STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
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POST OFFICE BOX 301410
MONTGOMERY, AL 36130-1410
WWW.MH.ALABAMA.GOV

Kay Ivey
Governor

Kimberly G. Boswell
Commissioner

November 8, 2024

Dear Veterans Serving Organizations in Alabama,

On behalf of the Veterans Mental Health Steering Committee, thank you for the services you provide every day to Alabama veterans. To assist the Committee in reviewing all of the current programs and resources available in the state, **please consider responding to the attached Request For Information (RFI).**

As established in Act 2024-358, the Veterans Mental Health Steering Committee is charged by the Governor and Legislature to develop a comprehensive plan that addresses the unique behavioral health needs of Alabama veterans. To inform the plan, leverage resources, and identify gaps in care, the Committee must conduct a review of current veterans' mental health, substance use, recovery, and other support services in Alabama.

Specifically, we are looking for programs and services that address one or more of the Committee's goals:

- Improve lethal means safety
- Enhance crisis care and care transitions
- Increase access to and delivery of effective care
- Address upstream risk and protective factors

Please review the RFI in its entirety, and submit it to veterans@mh.alabama.gov by November 30, 2024. Questions about the RFI can be submitted to the same address from now until November 15, 2024.

We look forward to learning more about the success of your programs and using this information to inform future Requests for Proposals (RFPs) and statewide initiatives. Thank you for your service as well as your participation in this important mission.

Sincerely.

Kimberly G. Boswell
Commissioner

Veterans Mental Health Steering Committee

Request for Information

Overview

The Veterans Mental Health Steering Committee (VMHSC) was established through Act 2024-358 within the Alabama Department of Mental Health. The Committee is charged with developing a comprehensive plan to address the unique behavioral health needs of Alabama veterans. To create the comprehensive plan, the VMHSC must conduct a **review** of:

- The current state of Alabama veterans' mental health and rates of substance use.
- Current mental health, substance use, recovery and other support services in Alabama.
- Needs assessments previously conducted for the purpose of identifying gaps in services.

The purpose of this Request for Information (RFI) is to inform the review and identify programs that are currently serving veterans through veteran specific programs.

Please note that this RFI is for informational purposed only and no contract will be awarded as a result. Your response to the RFI- or lack thereof- will not impact on the evaluation of responses to any subsequent Request for Proposals released. Responses will be used solely for information and planning purposes.

We have designated the following email to serve as the official point of contact for this RFI.

veterans@mh.alabama.gov

Submission Details:

Please submit your response to this RFI via the email listed above. When submitting your responses, please make the subject line of the email "Veterans RFI Response".

If you have any questions about the RFI, please direct them to the email with a subject line "RFI Questions". The deadline for questions is 11/15/2024. The questions will be compiled and a response will be posted to the ADMH website.

RFI Timeline:

- RFI release: 11/08/2024
- RFI questions: Questions can be submitted through 11/15/2024.
- Responses due: 11/30/2024

If your organizations has multiple programs you can choose to submit a separate response for each program.

Background

The Veterans Mental Health Steering Committee was established through Act 2024-358. The Act provides for the following:

Establishes the Veterans Mental Health Steering Committee and its Purpose.

- The Veterans Mental Health Steering Committee (VMHSC) is made up of 20 members, including 18 voting and 2 ex-officio, non-voting members.
- The VMHSC is to conduct a review of the following:
    - The current state of Alabama veterans' mental health and rates of substance use.
    - Current mental health, substance use, recovery, and other support services in Alabama.
    - Needs assessments previously conducted for the purpose of identifying gaps in services and support.
- In response to the review, the VMHSC is charged with developing a Comprehensive Plan to address the unique behavioral health needs of Alabama veterans.
- ADMH shall align the Comprehensive Plan with state and national behavioral health standards, and implement it upon the Legislature's review/feedback, and Governor's approval.

Provides a timeline for the VMHSC's development of a Comprehensive Plan.

- **June 1, 2024:** The Act goes into effect.
- **July 1, 2024:** Deadline for VMHSC appointments.
- **September 1, 2024:** Deadline for the first meeting of the VMHSC.
- **January 1, 2025:** Deadline for the VMHSC's full review.
- **April 1, 2025:** Deadline for a Comprehensive Plan to be presented to the House and Senate Veterans and Military Affairs Committees.
- **June 30, 2025:** Deadline for ADMH to submit Comprehensive Plan to the Governor.
- **August 31, 2025:** The Governor shall act on the Comprehensive Plan no later than this date.
- **Continued Meetings:** Upon the Governor's approval, ADMH will implement the Comprehensive Plan, and ADMH will update the VMHSC on its progress.

Creates opportunity for pilot projects with newly appropriated dollars.

- ADMH may establish pilot projects utilizing evidence-based services certified by ADMH or organizations which agree to become certified by ADMH.
- Pilot projects will be awarded funding by ADMH through a fair and transparent RFP process.
- Pilot projects may begin upon the appropriation of funds and certification of projects.
- Pilot projects shall be based on the findings of the Comprehensive Plan.

- **Note, through Act 2024-426, ADMH received $3 million in Opioid Settlement Funds for this purpose.**

Goals and Outcomes

Specifically, we are looking for programs and services that address the following goals:

- **Improve lethal means safety** – interventions that aim to address lethal means safety training, safe storage options, or safety planning care. Research shows "time and space' between a person in crisis and their access to lethal means is lifesaving.
- **Enhance crisis care and care transitions** - increasing access to suicide crisis services that are effective and paired with improved facilitation of follow -up care beyond the crisis.
- **Increase access to and delivery of effective care** - efforts designed to increase capacity, ease access to, and improve the delivery of evidenced-based behavioral healthcare.
- **Address upstream risk and protective factors** – comprehensive suicide prevention must pair attention to and improvement in crisis care and clinical care with policies, programs and practices that reduce risk factors and protective factors. Multiple studies have demonstrated economic opportunity, mobility and stability represent important means to reduce risk factors.

