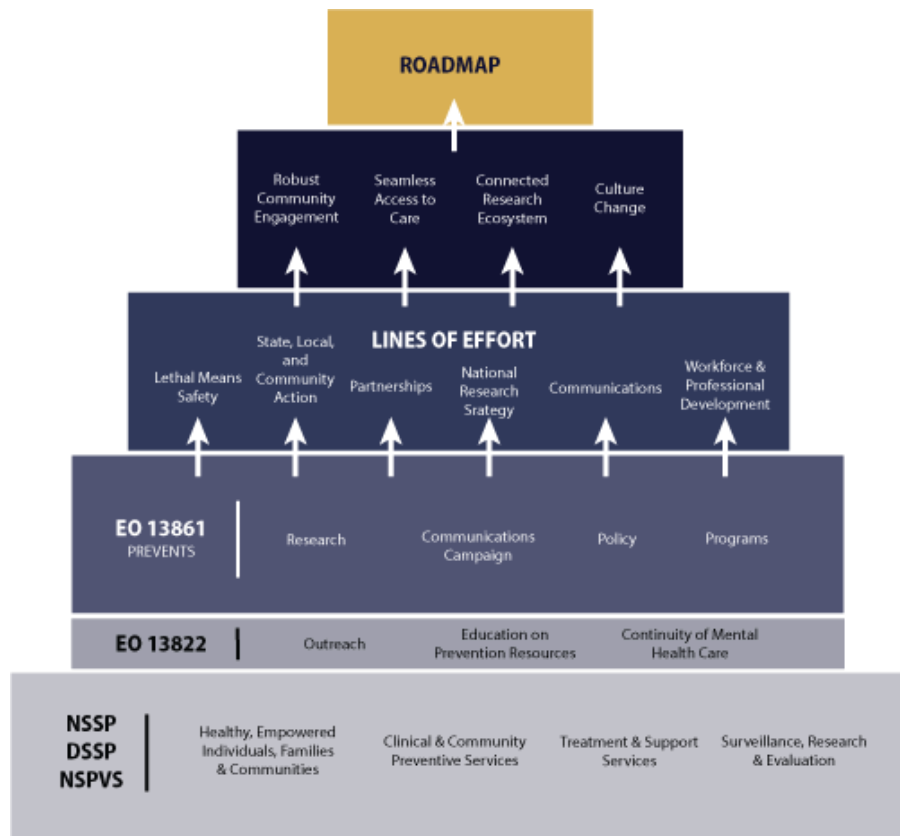
Under VA Solid Start, experienced VA representatives call *all* transitioning Service members at three intervals during their first year of transition to civilian life to discuss their transition and any challenges that the new Veteran may be facing. VA Solid Start phone calls increase Veterans' awareness of benefits and services they have earned that can help them live healthy, fulfilling civilian lives. Additionally, VA call representatives are trained to recognize signs of crisis and immediately connect Veterans to the Veterans Crisis Line for immediate support as needed.

Executive Order 13861, signed on March 5, 2019, is the focus of the PREVENTS Roadmap, which is broad in scope and requires a collective effort, not only among Federal agencies but also with state, local, and community-based organizations. It is based on the understanding that Veterans live in and are a part of communities across the country, and any successful effort to reach all Veterans must target their communities.



## Synergy Between the Strategic Frameworks

The PREVENTS Roadmap is founded on a strong strategic framework afforded by the NSSP, DSSP, and NSPVS. It follows a public health approach to address the issue of suicide in a practical, collaborative, multisectoral manner, with an emphasis on outcomes. The PREVENTS Roadmap builds upon the suicide prevention efforts underway and aims to build synergy between these efforts with a coordinated nationwide approach. It provides a framework for organizations to use to build partnerships and relationships between traditionally disparate sectors of the community. In this way, the PREVENTS Roadmap helps to synchronize the various suicide prevention efforts in the country, overcome barriers, and move toward a common goal of preventing this tragic loss of life. This approach places Veterans in a position to lead the Nation in this critical effort.



The Roadmap is the result of an inclusive process that builds on the NSSP, DSSP, NSPVS, and other broad-based collaborative efforts.

Figure A-2

## Key Concepts

### Overview of Adverse Childhood Experiences

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Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, or instability due to parental separation or incarceration of a parent, sibling, or other member of the household. Traumatic events in childhood can be emotionally painful or distressing and can have effects that persist for years. Factors such as the nature, frequency and seriousness of the traumatic event, prior history of trauma, and available family and community supports can shape a child's response to trauma.

