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Health Care for Veterans: Suicide Prevention

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Summary

This report focuses on suicide prevention activities of the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA). The VHA's approach to suicide prevention is based on a public health framework, which has three major components: (1) surveillance, (2) risk and protective factors, and (3) interventions.

Surveillance, or systematic collection of data on completed (i.e., fatal) suicides, is essential to define the scope of the problem (i.e., the suicide rate among veterans), identify characteristics associated with higher or lower risk of suicide, and track changes in the suicide rate. No nationwide surveillance system exists for suicide among all veterans. Information about deaths (including suicides) is collected in death certificates by state, territorial, and local governments. Death certificate data are aggregated into the National Death Index, which can be combined with data about who is a veteran to identify veteran suicides. The VHA collects detailed information about suicides among veterans that are known to VHA facilities; however, the majority of veterans are not enrolled in VHA health care, so other sources of information (e.g., Department of Defense data) are necessary to identify veterans.

Information collected in surveillance is used to identify suicide *risk factors* (i.e., characteristics associated with higher rates of suicide) and *protective factors* (i.e., characteristics associated with lower rates of suicide). This is essential in order to design interventions that reduce risk factors and/or increase protective factors, thus lowering overall risk of suicide. Risk factors are also helpful in identifying at-risk groups or individuals so that interventions can be delivered to the people who need them most. Within the VHA, this research is supported by the Office of Research and Development; a Center of Excellence in suicide prevention; and a Mental Illness Research, Education, and Clinical Center on suicide prevention.

The *intervention* cycle includes three stages: (1) design and test interventions, (2) implement interventions, and (3) evaluate interventions. The research components mentioned above have roles in small-scale pilot testing and large-scale evaluations of interventions. VHA suicide prevention interventions include easy access to care, screening and treatment, suicide prevention coordinators, suicide hotline, education and outreach, and limited access to lethal means.

The VHA has received both praise and criticism for its suicide prevention efforts and mental health services more generally. A 2010 progress report on the National Strategy for Suicide Prevention describes the VHA as “one of the most vibrant forces in the U.S. suicide prevention movement, implementing multiple levels of innovation and state of the art interventions, backed up by a robust evaluation and research capacity.” In contrast, some have testified before Congress that VHA's suicide prevention efforts have inadequacies, such as barriers to accessing care and lack of evidence-based treatments for those who do access care. A 2011 evaluation of VHA mental health services captures both sides of the argument, finding that VHA mental health care is generally at least as good as that of other health care systems, but that it “often does not meet implicit VA expectations.”

Potential issues for Congress and related recommendations by outside organizations fall into three categories: improving the timeliness and accuracy of surveillance data, building the evidence base, and increasing access to evidence-based mental health care. Public laws addressing suicide prevention among veterans are described in the **Appendix**.

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Congress has attempted to address the problem of suicide among veterans through legislation¹ and oversight hearings,² both on prevention of veteran suicide specifically and on veteran mental health more broadly. A task as challenging as preventing suicide requires collaboration among federal agencies, state and local governments, other organizations, communities, and individuals. This report, however, focuses on activities of the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA). The VHA's approach to suicide prevention is based in part on the National Strategy for Suicide Prevention,³ which involves multiple federal departments, including the VA, Defense (DOD), and Education (ED), as well as several agencies within Health and Human Services (HHS).⁴ While this CRS report focuses on suicide prevention efforts of the VHA, activities of other entities are discussed as they relate to VHA activities.

This CRS report begins with a brief overview of the public health framework for suicide prevention, which forms the basis for both the National Strategy for Suicide Prevention and the VHA's approach to suicide prevention. The three subsequent parts of the report correspond to the three major components of the public health framework: (1) suicide surveillance, (2) suicide risk factors and protective factors, and (3) suicide prevention interventions. The final section addresses potential issues for Congress, and the **Appendix** summarizes provisions of public laws addressing suicide prevention among veterans.

A Public Health Framework for Suicide Prevention

Prevention of suicide can be approached in two ways, which are not mutually exclusive. The public health approach intervenes with populations (e.g., distributing educational materials about mental illness and mental health services), whereas the clinical approach intervenes with individuals (e.g., prescribing antidepressant medication to a person diagnosed with depression). The individual focus of the clinical approach limits its reach to those who access the health care system;⁵ clinical interventions are necessary but not sufficient. The population-based public health approach is considered essential to address the broader problem of suicide among all veterans, including those who may not currently be in contact with the health care system.

¹ See the **Appendix** for public laws addressing suicide among veterans.

² See, for example, U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Ensuring Timely Access to High-Quality Care*, 113th Cong., 1st sess., March 20, 2013; U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Service Should Not Lead to Suicide: Access to VA's Mental Health Care*, 113th Cong., 2nd sess., July 10, 2014; and U.S. Congress, Senate Committee on Veterans' Affairs, *Mental Health and Suicide Among Veterans*, 113th Cong., 2nd sess., November 19, 2014.

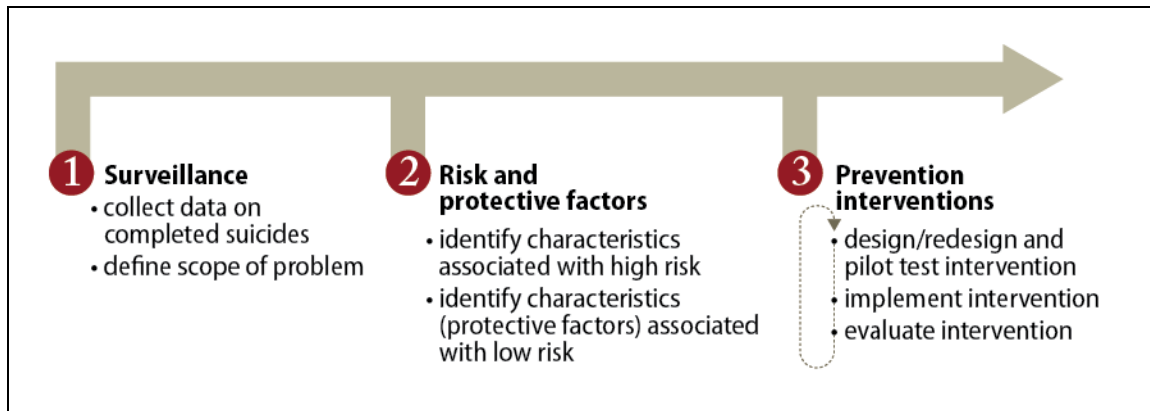
³ U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, Washington DC: HHS, September 2012, <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention>; hereinafter referred to as *National Strategy for Suicide Prevention*.