We are looking to achieve the following outcomes:

- Identify best practices, promising practices and effective programs serving veterans either currently being delivered on a small scale or programs you would like to deliver if funding was available.
- The information gathered through the RFI will be used to identify gaps in services and programs that can fill the gaps.
- Inform the comprehensive plan and develop financial strategies.
- Inform the development of an RFP to establish pilot projects utilizing evidenced-based services certified by ADMH or organizations which agree to become certified by ADMH. Since the funding is through Act2024-426 Opioid Settlement Funds, the dollars are designated to be used for treatment, prevention and recovery supports.

RFI Formatting

To ease the review process, RFIs should be written in size 12 Times New Roman font with black print. Please incorporate one-inch margins. Responses should correspond with the information requested on the following page, in the order the information is listed.

Information Requested

The Alabama Department of Mental Health is especially interested in hearing from community-based organizations successfully serving veterans through best practices, promising practices or effective programs.

The response should include the following:

- Program Name(s):
- Location(s) of Services (city and county):
- Target Veteran population(s):
- Organizational Chart:
    - What percentage of staff are Veterans?
- Program Description (i.e., treatment delivery, timeline, service providers, etc)
    - Please describe your veteran cultural competence training.
- Number of Veterans Treated/Served:
    - 2022
    - 2023
    - 2024 (year to date)
    - For each year, please breakdown the number served by the following age group
        - 18-34
        - 35-54
        - 55-74
        - 74+
- Measurable Outcomes:
- Funding Sources:
- Cost to Veteran:
- VA Affiliations (if any):
- Referral Sources if any):
- ADMH Certification Status:
- Annotated Bibliography (evidence basis) - last five years. A summary of evidence of effectiveness for your program or if you are submitting a program you would like to implement please provide the evidence-based practice research for the program.

The response should be no more than 5 pages. If the submission is more than 5 pages, it will be disqualified.

Appendix

Act 2024-358

Reducing Military and Veteran Suicide

SB135

ACT #2024 -358

GQHQCCC-3

By Senators Jones, Chesteen, Butler, Kelley, Stewart, Coleman-Madison, Coleman, Barfoot

RFD: Veterans and Military Affairs

First Read: 20-Feb-24

Enrolled, An Act,

Relating to the Alabama Department of Mental Health; to add Chapter 58 of Title 22, Code of Alabama 1975; to require the Alabama Department of Mental Health to work collaboratively with the Alabama Department of Veterans Affairs to develop a comprehensive plan to address Alabama veterans' behavioral health needs and to provide funding of certain programs addressing specific behavioral health needs.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Chapter 58 is added to Title 22, Code of Alabama 1975, to read as follows:

Chapter 58

§22-58-1

As used in this chapter, the following terms have the following meanings:

(1) ADMH. The Alabama Department of Mental Health.

(2) ADMH COMMISSIONER. The Commissioner of the Alabama Department of Mental Health.

(3) ADVA. The Alabama Department of Veterans Affairs.

(4) ADVA COMMISSIONER. The Commissioner of the Alabama Department of Veterans Affairs.

(5) BEHAVIORAL HEALTH CARE. The prevention, diagnosis, and treatment of mental health conditions, substance use disorders, and behavioral health crisis.

(6) COMPREHENSIVE PLAN. The comprehensive plan established pursuant to this chapter, as may be amended from time to time, to address the behavioral health needs of

veterans as a supplement to services already offered in Alabama.

(7) PTSD. Post traumatic stress disorder.

(8) RECOVERY. A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(9) TRAUMATIC BRAIN INJURY or TBI. An injury to the brain caused by a forceful bump, blast, or jolt to the head or body, or from an object that pierces the skull and enters the brain, which can be the result of external forces, including, but not limited to, assault or motor vehicle collisions.

(10) VETERAN. Any current resident of the state who:

a. Served in the active military, naval, air, or space forces of the United States who was discharged or released under conditions other than dishonorable;

b. Is or was a member of the Army National Guard or Air National Guard who was discharged or released from service under conditions other than dishonorable; or

c. Is or was a member of the reserve component of the Armed Forces who was discharged or released from service under conditions other than dishonorable.

§22-58-2

The Legislature finds the following:

(1) ADMH is the state's lead agency for this act, as well as the expert in the following areas:

a. Knowledge and expertise in behavioral health care services.

b. Certifications and implementation of the Certified

Community Behavioral Health Clinic (CCBHC) model.

c. State and national standards of behavioral health care, treatment, and services.

d. Infrastructure and best practices needed to implement behavioral health care treatment, recovery, and prevention services.

(2) ADVA is the state's expert in the following areas:

a. Military experience and culture.

b. Relationships and trust with Alabama veterans.

c. Knowledge of veterans' state and federal benefits and resources.

d. Types of support needed for veterans to reintegrate into civilian life.

§22-58-3

(a) The Veterans Mental Health Steering Committee is established. The purpose of the committee is to develop a comprehensive plan to address the behavioral health needs of Alabama veterans.

(b) The committee shall include the following individuals:

(1) The ADMH Commissioner, or his or her designee. The ADMH Commissioner shall chair of the committee.

(2) The ADVA Commissioner, or his or her designee. The ADVA Commissioner shall vice-chair the committee.

(3) The Alabama Department of Rehabilitation Services Commissioner, or his or her designee.

(4) The Adjutant General of the Alabama National Guard, or his or her designee.

(5) During their tenure as legislators, the lead sponsor for House Bill 197 and the lead sponsor for Senate Bill 135 from the 2024 Regular Legislative Session, who, upon leaving the Legislature, shall be replaced by the respective chairs of the Senate and House Veterans and Military Affairs Committees, or their designees.

(6) Representatives of two veterans service organizations with expertise in mental health, substance use, peer support, and other culturally competent care, appointed by the ADVA Commissioner, who shall serve for initial terms of one year and three years, respectively.

(7) Representatives of one other veterans support organization, appointed by the ADVA Commissioner, who shall serve for an initial term of four years, respectively.