In two large-scale U.S. studies, almost two-thirds of study participants reported at least one adverse childhood experience, and more than one in five have reported three or more.<sup>483,484</sup> The presence of one or more ACE is associated with poor health outcomes as an adult, particularly in the absence of protective factors.

While the experience of ACEs is common, there are some differences between populations. Men and women with military service report a higher number than those who have not served.<sup>485</sup> Children who experience a higher number of ACEs are more likely to not graduate from high school and earn lower incomes as adults. Men and/or women who identify as LGBTQ report a higher number of ACEs.<sup>484</sup>

The presence of one or more ACEs in an individual's life is a risk factor for numerous physical and mental health concerns. ACEs can increase the likelihood of injury, mental health concerns, maternal health concerns, infectious disease, chronic disease, and risky behaviors of an individual as an adult. As the number of ACEs increases, the odds of these concerns increase.<sup>486</sup>

One adverse childhood experience increases an individual's risk of attempted suicide two- to five-fold, and each additional experience increases the risk of attempted suicide by nearly 60%.<sup>487</sup> There is an association between one or more ACEs and suicide if an individual has other risk factors, including:

- Personal history of physical and/or mental health disorders, along with alcohol or substance misuse.<sup>488,489</sup>
- Underdeveloped executive functioning, or the mental processes that enable individuals to plan, focus attention, remember instructions, and juggle multiple tasks successfully.<sup>490</sup>
- Lower levels of income and educational attainment.<sup>491</sup>

Utilizing the best available evidence, the Centers for Disease Control and Prevention (CDC) released a compendium of prevention strategies for ACEs in 2019.

## ACEs Demographic and Prevalence Tables

This table summarizes participant demographic information from the CDC Kaiser ACEs study based at Kaiser Permanente's San Diego Health Appraisal Clinic as well as the Behavioral Risk Factor Surveillance System (BRFSS) study capturing data from 23 states and individuals with a history of military service.<sup>484,486</sup>

Table A-1

CDC Kaiser ACEs Study		BRFSS	
Data Collection Years: 1995-1997		Data Collection Years: 2011-2014	
Demographic Information	Percent (N=17,337)	Demographic Information	Percent (N=214,157)
GENDER			
Female	54.0%	Female	51.5%
Male	46.0%	Male	48.5%
RACE/ETHNICITY			
White	74.8%	White	68.1%
Black	4.5%	Black	8.4%
Asian/Pacific Islander	7.2%	Other	6.3%
Other	2.3%	Multiracial	1.6%
Hispanic	11.2%	Hispanic	15.6%
AGE (YEARS)			
19-29	5.3%	18-24	12.3%
30-39	9.8%	25-34	17.3%
40-49	18.6%	35-44	16.5%
50-59	19.9%	45-54	18.3%
60 and over	46.4%	55-64	16.2%
		65+	19.4%
EDUCATION			

CDC Kaiser ACEs Study		BRFSS	
Data Collection Years: 1995-1997		Data Collection Years: 2011-2014	
Demographic Information	Percent (N=17,337)	Demographic Information	Percent (N=214,157)
Not High School Graduate	7.2%	Less than High School	13.8%
High School Graduate	17.6%	High School Diploma/GED	28.1%
Some College	35.9%	Some College	32.6%
College Graduate or Higher	39.3%	College Degree	25.5%

Table A-2

CDC Kaiser ACEs Study				BRFSS			
Data Collection Years: 1995-1997				Data Collection Years: 2011-2014			
N=17,337 (Abuse, Household Challenges) N=8,629 (Neglect)				N=214,157 (Abuse, Household Challenges)			
ACEs Category	Women	Men	Total	ACEs Category	Women	Men	Total
ABUSE							
Emotional	13.1%	7.6%	10.6%	Emotional	33.9%	34.9%	34.4%
Physical	27.0%	29.9%	28.3%	Physical	17.5%	18.4%	17.9%
Sexual	24.7%	16.0%	20.7%	Sexual	16.3%	6.7%	11.6%
HOUSEHOLD CHALLENGES							
Mother Treated Violently	13.7%	11.5%	12.7%	Intimate Partner Violence	18.2%	16.8%	17.5%
Substance Abuse	29.5%	23.8%	26.9%	Substance Abuse	28.7%	26.3%	27.6%
Mental Illness	23.3%	14.8%	19.4%	Mental Illness	19.2%	13.7%	16.5%
Parental Separation or Divorce	24.5%	21.8%	23.3%	Parental Separation or Divorce	27.8%	27.5%	27.6%