⁴ Federal Working Group on Suicide Prevention, *National Strategy for Suicide Prevention: Compendium of Federal Activities*, 2009. HHS agencies involved in suicide prevention include the Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), and Administration on Aging (AoA).

⁵ This report focuses on the public health approach. A full discussion of the clinical approach to suicide prevention is beyond the scope of this report. The pharmacotherapy and psychotherapy mentioned in the "Screening and Treatment" section are examples of the clinical approach.

Both the National Strategy for Suicide Prevention and the VHA’s approach to suicide prevention are based on a public health framework. As illustrated in **Figure 1**, the framework has three major components: (1) surveillance, (2) risk and protective factors, and (3) prevention interventions. Suicide surveillance involves collecting data on completed (i.e., fatal) suicides in order to define the scope of the problem. Data collected in surveillance can be used to identify risk factors (i.e., characteristics associated with higher suicide risk) and protective factors (i.e., characteristics associated with lower suicide risk). Suicide prevention interventions aim to reduce risk factors and/or enhance protective factors that have been identified; interventions may target high-risk groups or individuals, identified based on known risk factors.

Figure 1.A Public Health Framework for Suicide Prevention



Source: CRS analysis of major components of U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, Washington DC: HHS, September 2012.

VHA Suicide Surveillance

No nationwide surveillance system exists for suicide among all veterans. Surveillance, or systematic collection of data on completed (i.e., fatal) suicides, is essential for three purposes. First, surveillance defines the scope of the problem, that is, the suicide rate among veterans. Second, information from surveillance is used to identify characteristics associated with higher or lower risk of suicide. Third, information from surveillance is used to track changes in the suicide rate and evaluate suicide prevention interventions. In order to evaluate interventions, suicide surveillance must measure the same thing, in the same way, repeatedly over time. In the case of veteran suicide, surveillance requires identifying both who is a veteran and who has died by suicide.

The VHA collects detailed information about suicides (and suicide attempts) among veterans *that are known to VHA facilities*. The VHA’s Behavioral Health Autopsy Program (BHAP)—which began in December 2012 and has not yet been fully implemented—will eventually collect information on suicides that are known to the VHA in four phases. The VHA has already implemented the first two phases: standardized chart reviews and interviews with family members. The third and fourth phases include interviewing the last clinician to see the veteran and locating public records that might indicate stressors (e.g., bankruptcy or divorce). A Government Accountability Office (GAO) evaluation found that some BHAP reports were not submitted, that some included inaccurate information, and that more than half of those reviewed

were incomplete. The GAO also found that VHA facilities had interpreted BHAP instructions differently and that no VHA or VA officials were reviewing BHAP reports for accuracy or completeness.⁶

Resolving the problems the GAO identified with BHAP would result in better information about suicides among veterans that are known to VHA facilities; however, information collected solely by the VHA would still exclude suicides among other veterans (i.e., those who are not known to the VHA). Of more than 21 million veterans estimated to live in the United States, fewer than 10 million are enrolled to receive health care from the VHA.⁷ The VA also has records of veterans who receive other benefits (e.g., home loans), regardless of whether they are enrolled in VHA health care, but does not have records of all veterans. The VA is working with the DOD to identify suicides among all veterans, including those who do not interact with the VA.

Information about deaths—including whether a death resulted from intentional self-harm (i.e., suicide)—is collected in death certificates by state, territorial, and local governments.⁸ The resulting data may not be comparable across jurisdictions.⁹ The Centers for Disease Control and Prevention (CDC) aggregates death certificate data into the National Death Index (NDI), which can then be combined with data about who is a veteran.¹⁰ The lag between a suicide event and identification of the decedent as a veteran may be years; this delays the availability of crucial information. Timely reporting of death certificates was identified as a core issue in a 2010 progress report on an earlier version (2001) of the National Strategy for Suicide Prevention.¹¹

VHA Research into Risk and Protective Factors

Identifying characteristics associated with higher rates of suicide (i.e., risk factors) and lower rates of suicide (i.e., protective factors) is essential in order to design effective interventions.

⁶ In addition to the BHAP, VA Medical Centers report data on *known* attempted and completed suicides (among other things) to the VA Central Office through the Suicide Prevention Application Network (SPAN). U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data*, GAO-15-55, December 12, 2014, <http://www.gao.gov/products/GAO-15-55>.

⁷ The estimated number of veterans living in the United States is from VetPop2011, at http://www.va.gov/vetdata/Veteran_Population.asp. The estimated number of veterans enrolled in VHA health care is from the VA budget submission for FY2015, available at <http://www.va.gov/budget/products.asp>.

⁸ Both the legal authority for maintaining registries of deaths and the responsibility for issuing death certificates reside with individual states, territories, and two cities (Washington, DC, and New York, NY).

⁹ Researchers at the RAND Corporation summarized variation in suicide statistics across jurisdictions in four domains: (1) how suicides are defined or how ambiguous deaths are classified, (2) qualifications of professionals certifying a death as a suicide, (3) the extent to which possible suicide deaths are investigated, and (4) the quality of data management. Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military*, The RAND Corporation, 2011, p. 13, <http://www.rand.org>; hereinafter referred to as *The War Within*.

¹⁰ CDC's National Center for Health Statistics (NCHS) works cooperatively with state, territorial, and local jurisdictions to collect information from death certificates in the National Vital Statistics System (NVSS). NCHS extracts information from NVSS to create the National Death Index (NDI), a data set that can be combined with other data sets for research purposes. For more information, see CDC, National Center for Health Statistics, *National Death Index*, <http://www.cdc.gov/nchs/ndi.htm>.