(8) Three mental health and substance use providers certified by ADMH who also serve veterans, appointed by the ADMH Commissioner, who shall serve for initial terms of one, two, and three years, respectively.

(9) The Associate Commissioner of the ADMH Division of Mental Health and Substance Abuse Services shall serve as an ex-officio, non-voting member of the committee.

(10) The Veterans Well-Being Program Manager of the ADVA shall serve as an ex-officio, non-voting member of the committee.

(11) The Governor or his or her designee.

(12) The Lieutenant Governor or his or her designee.

(13) The Speaker of the Alabama House of Representatives or his or her designee.

(14) The President Pro Tempore of the Senate, or his or her designee.

(15) The minority leaders of the House of Representatives and the Senate, or their designees.

(c) All appointing authorities shall coordinate their appointments so that diversity of gender, race, and geographical areas are reflective of the makeup of this state. To the extent practicable, appointing authorities are encouraged to prioritize appointments of service members, veterans, and family members of veterans. The designee of a committee member shall not be a health care provider or mental health care provider.

(d) Meetings of the committee shall be held no less than on a quarterly basis, or upon the call of the chair or a majority of committee members. Appointments to the committee shall be made by July 1, 2024, and the first meeting of the committee shall be held by September 1, 2024. All meetings shall comply with the Open Meetings Act.

§22-58-4

(a) ADMH shall work collaboratively with ADVA, leveraging each other's roles, relationships, and expertise. The committee shall develop a comprehensive plan in response to a review of the following:

(1) The current state of Alabama veterans' mental health and rates of substance use.

(2) Mental health, substance use, recovery, and other veteran support services in Alabama.

(3) Needs assessments previously conducted for the

purpose of identifying gaps in services and support. The review of needs assessments shall include qualitative and quantitative feedback of post-9/11 veterans in Alabama, as well as the need for additional services and coordination of existing services.

(b) The review shall be completed by January 1, 2025.

(c) The committee shall consult with others, to include the United States Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration, as appropriate, during the development of the comprehensive plan.

(d) ADMH shall align the comprehensive plan with state and national behavioral health standards.

§22-58-5

(a) ADMH may establish pilot projects utilizing existing evidence-based services certified by ADMH or organizations which agree to become certified by ADMH. Pilot projects shall be awarded funding by ADMH through a fair and transparent request for proposal process. Pilot projects may begin upon the appropriation of funds and certification of projects.

(b) The pilot projects may include any of the following:

(1) Eye movement desensitization and reprocessing therapy as an evidence-based treatment for PTSD.

(2) TBI screenings integrated into behavioral health services.

(3) Integrated behavioral health and primary care models.

(4) Agencies that have successfully met the SAMHSA criteria for the CCBHC model of care as certified by ADMH.

(c) Pilot projects shall be based on the findings of the comprehensive plan.

§22-58-6

ADMH and ADVA shall present the proposed comprehensive plan to the respective Veterans and Military Affairs Committees of the Alabama House of Representatives and the Alabama Senate for their review and input no later than April 1, 2025. ADMH shall then submit the proposed comprehensive plan to the Governor by June 30, 2025, for review and approval. The Governor shall act on the comprehensive plan no later than August 31, 2025.

§22-58-7

(a) Upon approval of the Governor and subject to sufficient appropriations, ADMH shall implement the comprehensive plan with continued input from ADVA.

(b) ADMH shall contract with multiple entities to implement pilot projects as described in Section 22-58-4 and provide services under this chapter. Contracts for the procurement of services shall be awarded on a competitive basis through a request for proposal process. Both ADMH and ADVA shall work collaboratively in the review and selection of the proposals in a fair and transparent manner.

(c) ADMH and ADVA shall comply with federal ethics laws in regard to its role in this chapter.

(d) Implementation of this chapter shall be contingent upon new funds appropriated by the Legislature. Nothing in this

act shall require existing resources to be diverted for this purpose.

(e) All pilot projects and services implemented under this act shall comply with all requirements, including data reporting and certification standards, set out by ADMH. If a recipient of funds fails to meet those requirements, ADMH may demand recovery of the full amount of funds awarded. Upon notification of any demand, ADMH shall also notify the committee outlining the rationale for taking that action.

(f) During the committee's regular meetings, ADMH shall update the committee on the progress of the comprehensive plan's implementation.

(g) The committee shall conduct an annual review and may make formal recommendations regarding the comprehensive plan. ADMH shall align these recommendations to state and national behavioral health standards and submit them to the Governor for approval.

(h) To inform this annual review, ADMH shall report annually to the committee the approximate number of veterans served through the pilot projects, the services provided by pilot projects, and the amount of funding expended for this purpose, as well as other available datapoints as determined by the committee.

(i) Nothing in this act shall supersede or diminish the existing powers enumerated to ADMH.

Section 2. This act shall become effective June 1, 2024.

President and Presiding Officer of the Senate

Speaker of the House of Representatives

SB135
Senate 30-Apr-24
I hereby certify that the within Act originated in and passed the Senate, as amended.

Patrick Harris,
Secretary.

House of Representatives
Passed: 08-May-24

By: Senator Jones

APPROVED 5/15/2024

TIME 11:15 am

Kay Ivey
GOVERNOR

Alabama Secretary Of State

Act Num....: 2024-358
Bill Num...: S-135

Recv'd 05/15/24 01:58pmKCW

ENGROSSED

Senate Bill No. 135

SPONSOR

1 Jones

CO-SPONSORS

2 Chesteen
3 Butler
4 Kelley
5 Stewart
6 Coleman-Madison
7 Coleman
8 Barfoot
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SENATE ACTION

I hereby certify that the Resolution as required in Section C of Act No. 81-889 was adopted and is attached to the Bill, SB 135.

yeas 31 nays 0 abstain 0

PATRICK HARRIS,
Secretary

I hereby certify that the notice & proof is attached to the Bill, SB _____ as required in the General Acts of Alabama, 1975 Act No. 919.