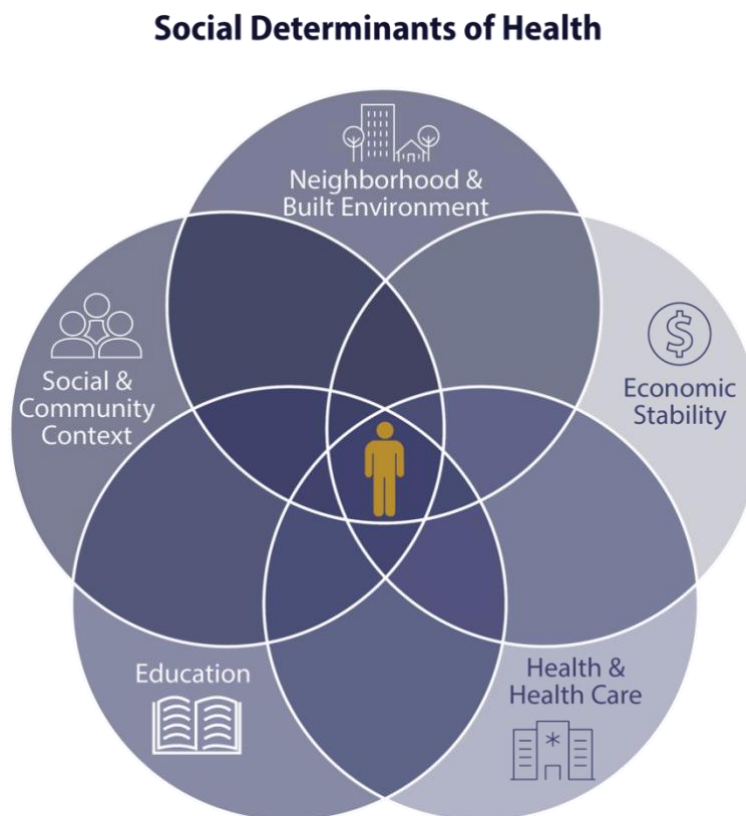
CDC Kaiser ACEs Study				BRFSS			
Data Collection Years: 1995-1997				Data Collection Years: 2011-2014			
N=17,337 (Abuse, Household Challenges) N=8,629 (Neglect)				N=214,157 (Abuse, Household Challenges)			
ACEs Category	Women	Men	Total	ACEs Category	Women	Men	Total
Incarcerated Household Member	5.2%	4.1%	4.7%	Incarcerated Household Member	7.3%	8.6%	7.9%
NEGLECT							
Emotional Neglect	16.7%	12.4%	14.8%	Data not collected			
Physical Neglect	9.2%	10.7%	9.9%				



## Social Determinants of Health

Social determinants of health (SDoH) is a broad category of determinants of health; the set of SDoH are a range of individual characteristics and behaviors, as well as social, economic, and environmental factors that influence health status. Simply put, they are the conditions in which people are born, grow, live, work, and age. There are five major SDoH domains: neighborhood and human-built environment, economic stability, health and health care, education, and social and community context.

Poor SDoH have been shown to be associated with increased suicide risk. As SDoH improve, suicide risk decreases.



**Social determinants of health can include:**

*Neighborhood and Built Environment*

- Quality of public safety
- Quality of housing
- Availability of transportation
- Access to safe drinking water and clean air
- Access to recreational and leisure opportunities
- Access to foods that support healthy eating patterns

#### *Economic Stability*

- Access to economic and job opportunities
- Occupation, employment status, and workplace safety
- Income level and poverty
- Access to stable housing and utilities

#### *Health and Health Care*

- Access to health care services
- Health literacy
- Quality and affordability of health care services

#### *Education*

- Quality of early childhood education
- Enrollment in higher education
- High school graduation
- Quality of education and job training
- Language literacy

#### *Social and Community Context*

- Access to social support
- Community involvement
- Social norms and attitudes
- Sex discrimination
- Racial segregation
- Exposure to violent behavior
- Rates of crime and incarceration