¹¹ Suicide Prevention Resource Center and Suicide Prevention Action Network (SPAN), *Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead*, 2010, p. 30; hereinafter referred to as *Charting the Future*.

Suicide prevention interventions aim to reduce risk factors and/or increase protective factors, thus lowering overall risk of suicide. Knowing what the risk factors are also helps in identifying at-risk groups or individuals so that interventions can be delivered to the people who need them most. Thus the second step in the public health framework for suicide prevention is identification of suicide risk and protective factors. **Table 1** provides examples of risk and protective factors among the general population.

Table 1. Selected Risk and Protective Factors in the General Population

Risk Factors	Protective Factors
Some major physical illnesses, mental disorders, and substance use disorders	Effective clinical care for physical illnesses, mental disorders, and substance use disorders
Barriers to accessing health care	Easy access to a variety of clinical interventions
Stigma associated with help-seeking behavior	Support for help-seeking behavior
Easy access to lethal means (e.g., firearms or poison)	Restricted access to lethal means (e.g., firearms or poison)
Lack of social support and sense of isolation	Strong connections to family and community support
Cultural/religious beliefs that accept suicide	Cultural/religious beliefs that discourage suicide

Source: Examples of risk and protective factors selected from U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Injury Center: Violence Prevention, Suicide: Risk and Protective Factors, <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>.

Veteran-specific research on suicide risk and protective factors is necessary because the veteran population differs from the non-veteran population on a variety of characteristics (e.g., gender distribution), some of which may also be associated with suicide risk. For example, research has explored whether combat exposure is associated with risk of suicide (with mixed results).¹² The subpopulation of veterans who are enrolled with the VHA may differ from non-enrolled veterans, as well.

The VHA conducts veteran-specific research that builds on research among the general population. Within HHS, both the CDC¹³ and the National Institute of Mental Health (NIMH)¹⁴ disseminate research on suicide risk and protective factors within the general population. Also, the Substance Abuse and Mental Health Services Administration (SAMHSA) collects data on suicide attempts and related behavior.¹⁵ It should be noted that risk factors for attempted suicide may differ from risk factors for completed suicide; for example, women have a higher rate of attempted suicide, but men have a higher rate of completed suicide.¹⁶ Despite a large number of

¹² VA, VHA, National Center for PTSD, *The Relationship Between PTSD and Suicide*, last updated January 3, 2014, <http://www.ptsd.va.gov/professional/co-occurring/ptsd-suicide.asp>.

¹³ Centers for Disease Control and Prevention, *Suicide: Risk and Protective Factors*, Atlanta, GA, <http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html>.

¹⁴ HHS, National Institutes of Health (NIH), National Institute of Mental Health, *Publications about Suicide Prevention*, <http://www.nimh.nih.gov/health/publications/suicide-prevention-listing.shtml>; and National Institute of Mental Health, *Science News about Suicide Prevention*, <http://www.nimh.nih.gov/science-news/science-news-about-suicide-prevention.shtml>.

¹⁵ SAMHSA asks about these topics in the National Survey on Drug Use and Health (NSDUH). See HHS, CDC, *Morbidity and Mortality Weekly Report: Suicidal Thoughts and Behaviors Among Adults ≥ 18 Years—United States, 2008 – 2009*, October 21, 2011, <http://www.cdc.gov/mmwr/pdf/ss/ss6013.pdf>.

¹⁶ *National Strategy for Suicide Prevention*, p. 18.

risk and protective factors identified by researchers, it is not yet possible to predict who will attempt or complete suicide.¹⁷ The inability to identify individuals most in need of interventions is one of the reasons a public health approach—with a focus on population-level interventions—is necessary for effective suicide prevention.

Within the VHA, mental health research—including research on suicide risk and protective factors—is supported by three research components: the Office of Research and Development (ORD), a Center of Excellence (COE) in suicide prevention, and a Mental Illness Research, Education, and Clinical Center (MIRECC) on suicide prevention. Administratively, both the COE and the MIRECC (as well as other centers) fall under the Mental Health Strategic Healthcare Group, which is a separate organizational unit from ORD. Examples of research conducted on risk and protective factors by each of these three components—ORD, COE, and MIRECC—are provided below.

VHA Office of Research and Development (ORD)

In general, the ORD funds intramural research by individual VHA investigators or researchers (including mental health care research).¹⁸ The ORD's Health Services Research and Development Service supports research into suicide risk factors and protective factors.¹⁹ For example, the VHA conducted a study of suicide risk among veterans with depression (a known risk factor in the general population, as well as among veterans).²⁰ Another study examined characteristics associated with suicide risk among patients seen in VHA primary care, to help identify factors that primary care providers may be able to use to detect suicide risk.²¹ These studies, and others like them, can help the VHA identify veterans at high risk of suicide, so that interventions can be targeted to them.

Center of Excellence (COE)

The COE at Canandaigua, NY, conducts research on suicide risk factors and protective factors, in addition to other suicide prevention activities. Established in August 2007 at the direction of Congress,²² the COE has the mission of developing and studying evidence-based public health

¹⁷ For example, although the single strongest predictor of a completed suicide is a prior suicide attempt, most people who attempt suicide do not subsequently complete suicide, and most people who complete suicides have no history of prior attempts. See *The War Within*, p. 29; and Joel Paris, "Predicting and Preventing Suicide: Do We Know Enough to Do Either?" *Harvard Review of Psychiatry*, vol. 14, no. 5 (2006), pp. 233-240.

¹⁸ The ORD supports research through four research divisions: Biomedical Laboratory Research and Development (BLR&D), Clinical Science Research and Development (CSR&D), Rehabilitation Research and Development (RR&D), and Health Services Research and Development (HSR&D).

¹⁹ A search for "suicide" at <http://www.hsr.d.research.va.gov/research/> yields dozens of suicide-related studies conducted within ORD's Health Services Research and Development (HSR&D) Service; some of the resulting studies investigate risk factors and/or protective factors.

