



Suicide Prevention Efforts of the Veterans Health Administration

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Summary

Responsibility for prevention of veteran suicide lies primarily with the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA). The VHA Strategic Plan for Suicide Prevention is based on a public health framework, which has three major components: (1) surveillance, (2) risk and protective factors, and (3) prevention interventions.

No nationwide *surveillance* system exists for suicide among all veterans; therefore, the actual incidence of suicide among veterans is not known. 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 over time to evaluate suicide prevention interventions. In the absence of a nationwide surveillance system for veteran suicide, the VHA is attempting to determine the rate of suicide among veterans in two ways, both in collaboration with the Centers for Disease Control and Prevention (CDC).

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: design and test interventions, implement interventions, and evaluate interventions. The research components mentioned above have roles in small-scale pilot testing and large-scale evaluations of interventions. This report discusses seven areas of VHA suicide prevention interventions: (1) easy access to care, (2) education, (3) screening and treatment, (4) limited access to lethal means, (5) suicide hotline, (6) media restrictions, and (7) suicide prevention coordinators.

This report identifies challenges the VHA faces in each component of suicide prevention and discusses potential issues for Congress. A recurring theme is the need for the VHA to work in concert with other federal, state, and local government agencies; private for-profit and not-for-profit health care providers; veterans, their families, and their communities; and other individuals or organizations that might be able to help. Specific challenges in surveillance include timeliness of data, accurate identification of decedents as veterans, and consistent classification of deaths as suicides. Challenges in risk and protective factors research include a need for more collaboration and dialogue among agencies involved in suicide prevention and across other areas of public health (because suicide has some of the same risk and protective factors as other public health problems). Challenges in VHA suicide prevention interventions also include the need for more collaboration and dialogue, as well as an apparent gap between policy and practice, and misperceptions about mental illness and mental health care.

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Introduction

Congress has attempted to address the problem of suicide among veterans through legislation,¹ and the House and Senate Committees on Veterans' Affairs have conducted oversight hearings, both on prevention of veteran suicide specifically and on veteran mental health more broadly.² The actual number or rate of veteran suicides is not known, because no nationwide surveillance system for suicide among all veterans exists, but there is consensus that the number is too high. Responsibility for prevention of veteran suicide lies primarily with the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA). Such a challenging task, however, demands collaboration with other federal agencies, state and local governments, other organizations, communities, and individuals.

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;³ clinical interventions are necessary but not sufficient. If the goal is to reach a broader population, the public health approach is considered essential.

The public health approach provides the framework for two suicide prevention strategies that are referenced in this report. The National Strategy for Suicide Prevention⁴ involves multiple federal departments, including the VA, Defense (DOD), and Education (ED), as well as several agencies within Health and Human Services (HHS).⁵ The VHA Strategic Plan for Suicide Prevention⁶ is a compilation of VHA activities related to suicide prevention. While this CRS report focuses on suicide prevention efforts of the VHA, activities of other entities are discussed as they relate to VHA activities. The textbox briefly discusses eligibility for, enrollment in, and use of VHA services. As noted in the textbox, the majority of veterans do not use VHA services. VHA efforts

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: Closing the Gaps*, 112th Cong., 1st sess., July 14, 2011; U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Addressing Wait Times and Access to Care*, 112th Cong., 1st sess., November 30, 2011; U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Understanding and Preventing Veteran Suicide*, 112th Cong., 1st sess., December 2, 2011; and U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Evaluating Access and Assessing Care*, 112th Cong., 2nd sess., April 25, 2012.

³ 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.

⁴ 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*.

⁵ 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).

⁶ Veterans Health Administration, *VHA Strategic Plan for Suicide Prevention: FY 2009–2011*; hereinafter referred to as *VHA Strategic Plan*. The VHA Strategic Plan is based on both public health and clinical approaches; see Element 2.1.

to increase access to care—and to prevent suicide among veterans who do not use VHA services—are discussed later in this report.