## Key Terms

Table A-3

Term	Definition
Active Component	The portion of the armed forces as identified in annual authorization acts as ‘active forces,’ and in section 115 of Title 10 of the United States Code as those active duty personnel paid from funds appropriated for active duty personnel.
Active Duty (AD)	Full-time duty in the active military service of the United States. The term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Active duty is defined by Title 10 of the United States Code.
Affected by suicide	All those who may feel the effect of suicidal behaviors, including survivors; those bereaved by suicide, employers, and community members; and others.
Behavioral health	A state of mental and emotional being, along with choices and actions, that affects wellness. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental health deterioration, substance misuse, and related problems; treatments and services for mental and substance use disorders; and recovery support.
Bereaved by suicide	Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).
Collective impact	Requires a group of important community actors from different sectors to commit to a common agenda to solve a complex social problem.
Community coalition	A group of diverse organizations and constituencies who work together to reach a common goal or goals.
Community Veterans Engagement Board	A group of individuals that enable Veterans, Service members, military families, Veteran advocates, community service providers, and stakeholders to have a collective voice in identifying their community goals and work to resolve gaps in service at the local level to improve service delivery for Veterans, military families, caregivers, and survivors.
Contagion	A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person’s suicidal acts. Closeness to an individual, group, or individuals within a specific organization may increase the risk of contagion.

Term	Definition
Counseling on Access to Lethal Means (CALM)	A workshop designed to help providers implement counseling strategies to help clients at risk for suicide and their families reduce access to lethal means, particularly (but not exclusively) firearms. It includes a number of components: background on suicide data and lethal means; an introduction to firearms; video presentation that models the counseling strategy; a presentation and discussion on conducting a counseling session; optional role plays; and a course evaluation.
Cultural competence	A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or a professional environment that enables effective work in cross-cultural situations. Fundamental components of cultural competence include respect for variation among cultures, awareness of a person's own beliefs and biases, interest in learning about other cultures and in developing skills to enhance cross-cultural communication, and knowledge.
Downstream prevention	Involve individual-level behavioral approaches for prevention or disease management at the point of crisis.
Firearm safety decision aids	A tool used to inform patients about available ways to reduce firearm access in times of suicide risk, ranging from locking devices to storage with firearm retailers, along with the potential benefits, risks, and costs during clinical encounters. Decision aids use a shared, informed approach to help individuals find the approach that is right for them.
Firearm safety devices	Any device that locks and is designed to prevent children and unauthorized users from firing a firearm. The device may be installed on a firearm, be incorporated into the design of a firearm, or limit access to the firearm.
Gatekeeper	Includes anyone (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, or police officers) who is strategically positioned to recognize and refer someone at risk for suicide to care.
Intervention	A strategy or approach that is intended to prevent an outcome or alter the course of an existing challenge or stress; also known as "secondary prevention."
Just culture	A framework that ensures balanced accountability both for individuals and for the organization responsible for designing and improving systems in the workplace. Engineering principles and human factors analysis influence the design of these systems, so they are safe and reliable.
Lethal means	An instrument or object (e.g., medicines, firearms, bridges) capable of causing death.
Lethal means safety	The process of increasing the time and/or spatial distance between lethal means and a person experiencing suicidal ideation.

Term	Definition
Living systematic reviews	Continually updating and incorporating changes to clinical guidelines rather than on a set schedule.
Mental health	A person's psychological and emotional well-being.
Mental illness	A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) that causes distress or impairment in cognitive, emotional, or social abilities.
Military community	An applicable group of Service members and military family members, or the general surroundings in which they live and work (e.g., unit, base, or station).
Military family members (or military dependents)	Military family members (also known as military dependents) are the spouses, children, and other familial relationship categories of a sponsoring military member for purposes of pay as well as special benefits, privileges, and rights that meet the requirement for a military dependent as defined by Title 10 U.S. Code Section 1072 (2).
Military Treatment Facility	A military hospital or clinic on or near a military base.
National Death Index (NDI)	A centralized database of death record information on file in state vital statistics offices. The CDC's National Center for Health Statistics works with state offices to establish the NDI as a resource to aid epidemiologists and other health and medical investigators with their mortality ascertainment activities.
Postvention	Response activities that should be undertaken in the immediate aftermath of a suicide. Postvention helps suicide attempt survivors cope with their grief and to prevent additional suicides. It also may provide an opportunity to disseminate accurate information about suicide, encourage help-seeking behavior, and provide messages of resilience, hope, and healing. Also known as "tertiary prevention."
Protective factors	Skills, strengths, or resources that help people deal more effectively with stressful events. Protective factors enhance resilience and help to counterbalance risk factors. Protective factors may be personal (e.g., attitudes, values, and norms prohibiting suicide) or external or environmental (e.g., strong relationships, particularly with family members).
Reserve Component	The Armed Forces of the United States Reserve Component consist of the Army National Guard of the United States, Army Reserve, Marine Corps Reserve, Navy Reserve, Air National Guard, Air Force Reserve, and the Coast Guard Reserve.
Resilience	The ability to withstand, recover, and grow in the face of stressors and changing demands.