PATRICK HARRIS,
Secretary

CONFERENCE COMMITTEE

Senate Conferees _____

_____

_____

HOUSE ACTION

DATE: 5-2 2024

RD 1 RFD WMGT

REPORT OF STANDING COMMITTEE

This bill having been referred by the House to its standing committee on WMGT was acted upon by such committee in session, and returned therefrom to the House with the recommendation that it be Passed, w/amend(s) _____ w/sub _____.

This 7th day of May, 2024

Reynolds 21, Chairperson

DATE: 5-7 2024

RF RD 2 CAL

DATE: 20__

RE-REFERRED ☐ RE-COMMITTED ☐

Committee _____

I hereby certify that the Resolution as required in Section C of Act No. 81-889 was adopted and is attached to the Bill, SB 135.

YEAS 97 NAYS 0

JOHN TREADWELL,
Clerk

FURTHER HOUSE ACTION (OVER)

REDUCING MILITARY AND VETERAN SUICIDE:

ADVANCING A COMPREHENSIVE, CROSS-SECTOR, EVIDENCE-INFORMED PUBLIC HEALTH STRATEGY

THE WHITE HOUSE
WASHINGTON

Contents

Introduction

Suicide among service members, veterans, and their families is a public health and national security crisis. In 2019 alone, the Department of Veterans Affairs reported that 6,261 veterans died by suicide.[i] The Department of Defense reported 580 suicide deaths among Active Components, Reserve, and National Guard service members in 2020; and 202 suicide deaths among military family members in 2019.[ii] While suicide in the general population has been increasing, the rate among service members and veterans remains too high despite ongoing effort to reduce suicide through the implementation of federal policies, programs, and practices.

For more than a decade, the suicide rates have been higher and have risen faster among veterans as compared to non-veterans. Women veterans die by suicide at almost twice the rate than non-veteran women, and veterans ages 18-34 have a suicide rate almost three times higher than non-veterans the same age.[iii] In the military, young (less than 30 years of age) and enlisted service members are at heightened risk.[iv] As with the general population, among service members, veterans and their family members, firearms are the most common method of suicide.

Suicide is a complex problem with no single cause and no single solution. Risk factors for suicide among service members and veterans are both similar and different than those for non-military and veteran groups. We know, however, that service members and veterans are at higher risk for some of the common risk factors, including experiencing a mental health condition and having a physical health problem.

> ***Suicide is a complex problem with no single cause and no single solution.***

Given the multiple factors that may lead to suicide death, preventing suicide requires a comprehensive public health approach that harnesses the full breadth of the federal government in close coordination with States, Territories, Tribes, and local governments, as well as collaboration with industry, academia, communities and community-based organizations, families, and individuals.[v] **Reducing suicide cannot be accomplished singularly through reactive policy change, rather it requires a long-term strategic vision and commitment designed to create and implement systemic changes in how we support service members, veterans, and their families across the full continuum of risk and wellness.**

Reducing suicide risk requires policies and programs that enhance economic opportunities and stability and deliver services, including crisis care as well as ongoing primary and behavioral healthcare, where and when needed. It also requires that we focus on making the environment safer from risk, especially from lethal means. Preventing suicide requires attending to the factors that increase risk, but also attending to the factors that we know can be protective. Implementing a comprehensive approach also requires integration of effort and collaboration across and within government agencies and non-governmental organizations.

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Reducing suicide cannot be accomplished singularly through reactive policy change, rather it requires a long-term strategic vision and commitment designed to create and implement systemic changes in how we support service members, veterans, and their families across the full continuum of risk and wellness.

Approaches for reducing suicide among military service members, veterans, and their family members **should be rooted in a strong public health framework that addresses the full range of risk and protective factors through evidence-based, interdisciplinary approaches, and balances the role of policy, program execution, engagement, and evaluation**. Over the past 20 years, there have been many efforts designed to address suicide, including among the military and veteran populations. In outlining this strategy, we aim to build upon these efforts, rather than creating duplication or confusion across initiatives.

In this document, we outline a series of priority goals and executive actions that the Biden-Harris Administration will pursue to reduce and prevent suicide within the military and veteran population. Our effort builds upon an existing foundation of government programs and public-private partnerships, and it serves to accelerate across the interagency efforts.

Background

In 2012, Executive Order 13625 *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* established the Interagency Task Force on Military and Veterans Mental Health. The early work of this Interagency Task Force had a specific emphasis on facilitating interagency collaboration, expanding staffing capacity at the Veteran Crisis Line, and joint development of a national suicide prevention campaign focused on connecting veterans and service members to resources and support.

In addition to this instrumental work, building upon the 2012 National Strategy to Prevent Suicide, the Departments of Defense and Veterans Affairs released an adaptation of the National Strategy to Prevent Suicide specific to their populations and settings in 2015 and 2018, respectively. The 2012 National Strategy outlined four strategic directions:

Strategic Direction 1: Healthy and Empowered Veterans, Families & Communities

Strategic Direction 2: Clinical and Community Prevention Services

Strategic Direction 3: Treatment, Recovery, and Support Services

Strategic Direction 4: Surveillance, Research, and Evaluation

These strategic directions continue to guide suicide prevention efforts in each agency; however, subsequent efforts have sought to bring focus to specific policy and program execution efforts,

particularly as Congress has mandated new efforts and directed resources. Below, we briefly describe the framework applied within the Departments of Defense, Veterans Affairs, and Health and Human Services.

Department of Defense

The Department of Defense's (DoD) suicide prevention efforts are guided by the 2015 Defense Strategy for Suicide Prevention (DSSP), and aligned with the 2017 Centers for Disease Control and Prevention's (CDC) seven strategies for suicide prevention outlined in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. The DSSP created the foundation for DoD's suicide prevention activities by using a public health approach, which acknowledges a complex interplay of individual-, relationship-, and community-level risk factors. The Department instituted the first-ever enterprise-wide suicide prevention policy through Department of Defense Instruction (DoDI) 6490.16, "Defense Suicide Prevention Program," originally published on November 6, 2017, and updated on September 11, 2020. The policy provides direction to the Military Services and Office of the Secretary of Defense components on their roles and responsibilities with respect to the Defense Suicide Prevention Program, and also establishes standards for suicide prevention, intervention, and postvention efforts that reflect a holistic, public health approach to suicide prevention.