Who Is a Veteran? Eligibility for, Enrollment in, and Use of VA Health Care

The term “veteran” may refer broadly to anyone who has served in the Armed Forces, including those currently serving. In this report, a veteran is someone who has separated from military service following a period of active duty. Although an individual may return to active duty following separation (a particular issue among National Guard and Reserve members who have been activated), current active duty servicemembers are not the focus of this report.

Three additional points may be made relative to veterans and VA health care services:

- **Eligibility:** Not all veterans are eligible for VA health care services (see <http://www.va.gov/healthbenefits>); Vet Centers (non-medical facilities that provide readjustment counseling services for veterans and their families) have their own eligibility criteria (see <http://www.vetcenter.va.gov/Eligibility.asp>).
- **Enrollment:** Not all eligible veterans enroll in VA health care services. The number of enrolled veterans in FY2011 was 8.6 million, which is 39% of the estimated veteran population of 22.2 million. As noted above, some veterans are not eligible for VA health care services; others may choose not to enroll for various reasons (e.g., they might have employer-sponsored health insurance or other sources of health care services).
- **Use:** Not all enrolled veterans actually use VA health care services. The number of veterans who received health care services in FY2011 was 5.6 million, which is 65% of the 8.6 million enrolled veterans, or 25% of the estimated veteran population of 22.2 million. Enrolled veterans may choose not to receive care for various reasons (e.g., they might not perceive a need for health care services).

Sources: Estimated number of veterans is from Department of Veterans Affairs, FY2013 Budget Submission, Summary Volume, Volume 1 of 4, pp. 1F-1; numbers of veterans enrolled using services are from Department of Veterans Affairs, FY2013 Budget Submission, Medical Programs and Information Technology Programs, Volume 2 of 4, 2012, pp. 1B-3. See also CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala and Erin Bagalman.

The VHA has received both praise and criticism for its suicide prevention efforts and mental health services more generally. In 2010 the federally funded Suicide Prevention Resource Center, in collaboration with the non-profit Suicide Prevention Action Network, published a progress report on an earlier version (2001) of the National Strategy for Suicide Prevention; the progress report (hereinafter referred to as *Charting the Future*) praises VHA’s suicide prevention practices and recommends disseminating them to the rest of the health care system.⁷ *Charting the Future* 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.”⁸ 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.⁹ 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

⁷ 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. 18; hereinafter referred to as *Charting the Future*.

⁸ *Charting the Future*, p. 11.

⁹ See, for example, U.S. Congress, Senate Committee on Veterans’ Affairs, *VA Mental Health Care: Closing the Gaps*, 112th Cong., 1st sess., July 14, 2011; U.S. Congress, Senate Committee on Veterans’ Affairs, *VA Mental Health Care: Addressing Wait Times and Access to Care*, 112th Cong., 1st sess., November 30, 2011; U.S. Congress, House Committee on Veterans’ Affairs, Subcommittee on Health, *Understanding and Preventing Veteran Suicide*, 112th Cong., 1st sess., December 2, 2011; and U.S. Congress, Senate Committee on Veterans’ Affairs, *VA Mental Health Care: Evaluating Access and Assessing Care*, 112th Cong., 2nd sess., April 25, 2012.

generally at least as good as that of other health care systems, but that it “often does not meet implicit VA expectations.”¹⁰