²⁰ VA, VHA, Health Services Research and Development, *Risk of Death Among Veterans with Depression*, Study IIR 10-176, http://www.hsr.d.research.va.gov/research/abstracts.cfm?Project_ID=2141701218.

²¹ VA, VHA, Health Services Research and Development, *Veteran Interactions with VA Primary Care Prior to Suicide*, Study IIR 10-331, http://www.hsr.d.research.va.gov/research/abstracts.cfm?Project_ID=2141701170.

²² U.S. Congress, Committee of Conference, *Making Appropriations for Military Quality of Life Functions of the Department of Defense, Military Construction, the Department of Veterans Affairs, and Related Agencies for the Fiscal Year Ending September 30, 2006, and for Other Purposes*, report to accompany H.R. 2528, 109th Cong., 1st sess., November 18, 2005, H.Rept. 109-305 (Washington: GPO, 2006), p. 39. The committee report directed the VHA "to (continued...)"

approaches to prevention of veteran suicide, with the goal of reducing morbidity and mortality associated with suicide in the veteran population. In pursuit of its mission, the Epidemiology and Interventions Research Core within the COE collects and analyzes data on suicide risk factors and protective factors (as well as other topics) among both veterans who use VHA services and those who do not.²³

Mental Illness Research, Education, and Clinical Center (MIRECC)

The MIRECCs, also established at the direction of Congress,²⁴ conduct research on a range of mental health-related topics, including suicide risk factors and protective factors. Specifically, the MIRECC of the VA Rocky Mountain Network pursues the goal of reducing suicidality in the veteran population, by conducting research on potential contributions of cognitive and neurobiological factors, among other activities.²⁵ For example, one study assesses the relationship (if any) between suicidal ideation and thinking under stress.²⁶ Another study investigates cognitive functioning, distress, and suicide risk in Veterans with HIV/AIDS.²⁷ Other MIRECCs may also conduct research related to suicide, in the course of pursuing their other goals.

Selected VHA Suicide Prevention Interventions

Suicide prevention interventions aim to reduce risk factors and/or enhance protective factors, thereby lowering the risk of suicide. They may address entire populations (e.g., all veterans), at-risk subgroups (e.g., veterans diagnosed with a mental disorder), or high-risk individuals (e.g., veterans with recent suicide attempts).

Interventions are refined in a three-stage cycle. The first stage is to develop and pilot test interventions on a small scale to ensure that they are safe, ethical, feasible, efficacious (i.e., they work under ideal conditions), and effective (i.e., they work under real-world conditions). If interventions are successful in the first stage, the second stage is to implement them on a larger scale. The third stage is to evaluate interventions that have been implemented on a larger scale, to verify their effectiveness and determine for whom they are most effective. The three stages can then be repeated to refine interventions, either to improve their effectiveness or to adjust them for use with a different population (e.g., applying an intervention developed for male veterans to a population of female veterans).

(...continued)

place more emphasis on psychiatric care of our veterans by designating three centers of excellence to focus on mental health/PTSD needs. These three centers will be established at Waco Medical Center, Texas; San Diego Medical Center, California; and the Canandaigua Medical Center, New York.”

²³ VA, VHA, *VISN 2 Center of Excellence at Canandaigua*, http://www.mirecc.va.gov/docs/2010InfoSheets/VISN_2_CoE_Canandaigua_Info_Sheet_2010.pdf.

²⁴ P.L. 104-262, Veterans’ Health Care Eligibility Reform Act of 1996, enacted 10/09/1996 (38 U.S.C. §7320).

²⁵ VA, VHA, *MIRECC of the VA Rocky Mountain Network (VISN 19 MIRECC)*, [http://www.mirecc.va.gov/visn19/index.asp](http://www.mirecc.va.gov/visn19http://www.mirecc.va.gov/visn19/index.asp).

²⁶ VA, VHA, VISN 19 MIRECC, *The Relationship Between Suicidal Ideation and Thinking Under Stress*, <http://www.mirecc.va.gov/visn19/research/projects.asp>.

²⁷ VA, VHA, VISN 19 MIRECC, *Assessment of Cognitive Functioning as it Relates to Suicide Risk in Veterans with HIV/AIDS*, <http://www.mirecc.va.gov/visn19/research/projects.asp>.

Within the VHA, the same three research components involved in risk and protective factors research are involved in the intervention cycle: ORD,²⁸ COE,²⁹ and MIRECC.³⁰ Because small-scale testing and large-scale evaluation are both integral to suicide prevention interventions, it is worth noting that rigorous research on effectiveness is difficult and lacking for most interventions, both within and outside the VHA.³¹

Easy Access to Care

Easy access to care is a protective factor against suicide, and the VHA is making efforts to increase access to care by addressing known barriers to care, including lack of understanding or awareness of mental health care, stigma associated with mental illness, and concerns about VHA care, and challenges in scheduling appointments.³² The VHA provides information to help increase awareness of mental health care services, reduce the stigma associated with seeking care, and correct misconceptions about VHA care.³³ Some mental health and substance use evaluation and treatment services have been integrated into other treatment settings, which both increases the convenience and reduces the stigma associated with seeking care.³⁴

VHA policy requires that emergency mental health care be available 24 hours per day through emergency rooms at VA facilities or local, non-VA hospitals,³⁵ that new patients referred for mental health services receive an initial assessment within 24 hours and a full evaluation appointment within 14 days; and that follow-up appointments for established patients be scheduled within 30 days.³⁶ The extent to which these policies are implemented in practice has

²⁸ Suicide prevention is a goal of the Mental Health Quality Enhancement Research Initiative (QUERI) within ORD. See VA Mental Health QUERI Center, *Strategic Plan*, December 2011, http://www.queri.research.va.gov/about/strategic_plans/mh.pdf; and VA Mental Health QUERI Center, *Fact Sheet: Mental Health*, July 2014, http://www.queri.research.va.gov/about/factsheets/mh_factsheet.pdf.

²⁹ The COE at Canandaigua evaluates implementation of suicide prevention initiatives.