Term	Definition
Risk factors	Factors that increase the likelihood of developing a condition or illness. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.
Safety plan	Personalized document where an individual identifies their warning signs, coping responses, and available resources to use when having thoughts of suicide.
Screening	Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.
Screening tools	Instruments and techniques (e.g., questionnaires, checklists, and self-assessment forms) used to evaluate individuals for increased risk of certain health problems.
Service member	A person appointed, enlisted, or inducted into a branch of the military services, including Reserve Components (e.g., National Guard), cadets, or midshipmen of the military service academies.
Social determinants of health (SDoH)	Conditions that can affect a wide range of health risks and outcomes based on where people live, learn, work, and play.
Stigma	Negative beliefs that society or a group of people associate with a particular circumstance, quality, action, or person.
Stratified/targeted medicine	The act of refining populations into subgroups to identify treatments better tailored to the individual patient.
Suicidal behaviors	Any action an individual takes with the intent to end his or her life.
Suicidal ideation	Thoughts of engaging in suicide-related behavior.
Suicide	Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
Suicide attempt	A non-fatal, self-directed behavior with an intent to die as a result of the behavior.
Veterans Service Organizations	Organizations dedicated to raising awareness about Veteran issues and/or helping Veterans in a variety of ways, including offering claims and benefits assistance, scholarships, training, counseling, and other programs.
Whole health	Patient-centered care that affirms the importance of the relationship and partnership between the patient and their community of health care providers. The focus is on educating and empowering the individual to participate in creating a personalized, proactive, patient-driven experience to achieve optimal health and well-being.

## Acronyms and Abbreviations

Table A-4

Acronym	Definition
ACL	Administration for Community Living
AFSP	American Foundation for Suicide Prevention
AHRQ	Agency for Healthcare Research and Quality
AI	Artificial Intelligence
AMA	American Medical Association
APIs	Application Programming Interfaces
BIC	Brief Intervention and Contact
CALM	Counseling on Access to Lethal Means
CAP	Cross-Agency Priority
CAP	Child Access Protection
CARF	Commission on the Accreditation of Rehabilitation Facilities
CBO	Community-based Organization
CBT	Cognitive Behavioral Therapy
CC	Collaborative Care
CDC	Centers for Disease Control and Prevention
CDE	Common Data Element
CDMRP	Congressionally Directed Medical Research Program
CEIR	Center for Evaluation and Implementation Resources
CEU	Continuing Education Units
CFR	Code of Federal Regulations
CME	Continuing Medical Education

Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
CNCS	Corporation for National and Community Service
CPG	Clinical Practice Guidelines
CPT	Current Procedural Terminology
CVEB	Community Veterans Engagement Boards
DBT	Dialectical Behavioral Therapy
DEA	Drug Enforcement Agency
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DoDSER	Department of Defense Suicide Event Report
DOE	Department of Energy
DOL	Department of Labor
DOT	Department of Transportation
DSPO	Defense Suicide Prevention Office
DSSP	Department of Defense Strategy for Suicide Prevention
DUA	Data Use Agreement
EBP	Evidence-Based Practice
ED	Emergency Department
ED-SAFE	Emergency Department-Safety Assessment and Follow-up Evaluation
EHR	Electronic Health Records
EO	Executive Order
FDA	Federal Drug Administration
FITBIR	Federal Interagency Traumatic Brain Injury Research



Acronym	Definition
GRADE	Grading of Recommendations Assessment, Development and Evaluation
GSA	General Services Administration
GUID	Global Unique Identifiers
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IBM	International Business Machines Corporation
ICD	International Classification of Diseases
IHS	Indian Health Services
IHI	Institute for Healthcare Improvement
IPT	Interpersonal Psychotherapy
IRB	Institutional Review Board
JAMA	Journal of the American Medical Association
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
LMS	Lethal Means Safety
LMSC	Lethal Means Safety Counseling
LOE	Line of Effort
MIRECC	Mental Illness Research, Education and Clinical Centers
MOS	Military Occupational Specialties
MOU	Memorandum of Understanding
MSO	Military Service Organizations
MST	Magnetic Stimulation Therapy