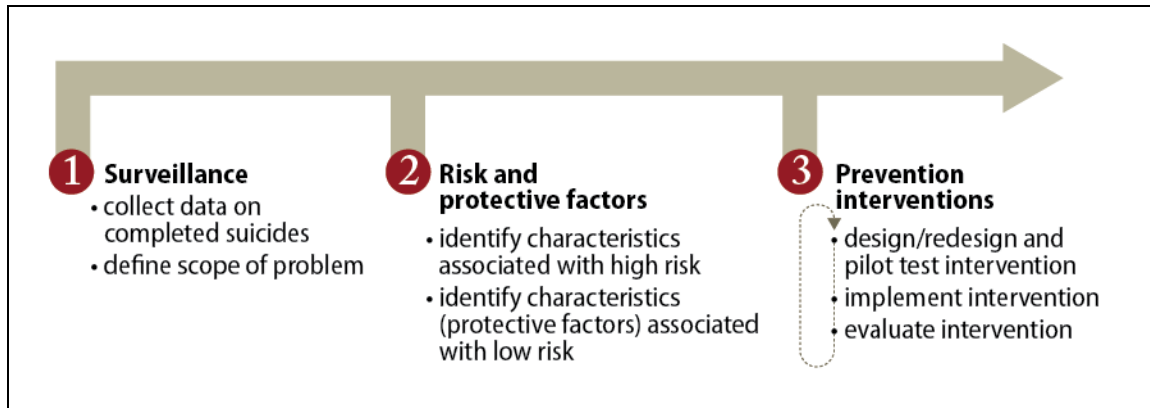
This report begins with a brief overview of the public health framework for suicide prevention. The three subsequent parts of the report correspond to the three major components of the public health framework: (1) suicide surveillance, (2) suicide risk factors and protective factors, and (3) suicide prevention interventions. The final section addresses potential issues for Congress.

The importance of collaboration and dialogue is a recurring theme across all components of the VHA’s suicide prevention efforts. Surveillance requires collaboration to address timeliness of data, accurate identification of decedents as veterans, and consistent classification of deaths as suicides. Risk and protective factors research requires dialogue among agencies involved in suicide prevention and across other areas of public health (because suicide has some of the same risk and protective factors as other public health problems). Successful prevention interventions also require collaboration. Challenges in prevention interventions include an apparent gap between policy and practice, as well as misperceptions about mental illness and its treatment.

A Public Health Framework for Suicide Prevention

As noted previously, both the National Strategy for Suicide Prevention and the VHA Strategic Plan for 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.

¹⁰ 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*.

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..

Suicide Surveillance

As noted previously, 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 over time and evaluate suicide prevention interventions. In order to evaluate interventions, suicide surveillance must measure the same thing, in the same way, repeatedly over time.

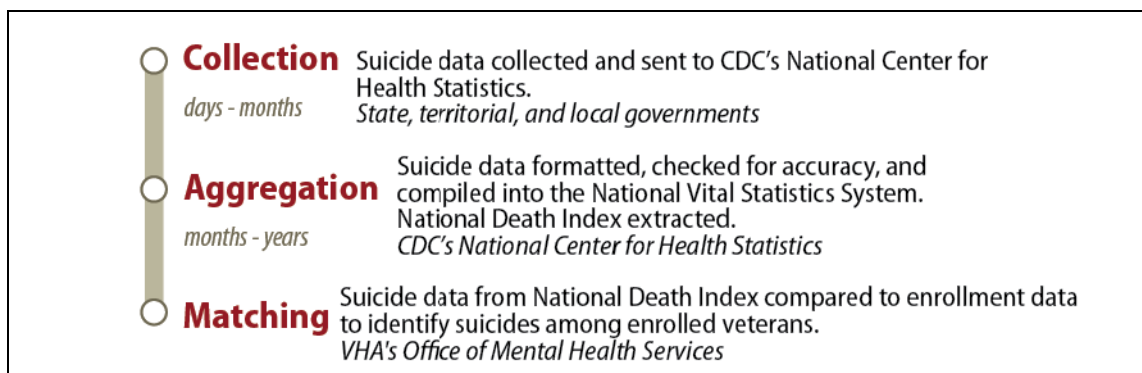
In the absence of a nationwide surveillance system for veteran suicide, the VHA is attempting to determine the rate of suicide among veterans in two ways, both in collaboration with the Centers for Disease Control and Prevention (CDC). Combining the two methods provides more information about veteran suicide than either method alone, but the combination remains inadequate to the task. For example, one method is limited to enrolled veterans, and the other is limited to fewer than half the states; thus even the combination does not capture all veteran suicides. Also, statistics from both methods have a lag time of years, so that timeliness of data is an ongoing challenge. Each of the two methods is described below, along with its limitations and (where applicable) efforts to overcome those limitations.