³⁰ For example, the MIRECC of the VA Rocky Mountain Network is conducting a study to determine whether providing prescription medication in blister packages (rather than bottles) is associated with greater treatment adherence and fewer suicide-related overdoses among those at high risk of suicide. VA, VHA, *Blister Packaging Medications*, <http://www.mirecc.va.gov/visn19/research/projects.asp>.

³¹ *The War Within*, p. 13.

³² U.S. Government Accountability Office, *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, GAO-12-12, October 14, 2011, pp. 15-17, <http://www.gao.gov/products/GAO-12-12>.

³³ See for example VA, VHA, *Guide to VA Mental Health Services for Veterans & Families*, July 2012, http://www.mentalhealth.va.gov/docs/MHG_English.pdf; and VA, VHA, Office of Rural Health, *Mental Health Stigma: 10 Things You Should Know About*, <http://www.ruralhealth.va.gov/ruralclergytraining/10things/stigma.asp>.

³⁴ Evelyn Chang and Alissa Simon, *Report on Integrating Mental Health Into PACT (IMHIP) in the VA*, VA Office of Patient Care Services, September 2013, <http://www.hsrp.research.va.gov/publications/internal/IMHIP-Report.pdf>.

³⁵ VA, VHA, *Uniform Mental Health Services in VA Medical Centers and Clinics*, VHA Handbook 1160.01, September 11, 2008; and VA, VHA, *About VA Mental Health*, <http://www.mentalhealth.va.gov/vamentalhealthgroup.asp>.

³⁶ VA, VHA, *Uniform Mental Health Services in VA Medical Centers and Clinics*, VHA Handbook 1160.01, September 11, 2008. In accordance with the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146), the VHA has established a wait-time goal (not specific to mental health) “to furnish care within 30 days of either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a veteran prefers to be seen.” Department of Veterans Affairs, “Expanded Access to Non-VA Care Through the Veterans Choice Program,” *79 Federal Register* 65571, November 5, 2014.

been questioned in congressional testimony,³⁷ news media,³⁸ and survey responses from both providers and patients.³⁹

Screening and Treatment

Some types of screening, pharmacotherapy, and psychotherapy are supported by evidence that they reduce the likelihood of suicide.⁴⁰ VHA policy requires screening for a variety of risk factors, including but not limited to posttraumatic stress disorder (PTSD), depression, and alcohol abuse. Those who screen positive are evaluated further and offered treatment if found to have a mental health problem. Positive screens for PTSD or depression, in particular, are followed by a suicide risk assessment.⁴¹

An evaluation of VHA mental health care by the Altarum Institute and RAND Health finds that treatment in the VHA is generally better than in other systems on a variety of measures, but still has room for improvement.⁴² In particular, the evaluation finds that evidence-based treatments (both pharmacotherapy and psychotherapy), while widely available, are not usually provided.⁴³ Researchers based this finding on a review of medical records, which showed that prescriptions for medication were often not filled for as long as recommended and that psychotherapy, as documented, was often not delivered according to evidence-based guidelines. Additionally, the evaluation found that assessment is lacking, both at the beginning of treatment and during treatment (to track progress).⁴⁴ Even if a particular treatment is supported by evidence, it will not necessarily be effective for every patient. The only way to know whether a patient is improving, holding steady, or growing worse is to assess his or her symptoms at intervals.

Suicide Prevention Coordinators

Per department policy, every VA Medical Center has at least one suicide prevention coordinator, whose responsibilities include (among other things) tracking patients who have been identified as

³⁷ See, for example, U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Ensuring Timely Access to High-Quality Care*, 113th Cong., 1st sess., March 20, 2013; U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Service Should Not Lead to Suicide: Access to VA's Mental Health Care*, 113th Cong., 2nd sess., July 10, 2014; and U.S. Congress, Senate Committee on Veterans' Affairs, *Mental Health and Suicide Among Veterans*, 113th Cong., 2nd sess., November 19, 2014.

³⁸ Meghan Hoyer and Tom Vanden Brook, "New data show long wait times remain at many VA hospitals," *USA Today*, November 16, 2014.

³⁹ *VHA Mental Health Program Evaluation*; and VHA, 2013 U.S. Department of Veterans Affairs National Mental Health Provider Survey, <http://www.hospitalcompare.va.gov/>.

⁴⁰ *The War Within*, p. 119.

⁴¹ VA, VHA, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, VHA Handbook 1160.03, March 12, 2010, p. 5, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2174.

⁴² *VHA Mental Health Program Evaluation*, p. 153.

⁴³ *VHA Mental Health Program Evaluation*. For example, among veterans for whom maintenance medication is recommended, less than one-third received the recommended continuous treatment (p. 160). Similarly, among veterans receiving psychotherapy, "most did not include elements of an evidence-based modality" (p. 154).

⁴⁴ *VHA Mental Health Program Evaluation*. Less than two-thirds of veterans in a new treatment episode "have a documented assessment of their housing and employment needs" (p. 161). Among veterans with major depressive disorder who were receiving psychotherapy, less than a quarter (23%) "had documentation of an assessment of response to psychotherapy" (p. 155).

at high risk for suicide. The VHA's computerized patient record system enables clinicians to flag high-risk patients, and policy requires that safety plans be developed for them.⁴⁵ A safety plan is a written document developed jointly by a patient and a clinician that identifies strategies for coping in a crisis (e.g., recognizing warning signs and contacting family members, friends, or mental health providers). Outside the VHA, the use of suicide prevention coordinators has not been widely adopted, although some components of the program (e.g., safety plans) are widely used. The suicide prevention coordinator program has been identified as a practice worth emulating by a DOD task force on suicide prevention.⁴⁶

Suicide Hotline

Suicide hotlines are telephone numbers individuals can call for help in crisis situations (e.g., at the moment they are considering suicide). Hotlines are generally toll-free and available around the clock. The Veterans Crisis Line is a joint effort of the VHA and SAMHSA.⁴⁷ The main line (1-800-273-8255) is the National Suicide Prevention Lifeline, operated by SAMHSA.⁴⁸ Veterans (or others calling with concerns about veterans) may select option 1 to be directed to the VHA's Veterans Crisis Line, answered by staff at the COE in Canandaigua, NY. Callers may remain anonymous or disclose their identities in order to allow the COE staff to access their VA medical records during the call. The Veterans Crisis Line is supplemented by an online chat service (<http://www.VeteransCrisisLine.net/chat>) and support via text messaging (text 838255). The Veterans Crisis Line has answered more than 1.25 million calls since it began in 2007, has engaged in more than 175,000 chats since it added the chat service in 2009, and has responded to more than 24,000 texts since it added the text-messaging service in 2011.⁴⁹