In 2020, the Department of Defense adopted an integrated violence prevention framework in recognition that risk and protective factors for suicide are similar to those of many violent, abusive, or harmful acts that DoD is also working to address. DoD is, therefore, focusing on a comprehensive approach to violence prevention and reduction of harmful behaviors towards oneself and others. The Department published an integrated violence prevention policy and approach through DoDI 6400.09, "DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm," on September 11, 2020. This policy addresses risk and protective factors shared by multiple readiness-detracting behaviors – including suicide, sexual assault and other behaviors – with young and enlisted service members being a key population of focus, and aligns with the CDC's seven strategies for suicide prevention.

The National Defense Authorization Act for FY 2015 also mandated that the Department of Defense begin reporting on suicide deaths among military family members. The Department's suicide prevention programs include a specific focus on family members in addition to service members. More details about the DoD suicide prevention program, including how the Department is assessing the potential impact of COVID-19 on suicide risk, can be found at www.dspo.mil.

Department of Veterans Affairs

The Department of Veterans Affairs' (VA) 2018-2028 National Strategy for Preventing Veteran Suicide outlines a broad vision for implementation of a public health approach to end suicide**.** In 2020, VA translated the vision offered in the 10-year National Strategy into operational plans via three mechanisms employed by the Veterans Health Administration (VHA): Suicide Prevention

2.0 Initiative (SP 2.0), Suicide Prevention Now initiative (Now), and the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS).

SP 2.0 focuses on implementing and operationalizing community-based and clinically-based services and programs on a national level. The Now initiative focuses on enhancing, expanding, and reinforcing existent suicide prevention clinical and outreach services, including predictive analytics, safety planning in the emergency department, caring contacts, lethal means safety training and resources, and universal suicide screening. PREVENTS, housed within the Office of Mental Health and Suicide Prevention (OMHSP), effective FY 2021, focuses on a holistic public health approach to suicide prevention with particular focus on population-based suicide prevention awareness and messaging. Taken together, OMHSP maintains a crosswalk of SP 2.0, Now, and PREVENTS targets, objectives, and actions to ensure that each are clearly linked to the National Strategy for Preventing Veteran Suicide and are unique yet complementary and contributory to the mission. More information about VA suicide prevention efforts, including recent data assessing the impact of COVID-19 on suicide risk, can be found at www.mentalhealth.va.gov/suicide_prevention

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

Department of Health and Human Services

Several components within the Department of Health and Human Services (HHS) oversee programs related to suicide prevention. Work specifically related to military and veteran suicide are concentrated in three components: the CDC, the National Institutes of Mental Health (NIMH), and the Substance Abuse and Mental Health Administration (SAMHSA).

CDC provides a range of resources for state and local public health leaders to help guide their efforts in implementing comprehensive suicide prevention within an evidence-based public health framework. In 2021, CDC received an appropriation for its Comprehensive Suicide Prevention (CSP) program. This program currently funds 10 states and one university to use data and create partnerships to implement comprehensive strategies and approaches from CDC's suicide prevention technical package, with a focus on disproportionately-affected populations, including Veterans.

In addition, CDC and the CDC Foundation have partnered to provide funding and technical assistance to14 community-based Veteran Serving Organizations who are focused on addressing the holistic needs of Veterans (for example, housing, employment, social connection), building community connectedness, and supporting capacity-building efforts to evaluate the effectiveness of their programs in reducing suicide risk and promoting protective factors within the veteran population.

NIMH has supported several research efforts designed to understand risk for suicide in military and veteran populations, as well as to evaluate prevention and treatment programs for service members and veterans at risk of suicide. One of the most notable research efforts in this area was the NIMH/Army jointly-sponsored Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), which defined major predictors of risk for suicide in the active duty Army. NIMH has also partnered with researchers at VA to develop analytic approaches to help predict suicide risk among veterans receiving VA health care.

Since 2010, the SAMHSA Service Members, Veterans, and their Families Technical Assistance (SMVF TA) Center has provided technical assistance, subject matter expertise, and support to state and territory interagency teams working to strengthen behavioral health and suicide prevention for service members, veterans, and their families. A SAMHSA/VA Interagency Agreement supports this work, as well as the linkages between the National Suicide Prevention Lifeline and the Veterans Crisis Line.

Through the SMVF TA Center, webinars, policy academies, and resources are available to providers and policy makers across the federal government as well as in state and local communities and territories. HHS also supports the National Action Alliance for Suicide Prevention, a public-private partnership dedicated to advancing the National Strategy for Suicide Prevention; other federal agencies are also instrumentally involved in supporting this alliance.

Priority Goals for Reducing Military and Veteran Suicide

Through a series of interagency discussions and based upon the progress made in implementing the 2020 PREVENTS Roadmap, a series of priority goals were identified to help organize a focused set of agency actions that will advance evidence-based approaches to reduce military and veteran suicide. These priorities are briefly described below.

Priority Goal 1: Improve Lethal Means Safety.

Suicide crises are often brief and action to assure immediate safety can be highly effective in preventing suicide. This priority focuses on ensuring time and space between a person and crisis and their access to lethal means, including firearms and medications.

Priority Goal 2: Enhance Crisis Care and Facilitate Care Transitions.

Individuals at imminent or high risk of suicide should be guaranteed equitable access to high quality crisis care and follow-on support. This priority focuses on improving care in emergency settings and implementing efforts to ensure appropriate care and support as individuals transition from crisis care into follow-on settings, including other stabilization services and outpatient care.

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Priority Goal 3: Increase Access to and Delivery of Effective Care.

Ensuring access to evidence-based care for mental health has been shown to greatly reduce suicide risk among those with behavioral health problems, including depression, post-traumatic stress disorder, and addiction. This priority aims to reduce barriers to care, including those that can promote and encourage help-seeking among service members, veterans, and their families.