Combining VHA Data with the National Death Index (NDI)

The VHA's primary approach to surveillance is illustrated in **Figure 2**. Information about completed (i.e., fatal) suicides is collected in death certificates by state, territorial, and local governments;¹¹ aggregated into the National Death Index (NDI) by the CDC,¹² and combined with enrollment data by the VHA in order to identify suicides among enrolled veterans.¹³

¹¹ Suicide surveillance relies on information derived from death certificates. Both the legal authority for maintaining registries of deaths and the responsibility for issuing death certificates reside with individual states, territories, and two (continued...)

Figure 2. Combining VHA Data with the National Death Index



Source: CRS summary of information from CDC, National Center for Health Statistics, *About the National Death Index*, http://www.cdc.gov/nchs/data_access/ndi/about_ndi.htm; and from the VHA.

This approach is subject to the following limitations:

- The resulting data may not be comparable across jurisdictions.¹⁴
- The lag between a suicide event and identification of the decedent as an enrolled veteran may be years; this delays the availability of crucial information.
- Suicides among non-enrolled veterans are not captured;¹⁵ this leaves out the majority of veterans.¹⁶

Figure 3 presents annual suicide rates among VA-enrolled veterans. Suicide data are presented as rates to make them more meaningful (as opposed to a number of suicides without the size of the relevant population) and to make comparisons possible (e.g., across years or between genders). Annual suicide rates are commonly presented per 100,000 because the numbers would otherwise be extremely small (e.g., instead of 35.9 per 100,000 the number would be 0.000359).

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cities (Washington, DC, and New York, NY).

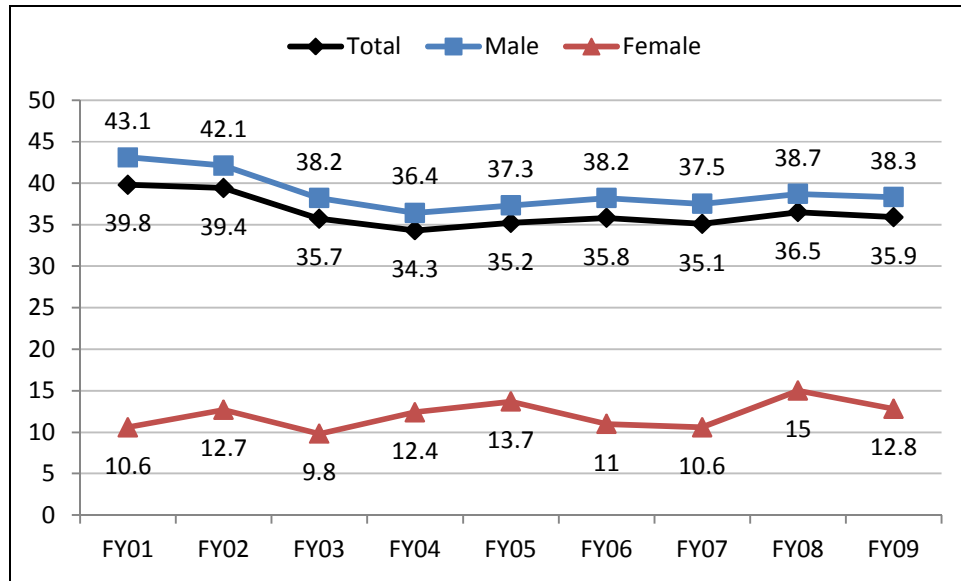
¹² The National Center for Health Statistics (NCHS) is part of the Centers for Disease Control and Prevention (CDC), within the Department of Health and Human Services (HHS). NCHS works cooperatively with state, territorial, and local jurisdictions to collect information from death certificates in the 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, *About the National Death Index*, http://www.cdc.gov/nchs/data_access/ndi/about_ndi.htm.

¹³ VHA combines suicide data from the NDI with enrollment records to identify suicides among enrolled veterans. The enrollment file includes veterans receiving benefits from the Veterans Benefits Administration, even if the veterans are not receiving care from VHA.