The evidence base for suicide hotlines is not sufficient to determine their effectiveness in reducing suicide rates, due to the difficulties inherent in conducting such evaluations.⁵⁰ The confidentiality of suicide hotlines renders follow-up with each individual caller impossible. Moreover, national hotlines, such as those operated by SAMHSA and the VHA, serve a large geographic area. A range of other interventions may be in place in localities within the hotline's reach, such that any change in the suicide rate may not be attributable to the hotline.

⁴⁵ VA, Office of Inspector General, *Healthcare Inspection: Evaluation of Suicide Prevention Program Implementation in VHA Facilities, January–June 2009*, Report No. 09-00326-223, Washington, DC, September 22, 2009; and VA, Office of Inspector General, *Combined Assessment Program Summary Report: Re-Evaluation of Suicide Safety Plan Practices in Veterans Health Administration Facilities*, Report No. 11-01380-128, Washington, DC, March 22, 2011.

⁴⁶ Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives*, August 2010, pp. 55, 89, http://www.sprc.org/library_resources/items/challenge-and-promise-strengthening-force-preventing-suicide-and-saving-live; hereinafter referred to as *The Challenge and the Promise*.

⁴⁷ VA, VHA and Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), *Veterans Crisis Line*, <http://www.veteranscrisisline.net/>.

⁴⁸ HHS, SAMHSA, *National Suicide Prevention Lifeline*, <http://www.suicidepreventionlifeline.org/>.

⁴⁹ VA, VHA and HHS, SAMHSA, *About the Veterans Crisis Line*, <http://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx>.

⁵⁰ J. John Mann et al., "Suicide Prevention Strategies: A Systematic Review," *Journal of the American Medical Association*, vol. 294, no. 16 (October 26, 2005), pp. 2064-2074.

Education and Outreach

The VHA offers suicide prevention education and outreach to staff, patients, and surrounding communities. All VHA health care providers are required to complete web-based training on suicide risk and intervention and to pass a post-test.⁵¹ VHA Suicide Prevention Coordinators are required to conduct outreach activities in their local communities.⁵² The VHA has co-sponsored (with the Department of Defense) conferences on suicide prevention to educate clinicians and has sponsored Suicide Prevention Days to raise awareness. Efforts to promote the Veterans Crisis Line (e.g., public service announcements and distribution of brochures, wallet cards, key chains, etc.) also help raise awareness.

Limited Access to Lethal Means

The three most common means of completing suicide among the general population are firearms (50%), suffocation (24%), and poisoning (18%).⁵³ Evidence supports restricting access to lethal means (e.g., firearms, gas, drugs) as a way to reduce suicide rates.⁵⁴ The VHA has a gun safety program (as both a child safety initiative and a suicide prevention initiative), which includes distribution of free gun locks and dissemination of gun safety information.⁵⁵ The VHA also conducts research on blister packaging medications as a potential way to reduce the incidence of medication overdoses.⁵⁶

Potential Issues for Congress

The VHA has received both praise and criticism for its suicide prevention efforts and mental health services more generally. A 2010 progress report on an earlier version (2001) of the National Strategy for Suicide Prevention praises VHA's suicide prevention practices and recommends disseminating them to the rest of the health care system, describing the VHA as “one of the most vibrant forces in the U.S. suicide prevention movement, implementing multiple levels of innovation and state of the art interventions, backed up by a robust evaluation and research

⁵¹ VA, VHA, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, VHA Directive 1071, June 27, 2014, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3011.

⁵² VA, VHA, Office of Patient Care Services, Office of Mental Health Services, *Fact Sheet: VA Suicide Prevention Program*, March 2012, <http://www.visn20.med.va.gov/VISN20/docs/SuicidePreventionFactSheet32312.pdf>.

⁵³ Mechanism of injury for suicides among the general U.S. population in CY2007 identified from Centers for Disease Control and Prevention, National Center for Health Statistics. *Compressed Mortality File 1999-2007. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2007 Series 20 No. 2M, 2010*, <http://wonder.cdc.gov/cmfi-icd10.html>.

⁵⁴ Marco Sarchiapone et al., “Controlling Access to Suicide Means,” *International Journal of Environmental Research and Public Health*, vol. 8, no. 12 (2011), pp. 4550-4562; and Paul S.F. Yip et al., “Suicide 3: Means Restriction for Suicide Prevention,” *The Lancet*, vol. 379, no. 9834 (2012), pp. 2393-2399.

⁵⁵ VA, VHA, *Health Awareness Campaigns: Gun Safety*, <http://www.womenshealth.va.gov/WOMENSHEALTH/outreachmaterials/safety/gunsafety.asp>; and Caitlin Thompson, *Gun safety: An important conversation during Suicide Prevention Month*, VA, VHA, September 30, 2014, <http://www.blogs.va.gov/VAntage/15434/gun-safety-an-important-conversation-during-suicide-prevention-month/>.

⁵⁶ For example, the MIRECC of the VA Rocky Mountain Network is conducting a study to determine whether providing prescription medication in blister packages (rather than bottles) is associated with greater treatment adherence and fewer suicide-related overdoses among those at high risk of suicide. VA, VHA, *Blister Packaging Medications*, <http://www.mirecc.va.gov/visn19/research/projects.asp>.

capacity.”⁵⁷ In contrast, some congressional testimony has criticized VHA’s suicide prevention efforts for inadequacies, such as barriers to accessing care and lack of evidence-based treatments for those who do access care.⁵⁸ A 2011 evaluation of VHA mental health services (not limited to suicide prevention efforts) by the Altarum Institute and RAND Health captures both sides of the argument, finding that VHA mental health care is generally at least as good as that of other health care systems, but that it “often does not meet implicit VA expectations.”⁵⁹

Potential issues for Congress and related recommendations by outside organizations fall into three categories: improving the timeliness and accuracy of surveillance data, building the evidence base, and increasing access to evidence-based mental health care.