Priority Goal 4: Address Upstream Risk and Protective Factors.

Reducing the likelihood that an individual will experience a suicidal or mental health crisis requires implementing primary prevention efforts that can minimize risk and enhance factors known to be effective. This priority highlights efforts that span the social determinants of health, build problem solving skills, and support connectedness.

Priority Goal 5: Increase Research Coordination, Data Sharing, and Evaluation Efforts.

The federal government invests significant resources in suicide prevention research, however, continued learning is essential for informing the development and implementation of new interventions and prevention programs. Suicide prevention research is spread across agencies and challenged by the lack of integrated data systems. This priority goal will focus on efforts to advance interagency coordination.

Cross-Cutting Implementation Principles

In advancing these priorities, there are a number of principles that must anchor the work. These include:

- **Focusing on activation, not just awareness.** Within the field of suicide prevention, we know that raising awareness is a vital aspect of prevention programming. Awareness efforts must be founded upon valid data, facts, and principles. Public education and outreach efforts should also include constructive engagement opportunities—suggestions for what people should do with the information or how to help those in crisis. Suicide prevention efforts must create bridges for people to cross from awareness into engagement. Similarly, efforts to change the culture around help-seeking should include specific actions that decrease negative perceptions, minimize bias and eliminate discrimination. **Efforts must extend beyond calls for public education campaigns and include policies and programs designed to change behaviors among leaders and supervisors, peers, family members, as well as health and social service providers.**

- **Engaging and leveraging partnerships within and outside of government.** Ensuring a comprehensive, cross-sector approach requires a broad coalition of stakeholders, particularly because those at risk may not engage directly with government programs. As such, partnerships with community organizations, local health systems, and other stakeholders will be essential in reaching those in need and delivering comprehensive solutions. Our strategy recognizes and **embraces the value of public-private partnerships** for fully addressing the range of socio-ecological variables critical to a comprehensive suicide prevention strategic plan.

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- **Prioritizing evidence-based strategies.** With limited time and resources to address this critical issue, evidence-based strategies must be prioritized.[vi] It is well recognized that the field of suicide prevention will advance through innovation in policy and program development, and through rigorous program and policy evaluation. Evidence-based innovation is key to a public health strategy. As evidence of new or innovative approaches develops, protocols for suicide prevention programs and clinical practice guidelines should be updated in a timelier manner and be coupled with increased efforts to effectively disseminate new material to the field.

Our efforts must extend beyond calls for public education campaigns and include policies and programs designed to change behaviors among leaders and supervisors, peers, family members, as well as health and social service providers.

- **Tailoring solutions to sub-populations where possible.** There are significant differences in risk of death by suicide among women and men, as well as by race/ethnicity within the service member and veteran population in any given year. This evidence suggests that **one-size-fits-all approaches will not be effective**. Data on these differences should be used in the prevention framework and programs should be culturally appropriate to the specific groups at higher risk than their peers. The field of mental health has advanced over the course of the last 70 years from theory-based implementation of therapeutic interventions, to tailored implementation of interventions based upon nuanced research regarding "right time, right treatment, right intensity, right person" approaches. In a similar way, the application of evidence-based suicide prevention strategies must be tailored to the unique needs and contexts represented by important subpopulations, particularly those at higher risk for suicide including: women veterans under 35, American Indian/Alaska Native veterans, LGBTQ+ veterans, survivors of military sexual trauma, white veteran males over the age of 55, geographically remote veterans, and enlisted Service members under 30.

- **Promoting continuous quality improvement.** Our veterans, service members, and their families deserve the best that our nation has to offer. Efforts to ensure systematic implementation of evidence-based suicide prevention programs should be paired with equal attention to rigorous program evaluation and reporting. In addition, applying principles of a High Reliability Organization[vii] paradigm, our systems should be committed to using this process to facilitate continuous quality improvement. This will require increased investment by program leaders and stakeholder organizations in creating and sustaining a culture of program evaluation and continuous improvement within their suicide prevention programs.

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Planned Executive Actions

In the coming weeks, the Administration will be moving forward with a series of executive actions designed to advance our priorities. Recognizing that service members, veterans and their families live within our broader community and access resources beyond those delivered by DoD, VA, and HHS, these actions represent a whole-of-government approach. These actions are outlined below, organized by Priority Goal.

Priority Goal 1: Improve Lethal Means Safety.

Studies have shown that creating environments that reduce risk and enhance protective factors where individuals live, work, and play can help prevent suicide.[viii] This includes efforts to reduce access to lethal means, including firearms and medications, particularly in times of crisis, and to increase safe storage practices for lethal means.[ix] Research also shows that suicide crises are often brief. Specifically, 25 percent of suicide attempts advance from thought to action within 20 minutes or less; 75 percent of suicide attempts advance from thought to action within 60 minutes or less.[x] [xi]

In this context, "**time and space" between a person in crisis and their access to lethal means is lifesaving.** Interventions that aim to address lethal means safety, such as lethal means safety training, safe storage options, or safety planning care, are clinically indicated for populations at risk of suicide. Efforts to promote protective environments and enhance organizational culture with regard to lethal means safety can also lead to changes in safe storage behaviors.

In implementing this strategy, DoD, VA, HHS, the Department of Homeland Security (DHS), the Department of Justice (DOJ), and the Office of Emergency Medical Services within the Department of Transportation (DOT) will jointly create a plan for addressing lethal means safety awareness, education, training, and program evaluation. The agencies will work together to identify, develop, and test tailored messaging for a coordinated lethal means safety public education campaign. Agencies will base their activities on expert guidance (including from suicide prevention experts and law enforcement professionals) and data. This campaign will include plans to:

- Educate the public on lethal means safety, and in turn encourage safer storage practices, safety planning, and time and space behavioral measures for crisis response. The agencies are planning to use:
    - Professionally developed public service announcements;
    - Paid media promoted via social media platforms as well as internet search engines;
    - Toolkits developed with industry partners, as appropriate, designed to amplify campaign calls to action;
    - Multi-state storage maps to help individuals find where they can safely store firearms outside of their homes; and
    - Lethal means safety training opportunities and engagement for non-medical counselors, crisis responders, health care professionals, family members, and

other gate keepers, both within the government and within non-government community service delivery systems.