¹⁴ 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*.

¹⁵ The standard death certificate allows officials to indicate if a decedent has ever served in the U.S. Armed Forces; however, this indication captures both veterans and current servicemembers, with no means of distinguishing between the two. Also, the individual responsible for completing the death certificate may not know whether the decedent is a veteran.

¹⁶ See textbox in the Introduction.

Figure 3. Annual Suicides per 100,000 VA-Enrolled Veterans, FY2001-FY2009

Source: CRS analysis of data provided by the Department of Veterans Affairs.

Notes: Rates are presented per 100,000 veterans enrolled in VA health care; for example, in FY2009, the rate of suicides was 35.9 per 100,000 veterans (male and female) enrolled in VA health care.

Accessing the National Violent Death Reporting System (NVDRS)

In an attempt to identify suicides among veterans regardless of enrollment with the VA, the VHA uses the CDC's National Violent Death Reporting System (NVDRS), among other sources of information.¹⁷ The NVDRS is a CDC-funded program that enables participating states to supplement death certificates with information from law enforcement agencies, crime laboratories, coroner or medical examiner reports, health providers, and other state and local agencies. Through ongoing active surveillance, NVDRS may increase the likelihood that a death is recognized as a suicide and that a decedent's veteran status is captured (regardless of enrollment with the VHA). The CDC is working to address the limitations of this approach through the following activities:

- Expand the NVDRS to all 50 states, the District of Columbia, and the territories;¹⁸ currently, the NVDRS is in operation in fewer than half the states.¹⁹
- Increase standardization of data collection and analysis, in order to increase comparability across states.²⁰
- Assess the feasibility of linking VHA data directly to state NVDRS programs, thereby eliminating a step in the process and potentially reducing the lag time.²¹

¹⁷ VHA Strategic Plan, Element 7.1.

¹⁸ HHS, CDC, *Fiscal Year 2012 Justification of Estimates for Appropriation Committees*. This goal is not reflected in the FY2013 Justification.

¹⁹ HHS, CDC, *National Violent Death Reporting System*, <http://www.cdc.gov/violenceprevention/nvdrs>.

²⁰ HHS, CDC, *Fiscal Year 2012 Justification of Estimates for Appropriation Committees*. This goal is not reflected in the FY2012 Justification.

- Link the NVDRS to data from the VHA and the DOD’s Suicide Event Report, in order to increase accurate identification of veteran status.²²

The timeliness of the data is a challenge for the VHA in both methods of surveillance described above. This is a challenge for suicide surveillance nationwide, not limited to suicide surveillance among veterans. Timely reporting of death certificates is identified as a core issue in the 2010 progress report on the earlier version (2001) of the National Strategy for Suicide Prevention.²³

Suicide Risk Factors 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. 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 using data collected in surveillance. **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. The subpopulation of veterans who are enrolled with the VHA may differ from non-enrolled veterans, as well.

(...continued)

²¹ HHS, CDC, National Center for Injury Prevention and Control, Division of Violence Prevention, *Preventing Suicide: Program Activities Guide*, Atlanta, GA, 2010.

²² HHS, CDC, *Preventing Suicide: Program Activities Guide*.

²³ *Charting the Future*, p. 30.

The VHA conducts veteran-specific research that builds on research among the general population. Within HHS, both the CDC²⁴ and the National Institute of Mental Health (NIMH)²⁵ disseminate research on suicide risk and protective factors within the general population. Also, SAMHSA collects data on suicide attempts and related behavior.²⁶ 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.²⁷ Despite a large number of risk and protective factors identified by researchers, it is not yet possible to predict who will attempt or complete suicide.²⁸ 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 two organizational units: the Office of Research and Development (ORD) and the Mental Health Strategic Healthcare Group (MHSHG). In general, the ORD funds intramural research by individual VHA investigators or researchers (including mental health care research).²⁹ The MSHSG funds a Center of Excellence (COE) in suicide prevention and a Mental Illness Research, Education, and Clinical Center (MIRECC) on suicide prevention, as well as centers addressing other mental health topics. Examples of research conducted on risk and protective factors by each of these three components—ORD, COE, and MIRECC—are provided below. The same three research components are also involved in the development and evaluation of suicide prevention interventions.