Improving the Timeliness and Accuracy of Surveillance Data

Challenges in suicide surveillance include timeliness of data, consistent classification of deaths as suicides, and accuracy of information. Addressing these challenges requires the involvement of entities other than VHA.

Recommendations related to the timeliness of suicide surveillance data include ensuring that the CDC’s ability to compile national death data expeditiously is not limited by a lack of resources; coordinating the annual analysis of veteran suicide data among VA, DOD, and HHS; and establishing “reasonable time requirements for states to provide death data to the CDC.”⁶⁰ It should be noted that states, territories, and cities *voluntarily* share vital statistics with the CDC, so offering incentives for timely data might be more feasible than imposing requirements.

It is widely believed that inconsistent reporting of suicides across jurisdictions, as well as underreporting of suicides in general, limits the effectiveness of surveillance efforts.⁶¹ Classification of a death as a suicide requires a determination that the death is both self-inflicted and intentional. Determining the decedent’s intent is difficult, and coroners or medical examiners may feel pressure not to classify a death as suicide, due to the stigma associated with suicide. Suicides may be underreported when the manner of death is misclassified as “undetermined” or “accidental” (e.g., poisonings or single-vehicle crashes). Additionally, each jurisdiction (state,

⁵⁷ *Charting the Future*, p. 11.

⁵⁸ See, for example, U.S. Congress, House Committee on Veterans’ Affairs, Subcommittee on Health, *Service Should Not Lead to Suicide: Access to VA’s Mental Health Care*, 113th Cong., 2nd sess., July 10, 2014; and U.S. Congress, Senate Committee on Veterans’ Affairs, *Ensuring Veterans Receive the Care They Deserve—Addressing VA Mental Health Program Management*, 113th Cong., 2nd sess., November 19, 2014.

⁵⁹ Katherine E. Watkins and Harold Alan Pincus, *Veterans Health Administration Mental Health Program Evaluation: Capstone Report*, Altarum Institute and RAND Health, 2011, p. 153; hereinafter referred to as *VHA Mental Health Program Evaluation*.

⁶⁰ Margaret Harrell and Nancy Berglass, *Losing the Battle: The Challenge of Military Suicide*, Center for a New American Security (CNAS), Washington, DC, October 2011, p. 9; hereinafter referred to as *Losing the Battle*. CNAS is a 501(c)3 tax-exempt nonprofit organization that describes itself as independent and non-partisan. See <http://www.cnas.org/about>.

⁶¹ See for example Stefan Timmermans, “Suicide determination and the professional authority of medical examiners,” *American Sociological Review*, vol. 70, no. 2 (2005), pp. 311-333; Hugh P. Whitt, “Where did the bodies go? The social construction of suicide data, New York City, 1976-1992,” *Sociological Inquiry*, vol. 76, no. 2 (2006), pp. 166-187; M.J. Breiding and B. Wiersema, “Variability of undetermined manner of death classification in the U.S.,” *Injury Prevention*, vol. 12(Suppl II) (2006), pp. ii49-ii54.

territory, or city) has its own requirements for investigating deaths, leading to variability across jurisdictions.

The GAO recommends that the VA implement processes to improve the completeness, accuracy, and consistency of data reported through the VHA's Behavioral Health Autopsy Program (BHAP) system.⁶² Beyond that, the VA must rely on outside data sources (e.g., the DOD) to identify decedents as veterans if they are enrolled with the agency.⁶³

Building the Evidence Base

Developing an adequate evidence base is necessary both to identify risk and protective factors and to develop and disseminate effective interventions. Recommendations include increased information sharing, collaboration, and dialogue across areas of public health, among government agencies, and between congressional committees.

Suicide prevention tends to operate in its own silo, even though suicide has some of the same risk and protective factors as other public health problems. Increased collaboration and dialogue between suicide prevention and other areas of public health “will help prevent the field from endlessly recreating wheels and spreading the limited funds too broadly to make a sustainable difference.”⁶⁴

If agencies (federal, state, or local) engage in ongoing collaboration and dialogue, sharing evaluations of existing interventions and research into new interventions, they may prevent unnecessary duplication of effort and help build the evidence base more quickly.⁶⁵ (Note that replication of studies is an integral part of the research process, so a distinction may be made between appropriate and unnecessary duplication of effort.) Specific recommendations include sharing research findings (e.g., risk and protective factors) between the VA, DOD, and HHS⁶⁶ and fast-tracking all phases of the intervention cycle (designing and pilot testing interventions, implementing interventions, and evaluating interventions), as well as the dissemination of the knowledge gained in each phase.⁶⁷

⁶² U.S. Government Accountability Office, VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data, GAO-15-55, December 12, 2014, <http://www.gao.gov/products/GAO-15-55>.

⁶³ The enrollment file includes veterans receiving benefits from the Veterans Benefits Administration, even if the veterans are not receiving care from VHA. VA researchers conducting a one-time study (not ongoing surveillance) combined information from the National Death Index with information from the DOD's Defense Manpower Data Center (DMDC) to identify suicides among veterans regardless of VA enrollment. The study was limited to veterans who served in Operations Enduring Freedom and/or Iraqi Freedom and who were separated alive from active duty between October 2001 and December 2005. See Han K. Kang and Tim A. Bullman, “Letter: Risk of Suicide Among US Veterans After Returning From the Iraq or Afghanistan War Zones,” *Journal of the American Medical Association*, vol. 300, no. 6 (2008), pp. 652-653.

⁶⁴ *Charting the Future*, p. 40.

⁶⁵ *Losing the Battle*, p. 9; and *Charting the Future*, p. 40.

⁶⁶ *Losing the Battle*, p. 9.

⁶⁷ *Charting the Future*, p. 40.