- Significantly increase Lethal Means Safety training engagement and completion for VA Community Care Network providers and for healthcare providers in the community.
- Expand VA Safety Planning in the Emergency Department (SPED) into community healthcare systems and Emergency Departments in an effort to increase implementation of evidence-based suicide prevention safety planning processes and to increase care management and coordination for high-risk individuals. The expansion effort will include also training family members and supporters on how to use safety plans.

Priority Goal 2: Enhance Crisis Care and Facilitate Care Transitions.

Ensuring access to critical, emergent services for individuals in crisis is an important variable for addressing a given community's suicide rate. Unfortunately, less access to emergency suicide prevention, mental health, and medical care is associated with higher population suicide rates as well as mortality rates.[xii] Transitions between acute and emergent care for mental health crises and follow-up mental health care is commonly identified as a period of elevated risk for individuals. For these reasons, increasing population access to emergent suicide crisis services that are effective paired with improved facilitation of follow-up care beyond the crisis is critical to lowering suicide rates at the population level. **It is expected that the onset of 988 services, a nationwide three-digit mental health crisis hotline, will offer a pivotal access point for the nation to deliver effective and efficient suicide prevention crisis services.** When launched fully, all calls will run through a national network of distributed crisis call centers with increased capacity and quality. It will also help create a system of care that facilitates recovery and wellness beyond the crisis point instead of reinforcing an "emergency cycle" of care engagement.

In implementing this strategy, HHS, VA, DoD, and DOT's Office of Emergency Medical Services Program and National 911 program will collaborate to create a Feasibility Analysis and Implementation Plan for broad implementation of evidence-based suicide risk assessment and safety planning within emergency care settings (emergency transport, urgent care, and emergency departments) throughout the United States. The analysis will include evaluation of ways in which federal policy and funding may be implemented to reinforce wide-scale implementation of evidence-based suicide risk assessment, safety planning, and post discharge follow-up care coordination across healthcare systems. The agencies plan to address the following domains:

- Implementation of 988, the new mental health crisis line, the ability of HHS, Indian Health Service (IHS), and VA capacity to create American Indian/Alaska Native (AI/AN)-specific crisis call centers to meet the mental health needs of Tribes and AI/AN populations; as well as coordination with 911.
- Expansion of interventions compatible with VA Safety Planning in the Emergency Department (SPED) for suicide assessment, safety planning, and follow-up care coordination procedures to all healthcare systems including within all DoD Military Treatment Facilities and IHS points of emergency care.

- Expansion of CDC capacity to monitor and to report suicide surveillance data through Emergency Department encounters coded for suicidal crisis or behaviors.
- Expansion of SAMHSA's crisis mapping initiative to assist cities and counties in identifying gaps and incorporating best practices in suicide prevention for veterans interacting with community crisis systems.
- Expansion of machine learning models within the Military and Veterans Crisis Lines operations to improve and augment risk prediction and safety planning.

Priority Goal 3: Increase Access to and Delivery of Effective Care.

While not all those at risk for suicide have a mental health diagnosis or are in treatment, we know delivery of evidence-based, high quality mental health care has been demonstrated to reduce suicide among those in treatment.[xiii] Thus, **increasing access to and delivery of mental health care can help to prevent suicide, especially among those with mental health treatment needs.**

Prior research and program evaluation indicate that access to mental health care should be considered across three dimensions: emergency/same day care, non-emergent engagement in care, and follow-up care. Within each of these dimensions, the delivery of evidence-based, high quality care has been shown to maximize recovery and promote wellness. Thus, efforts designed to increase capacity, ease access to, and improve the delivery of evidence-based care are an essential component of suicide prevention efforts.

HHS, DoD, VA, DHS, DOJ, and the Department of Labor (DOL) will collaborate to evaluate access and engagement barriers to evidence-based mental health care for service members, veterans, and their family members at elevated risk for suicide. Together, these agencies plan to produce a report within one year on actions taken to improve access to mental health care along with additional recommendations for future action. The report will include the following domains:

- Data and recommendations secondary to VA implementation of Public Law 116-214 (Veterans COMPACT Act of 2020) and Public Law 116-171 (Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019), both of which included several provisions related to suicide prevention activities.
- Summary of efforts and progress within VA and DoD to significantly reduce or eliminate co-payments for individuals seeking mental health and substance use care, including for those at elevated risk for suicide.
- Implementation of requirements for mental health and substance use treatment parity and expanded access to telehealth services across federal health programs.
- Efforts and initiatives within VA to modify or eliminate government debt and overpayment linked to engagement in VA care for individuals at elevated risk for suicide; and efforts and recommendations to identify veterans at elevated risk for suicide with agency debt to ensure engagement in health care services.
- Recommendations from IHS regarding the creation of region-specific mental health services to address and meet tribal needs in manners and modalities consistent with tribal concepts and paradigms pertaining to tribal wellness and holistic systems of healing.

- Policy efforts and recommendations within DoD to incentivize and reinforce service member access to and engagement in mental health care and to minimize or eliminate barriers to care due to concerns regarding confidentiality, fitness for duty, and medical profile issues.
- Policy efforts and recommendations within DHS for members of the Coast Guard, as well as employees across DHS operational components, to reinforce access to and engagement in mental health care and to minimize or eliminate barriers to care engagement linked to confidentiality concerns, fitness for duty issues, and medical profile or weapons bearing status issues.
- Policy efforts and recommendations within DOJ to reinforce access to and understanding of the benefits of engagement in mental health care among personnel with elevated risk factors (to include law enforcement, veterans, and other personnel); and to minimize or eliminate barriers to care engagement because of concerns related to confidentiality and fitness for duty.
- Policy efforts and recommendations within DOL to reinforce access to and engagement in mental health care for occupational categories at elevated risk for suicide, including efforts to ensure compliance with mental health parity requirement.