Acronym	Definition
MVP-CHAMPION	Million Veterans Program - Computational Health Analytics for Medical Targeted to Improve Outcomes Now
NCHS	National Center for Health Statistics
NDI	National Death Index
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NINDS	National Institute of Neurological Disorders and Stroke
NLP	Natural Language Processing
NPSG	National Patient Safety Goal
NRAP	National Research Action Plan
NRS	National Research Strategy
NSSF	National Shooting Sports Foundation
NSSP	National Strategy for Suicide Prevention
NSTC	National Science and Technology Council
NSVPS	National Strategy for Preventing Veteran Suicide
NVDRS	National Violent Death Reporting System
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
OMHSP	Office of Mental Health and Suicide Prevention
OPEN	Open, Public, Electronic, and Necessary
OSTP	White House Office of Science and Technology Policy
PCORI	Patient-Centered Outcomes Research Institute
PDMP	Prescription Drug Monitoring Program

Acronym	Definition
PII	Personally Identifiable Information
PREVENTS	President's Roadmap to Empower Veterans and End a National Tragedy of Suicide
PRIMED	Priorities for Gun-Related Injury in Medical Education
PSA	Public Service Announcement
PTSD	Post-Traumatic Stress Disorder
QI	Quality Improvement
QIF	Quality Implementation Framework
QUERI	Quality Enhancement Research Initiative
RCT	Randomized Controlled Trial
REACH VET	Recovery Engagement and Coordination for Health — Veterans Enhanced Treatment
RFI	Request for Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SDoH	Social Determinants of Health
SMVF	Service members, Veterans, and their Families
SP	Suicide Prevention
STORM	Stratification Tool for Opioid Risk Management
SUD	Substance Use Disorder
TAP	Transition Assistance Program
TAPS	Tragedy Assistance Program for Survivors
TBI	Traumatic Brain Injury
TMS	Transcranial Magnetic Stimulation
UK	United Kingdom

Acronym	Definition
USDA	United States Department of Agriculture
VA	Department of Veterans Affairs
VAHCS	Veterans Affairs Health Care System
VBA	Veterans Benefits Administration
VCL	Veterans Crisis Line
VCP	Veterans Community Partnership
VETS	Veterans Employment and Training Service
VFW	Veteran of Foreign Wars
VHA	Veterans Health Administration
VSO	Veterans Service Organization
VFW	Veteran of Foreign Wars

## Thank You

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### VSOs, MSOs, and Nonprofits

The following organizations have engaged with the PREVENTS Office in the development of the PREVENTS Roadmap (current as of 06/02/2020):

Arizona Coalition for Military Families	Hiring Our Heroes	Paralyzed Veterans of America
Air Force Sergeants Association	Independence Fund	Ranger Road
America's Warrior Partnership	Iraq and Afghanistan Veterans of America	Reserve Officers Association
American Legion	Jewish War Veterans	Student Veterans of America
AMVets	Marine Corps League	Team Red, White, and Blue
Blinded Veterans Association	Mighty Oaks Foundation	Team Rubicon
Blue Star Families	Military Family	The Enlisted Association of the National Guard of the United States
Bob Woodruff Foundation	Military Officers Association of America	The Mission Continues
Boulder Crest	Military Order of the Purple Heart	The Retired Enlisted Association
Bush Foundation – Veteran Program	National Military Family Association	Tragedy Assistance Program for Survivors
Code of Support	National Association of County Veterans Service Officers	Travis Manion Foundation
Cohen Veterans Network	National Association of State Directors of Veterans Affairs	Veterans of Foreign Wars
Concerned Veterans for America	National Association of Veteran Serving Organizations	VetsFirst
Disabled American Veterans		Vietnam Veterans of America
Elizabeth Dole Foundation		Wounded Warrior Project
Give an Hour		

## Partners

The PREVENTS Office has engaged the following organizations and offices during the creation of the PREVENTS Roadmap and is grateful for their specific assistance and expertise to develop, implement, and evaluate this critical effort.