VHA Office of Research and Development (ORD)

The ORD's Health Services Research and Development Service supports research into suicide risk factors and protective factors.³⁰ For example, the VHA conducted a study to identify patient characteristics associated with higher suicide rates among veterans in treatment for depression (a known risk factor in the general population, as well as among veterans).³¹ Another study

²⁴ Centers for Disease Control and Prevention, *Suicide: Risk and Protective Factors*, Atlanta, GA, <http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html>.

²⁵ 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>.

²⁶ 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/preview/mmwrhtml/ss6013a1.htm>.

²⁷ HHS, Men's Health, *Suicide*, <http://womenshealth.gov/mens-health/top-health-concerns-for-men/suicide.cfm>.

²⁸ 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* 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.

²⁹ 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).

³⁰ A search for "suicide*" at <http://www.hsr.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.

³¹ VA, VHA, Health Services Research and Development, *Suicide Among Veterans: Using the VA Depression Registry to Inform Care*, Study IIR 04-211, http://www.hsr.research.va.gov/research/abstracts.cfm?Project_ID=2141695453.

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.³² 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,³³ the COE has the mission of developing and studying evidence-based public health 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.³⁴

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

The MIRECCs, also established at the direction of Congress,³⁵ 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.³⁶ For example, one study assesses the relationship (if any) between prolonged grief and suicidal ideation.³⁷ Another study investigates the neurobiology of suicide risk in traumatic brain injury and substance abuse.³⁸ Other MIRECCs may also conduct research related to suicide, in the course of pursuing their other goals.

³² VA, VHA, Health Services Research and Development, *Suicidality: Correlates and Impact on Preference-Weighted Health Status of Veterans in VA Primary Care*, Study SHP 08-160, http://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141698711.

³³ 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 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.”

³⁴ VA, VHA, *VISN 2 Center of Excellence at Canandaigua*, http://www.mirecc.va.gov/docs/2010InfoSheets/VISN_2_CoE_Canandaigua_Info_Sheet_2010.pdf.

³⁵ P.L. 104-262, Veterans’ Health Care Eligibility Reform Act of 1996, enacted 10/09/1996 (38 U.S.C. §7320).

³⁶ VA, VHA, *MIRECC of the VA Rocky Mountain Network (VISN 19 MIRECC)*, <http://www.mirecc.va.gov/visn19/index.asp>.

³⁷ VA, VHA, VISN 19 MIRECC, *Examining Prolonged Grief Disorder and Its Relationship to Self-Directed Violence (SDV) Among Veterans*, <http://www.mirecc.va.gov/visn19/studies/grief/index.asp>.

³⁸ VA, VHA, VISN 19 MIRECC, *Neurobiology of Suicide Risk in Traumatic Brain Injury and Substance Abuse*, http://www.mirecc.va.gov/visn19/studies/tbi_sud/docs/tbi_sud_brochure.pdf.

Suicide Prevention Interventions

Through effective suicide prevention interventions, people's lives can be saved. 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 PTSD), or high-risk individuals (e.g., veterans with recent suicide attempts).

Suicide prevention 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).

Within the VHA, the same three research components involved in risk and protective factors research are involved in the intervention cycle: ORD,³⁹ COE,⁴⁰ and MIRECC.⁴¹ 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.⁴²

The rest of this section discusses seven areas of VHA suicide prevention interventions: (1) easy access to care, (2) education, (3) screening and treatment, (4) limited access to lethal means, (5) suicide hotline, (6) media restrictions, and (7) suicide prevention coordinators.