Priority Goal 4: Address Upstream Risk and Protective Factors.

The foundation of a public health approach to suicide prevention is understanding and addressing both risk and protective factors in community and clinical settings. Thus, comprehensive suicide prevention efforts must pair attention to and improvements in crisis care and clinical care with policies, programs, and practices that reduce risk factors and strengthen protective factors at the individual, relationship, and community level.

Multiple studies have demonstrated that factors related to economic well-being, such as financial literacy and security, educational, vocational development opportunities, and vocational stability can reduce the risk of suicide.[xiv] Similarly, coping and problem-solving skills, relational stability and connection, and access to community resources are also critical protective factors. Given the evidence, efforts to address these domains are essential to a public health approach to suicide prevention. Thus, **policies and programs designed to address economic opportunity, mobility, and stability represent important means to reduce risk factors**. These approaches are important for reducing risk of suicide, independent of addressing behavioral health needs, as studies have shown that risk factors for suicide extend well beyond individual mental health.[xv]

Following publication of this strategy, HHS, DOD, VA, DHS, DOL, and the Department of Education (ED) will continue to implement federal, state, territorial, Tribal, and local public and private partnerships with a specific focus on addressing risk and protective factors for suicide. This will include increased emphasis on promoting economic well-being and addressing the full spectrum of the social determinants of health for service members, veterans, and their families. It will also entail efforts to implement safe messaging and adopt appropriate strategies in the aftermath of suicide (known as postvention). The agencies plan to address these factors in the following ways:

- Review and create recommendations for increased and wide-spread inclusion of adverse childhood experiences (ACEs) and social determinants of health (SDOH) in routine clinical screenings and population-based epidemiological surveys, including through provider trainings on assessing for suicide risk.
- Recommend and implement policies supportive of safe prescribing and holistic, evidence-based pain management strategies.
- Review and recommend approaches related to ensuring best practices for media coverage and suicide reporting practices.
- Report out on results from VA and CDC community-based grant programs for suicide prevention.
- Expand the existing HHS and VA Governor's Challenge to complete training and technical assistance with all 50 states and US Territories by the conclusion of FY 2023, and explore additional opportunities to support and reinforce participating states' action plans.
- VA will review and report recommendations and progress on the establishment of a national veteran resource center to address education, prevention, and intervention services regarding financial literacy, financial stability, and debt management for Veterans. VA plans to collaborate with ED, DOL, and other federal agencies as appropriate.
- DOL-Veterans Employment and Training Service (VETS) will consult and coordinate with the VA and DoD to create a report regarding veteran employment trends, issues, barriers, and recommendations with a specific focus on understanding opportunities for addressing economic risk factors for suicide prevention.
- HHS will prepare a report and recommendations pertaining to creating an evidence-based and systematic method for communities to measure and report on risk and protective factors at the community-level and to use this information for action planning.

Priority Goal 5: Increase Research Coordination, Data Sharing, and Evaluation Efforts.

Unfortunately, research and evaluation within the field of suicide prevention is relatively nascent. Yet, escalating suicide rates demand that systems and processes be put into place that maximize and multiply actionable returns on suicide prevention research, program implementation, and program and policy evaluation.

To facilitate interagency research coordination and management, an updated analysis to identify gaps in suicide prevention and treatment intervention research across the federal and non-federal sector is needed. Once completed, it should inform the design of an intentional federal research agenda that includes specific studies or combinations of studies that could serve to create new and more effective interventions. Given the multiple agencies that fund research related to suicide and suicide prevention, the challenge will be to balance the research portfolio within individual agencies, and in combination across the interagency collaboration.

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Current barriers to data sharing must also be critically evaluated starting within and across federal agencies with equity in suicide prevention. Increased data sharing within the federal government and with external partners, with defined contexts and appropriate processes for ensuring integrity, confidentiality, and data security, will be needed. Furthermore, suicide surveillance capabilities must be improved in an effort to identify, if not potentially predict, suicide "hot spots" for the purpose of understanding and mitigating risk at the soonest possible point in time. Appropriate resource investment will be critical to advance suicide surveillance efforts. At the same time, there must be a commitment to develop and test new suicide prevention research or program efforts based upon emerging data on risk and protective factors, and to ensure that all programs have robust program evaluation components to measure the effectiveness right from their outset.

Following publication of this strategy, VA, HHS, DoD, and the Department of Energy (DOE) will work collaboratively toward improved suicide surveillance, research, and program evaluation. They plan, at minimum, the following:

- Continued implementation of the National Research Strategy.
- Completing an updated review of the science on suicide prevention, with a focus on identifying interventions that are ready for further scaling as well as scientific gaps that are not currently targeted by research investments.
- Providing structure and guidance toward improved and recommended program evaluation logic models applicable to suicide prevention, intervention, and postvention programs and services.
- Coordinating on the potential applications of and recommendations pertaining to the development of a machine-based learning model to estimate weekly U.S. suicide fatalities and advancing efforts to create a population-level system for enabling real-time epidemiological monitoring of suicide fatalities.[xvi]
- Supporting States' efforts (inclusive of work with medical examiners and coroners) to improve rapid suicide surveillance reporting including military and veteran status.

Implementation and Reporting

The *Interagency Task Force (ITF) on Military and Veterans Mental Health* was created in 2012 and is co-chaired by the designated representatives of the Secretaries of Defense, Veterans Affairs, and Health and Human Services. In addition to the Co-Chairs, the ITF includes representatives from the Department of Education, the Office of Management and Budget, the Domestic Policy Council, the National Security Council, the Office of Science and Technology Policy, and the Office of the National Drug Control Policy. The Co-Chairs have agreed to expand membership on the ITF to include representatives from the Departments of Justice, Labor, and Homeland Security. Members will work collaboratively on the strategies outlined in this document, meeting regularly to review progress on the priority goals outlined above. In performing its work, the ITF will consult with relevant non-governmental experts and organizations as necessary.

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