Table A-5

Name	Description
<b>Office of the Second Lady of the United States</b>	<b>Second lady of the United States Karen Pence is the lead PREVENTS Ambassador and has committed to spreading information and messages to empower Veterans and prevent suicide across the Nation.</b>
American Medical Association	Collaborate on effective practices to prevent suicide among Veterans.
American Psychological Association	Develop education and training materials for mental health professionals to assess suicide accurately and refer individuals properly.
American Red Cross Military Veteran Caregiver Network	Support VA in storing and distributing the Facebook portal devices.
Creative Forces	Provide the artwork created by Service members and Veterans for the Roadmap; work to raise awareness about the positive impact that creativity and art has in healing and suicide prevention.
Elizabeth Dole Foundation	Share PREVENTS messaging and community partner services through their Hidden Heroes Cities, a network of cities and counties dedicated to streamlining services to military caregivers.
Entertainment Industries Council	Develop a toolkit for writers, directors, and producers to practice safe messaging about suicide in their programming and to communicate stories about suicide risk, protective factors, and prevention.
Facebook	Provide nearly 7,500 Facebook portal devices to Veterans and their caregivers to increase social connectedness.
Google	Disseminate the PREVENTS public health messaging broadly and help reach at-risk users of their platforms.
Harvard University	Develop an evaluation protocol to measure both the effectiveness of the public health campaign and the various local programs recommended by the Roadmap.

McKinsey & Company	Provide analysis and support for the PREVENTS Roadmap.
National Association of Social Workers	Develop a web-based menu of suicide prevention educational and training tools for clinical and non-clinical social worker use and to provide recommendations for the Roadmap.
PenFed Credit Union and PenFed Foundation	Create a funding mechanism to support a national public health campaign on suicide prevention.
RallyPoint	Provide focus group opportunities as the public health campaign is developed and implemented and to spread the campaign messages.
SoldierStrong	In collaboration with the PREVENTS Office and PenFed, provide support for the public health campaign and connect the work of PREVENTS to a broad range of Veteran-related audiences.
South Carolina Law Enforcement Assistance Program, Fairfax County, Arlington County, and New York City Police Departments	Use their experiences and leadership expertise on peer support within their workforces to develop best practices to share with other First Responder agencies.
Meadows Mental Health Policy Institute	Work on tracking depression in the Greater Dallas area.
The University of California Los Angeles	Share its partnership journey as it works with 100 community organizations to build a local coalition to shift the culture around mental health through their Grand Depression Challenge. Its lessons learned can then be shared with other communities in their grassroots coalition-building efforts.
Veterans United	Provide credit consulting for Service members and Veterans free of charge through their Lighthouse Program.

## Ambassadors

The PREVENTS Office has engaged the following individuals as the first group of PREVENTS Ambassadors and is grateful for their dedication to raising awareness of the importance of caring for emotional well-being, empowering Veterans, and ending the national tragedy of suicide.

**Karen Pence**, Second Lady of the United States

**Vice Admiral Jerome Adams, MD, MPH**, U.S. Surgeon General of the United States

**Talinda Bennington**, Suicide Prevention Advocate (The Campaign to Change Direction)

**Bonnie Carroll**, Founder and President, Tragedy Assistance Program for Survivors (TAPS) and 2015 recipient of the Presidential Medal of Freedom

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**DJ Nash**, Creator and Showrunner of *A Million Little Things*

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## National Resources

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### Previous Suicide Prevention Strategies

- [National Strategy for Suicide Prevention](#)
- [Defense Strategy for Suicide Prevention](#)
- [National Strategy for the Prevention of Veteran Suicide](#)

### Safe Messaging

- [Suicide Prevention Resource Center](#)
- [OMHSP Safe Messaging Fact Sheet](#)

### Veteran Executive Orders

- [Executive Order 13822](#)
- [Executive Order 13861](#)

### Suicide Data

- [Suicide Mortality in the United States, 1999–2017 \(CDC\)](#)
- [2018 Annual Suicide Report - Department of Defense](#)
- [2019 National Veteran Suicide Prevention Annual Report](#)

### Task Force Agency Websites

- [Department of Defense](#)
- [Department of Education](#)
- [Department of Energy](#)
- [Department of Health and Human Services](#)
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- [Department of Housing and Urban Development](#)
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*If you are thinking about suicide, are worried about a friend or loved one, or would like emotional support, the Lifeline network is available 24/7 across the United States.*

**Call 1-1-800-273-8255, Veterans Press 1**

*Chat: <https://suicidepreventionlifeline.org/chat/>*

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