Some have also recommended that the House and Senate Committees on Veterans' Affairs initiate discussions with the House and Senate Armed Services Committees to develop provisions addressing veteran suicide in the National Defense Authorization Act.⁶⁸

Increasing Access to High-Quality Mental Health Care

Providing timely access to high-quality mental health care has been a challenge for the VHA. The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146, as amended)⁷¹ aims to increase access and decrease wait times for veterans seeking VHA care (not limited to mental health care).⁶⁹ Among other things, the act establishes the Veterans Choice Program, which requires the VHA to authorize reimbursement for non-VHA care under specified conditions. One such condition occurs when a qualified veteran is unable to schedule an appointment within the VHA's wait-time goals. In accordance with Act, the VHA has established a wait-time goal "to furnish care within 30 days of either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a veteran prefers to be seen."⁷⁰

When veterans gain access to care—within or outside the VHA—they may not always receive high-quality care.⁷¹ While the VHA has made progress in disseminating knowledge about evidence-based treatment (e.g., through clinical practice guidelines developed jointly with DOD), that does not guarantee implementation or such treatments.⁷² A 2014 report by the RAND Corporation indicates that only 13% of mental health providers in the study met criteria for readiness to provide veteran-friendly, high-quality care.⁷³ Providers working within the VHA or a military setting were more likely than others to meet the criteria, which may raise questions for some about increasing the use of non-VHA care. The report includes recommendations to conduct better assessments of civilian provider capacity, assess the impact of trainings in cultural competency on provider capacity, expand access to effective trainings in selected evidence-based approaches, and facilitate providers' use of evidence-based approaches.

⁶⁸ *Losing the Battle*, p.9.

⁶⁹ See CRS Report R43704, *Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)*.

⁷⁰ Department of Veterans Affairs, "Expanded Access to Non-VA Care Through the Veterans Choice Program," 79 *Federal Register* 65571, November 5, 2014.

⁷¹ *VHA Mental Health Program Evaluation*. For example, among veterans for whom maintenance medication is recommended, less than one-third received the recommended continuous treatment (p. 160). Similarly, among veterans receiving psychotherapy, "most did not include elements of an evidence-based modality" (p. 154).

⁷² VA, VHA and DOD, *VA/DOD Clinical Practice Guidelines*, <http://www.healthquality.va.gov/>.

⁷³ The three study criteria were as follows: (1) providers reported having been trained in an evidenced-based therapy for posttraumatic stress disorder and major depressive disorder, (2) providers reported using evidence-based treatments for patients with those conditions, and (3) providers scored at least 15 on a 22-point scale of cultural competency with a military or veteran population. Terri Tanielian et al., *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families*, The RAND Corporation, Santa Monica, CA, 2014.

Appendix. Public Laws Addressing VA Suicide Prevention Efforts

Since Operations Enduring Freedom and Iraqi Freedom began, four public laws have addressed VHA suicide prevention efforts: the Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110); the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181); the Veterans' Benefits Improvement Act of 2008 (P.L. 110-389); and the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163). Relevant provisions of each are summarized below.

Joshua Omvig Veterans Suicide Prevention Act

The Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110), enacted in 2007, required the VA Secretary to develop and implement a comprehensive suicide prevention program, and to report to Congress on the program. The Congressional Budget Office estimated that implementing the Joshua Omvig Veterans Suicide Prevention Act would have “little, if any, cost,” because the VA already had implemented or was planning to implement each of the specific requirements.⁷⁴ The textbox below lists the required elements and additional authorized elements of the comprehensive suicide prevention program.

Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110)

Required elements of the comprehensive suicide prevention program include the following:

- mandatory suicide prevention training for appropriate VA staff and contractors;
- designation of a suicide prevention counselor at each VA medical center;
- outreach and education for veterans and their families to promote mental health;
- mental health assessments of veterans and referrals to appropriate treatment;
- availability of 24-hour mental health care for veterans;
- research on best practices for suicide prevention; and
- research on mental health among veterans with military sexual trauma.

Additional authorized (but not required) elements include the following:

- a 24-hour toll-free hotline staffed by trained mental health personnel;
- peer support counseling; and
- other actions to reduce the incidence of suicide among veterans.

⁷⁴ U.S. Congressional Budget Office, *Cost Estimate for H.R. 327 Joshua Omvig Veterans Suicide Prevention Act*, March 19, 2007; and U.S. Congressional Budget Office, *Cost Estimate for S.4797 Joshua Omvig Veterans Suicide Prevention Act*, July 10, 2007.

National Defense Authorization Act for Fiscal Year 2008

Section 1611 of the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181) directed the VA and DOD Secretaries to jointly develop a comprehensive care and transition policy for servicemembers recovering from serious injuries or illnesses related to their military service. The law specified that the policy must address (among other things) the training and skills of health care professionals, recovery coordinators, and case managers, to ensure that they are able to detect and report early warning signs of suicidal thoughts or behaviors, along with other behavioral health concerns. The law further specified that the policy must include tracking the notifications made by recovery care coordinators, medical care case managers, and non-medical care managers to health care professionals regarding suicidal thoughts or behaviors, along with other behavioral health concerns. A 2009 Government Accountability Office report indicates that DOD and VA have developed the relevant policies.⁷⁵

Veterans' Benefits Improvement Act of 2008

Section 809 of the Veterans' Benefits Improvement Act of 2008 (P.L. 110-389) grants the VA Secretary authority to advertise in the media for various purposes, including suicide prevention.

Caregivers and Veterans Omnibus Health Services Act of 2010

Section 403 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) requires the VA Secretary to conduct a study to determine the number of veterans who died by suicide between January 1, 1999, and May 5, 2010 (i.e., the date of enactment). The in-progress study, dubbed the State Mortality Data Project, is described in a VA report published in February 2013.⁷⁶

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⁷⁵ U.S. Government Accountability Office, *Recovering Servicemembers: DOD and VA Have Jointly Developed the Majority of Required Policies but Challenges Remain*, GAO-09-728, July 2009, p. 25.

⁷⁶ Janet Kemp and Robert Bossarte, *Suicide Data Report, 2012*, VA, Mental Health Services, Suicide Prevention Program, February 1, 2013, <http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf>.