Easy Access to Care

As noted previously, the majority of veterans do not use VHA services. Easy access to care is a protective factor against suicide,⁴³ and the VHA is making efforts to increase access to care by addressing identified barriers to care, including logistical challenges in scheduling or attending appointments, lack of understanding or awareness of mental health care, stigma associated with mental illness, and concerns about VHA care. In order to address these barriers, the VHA is taking two broad approaches: (1) increasing access to care by offering a broader range of mental health services (e.g., telehealth or off-hours clinics) and (2) providing education about mental

³⁹ 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*, April 2012, http://www.queri.research.va.gov/about/factsheets/mh_factsheet.pdf.

⁴⁰ The COE at Canandaigua evaluates implementation of suicide prevention initiatives.

⁴¹ For example, the MIRECC of the VA Rocky Mountain Network is conducting a pilot program to determine whether providing prescription medication in blister packages (rather than bottles) reduces the likelihood of overdose. Veterans Health Administration, *Blister Packaging Medication to Increase Treatment Adherence and Clinical Response: Impact on Suicide-Related Morbidity and Mortality*, <http://www.mirecc.va.gov/projects/blisterpack/index.asp>.

⁴² *The War Within*, p. 13.

⁴³ *Ibid.*

illness and mental health care to veterans, their families, health care providers, and others in their communities.⁴⁴

Offering expanded options in mental health services aims to alleviate logistical challenges by making services available in more places at more times.⁴⁵ VHA policy requires that new patients requesting or referred for mental health services receive an initial assessment within 24 hours and a full evaluation appointment within 14 days; follow-up appointments for established patients must occur within 30 days.⁴⁶ The extent to which these policies are implemented in practice has been questioned in congressional testimony, news media, and survey responses from both providers and patients.⁴⁷

Educating veterans and others aims to increase understanding of mental health care and mental illness, reduce the associated stigma, and correct misconceptions about VHA care. For example, the VHA incorporates messages intended to reduce stigma into public health and outreach activities. In addition, the VHA is working to integrate mental health and substance use evaluation and treatment services into other treatment settings, which both increases the convenience and reduces the stigma associated with seeking care.⁴⁸ Educational interventions are described in more detail in the next subsection.

Education

The VHA offers suicide prevention education to audiences within VHA facilities and in surrounding communities. VHA requires suicide prevention training for all VHA staff that interact with veterans, plus additional training for health care providers. In the community, the VHA provides education for veterans' families and community "guides."⁴⁹ Community guides are trained to recognize individuals who may be at risk of suicide and help them seek treatment. Evidence supports education of guides; however, they must be able to refer individuals to quality mental health services.⁵⁰ Thus, access to care and quality of care are essential.

⁴⁴ 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>.

⁴⁵ Ibid. Examples of expanded options include increasing use of telemental health services and call centers (i.e., telephone counseling), integrating mental health services into primary care settings, increasing the number of mental health staff and mental health clinic hours, and adding more Vet Centers.

⁴⁶ VA, VHA, *Uniform Mental Health Services in VA Medical Centers and Clinics*, VHA Handbook 1160.01, September 11, 2008.

⁴⁷ U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Closing the Gaps*, 112th Cong., 1st sess., July 14, 2011; U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Addressing Wait Times and Access to Care*, 112th Cong., 1st sess., November 30, 2011; Gregg Zoroya and Paul Monies, "Lag in Mental Health Care Found at a Third of VA Hospitals," *USA Today*, November 9, 2011, <http://www.usatoday.com/news/military/story/2011-11-09/veterans-mental-health-care/51143216/1>; and *VHA Mental Health Program Evaluation*.

⁴⁸ *VHA Strategic Plan*, Elements 4.1, 4.2, and 4.3.

⁴⁹ *VHA Strategic Plan*, Element 9.1, 9.2, 9.3, and 9.4.

⁵⁰ *The War Within*. Outside the VHA, the term "gatekeeper" (rather than "guide") is generally used.

Screening and Treatment

Some types of screening, pharmacotherapy, and psychotherapy are supported by evidence that they reduce the likelihood of suicide.⁵¹ VHA policy requires screening for a variety of risk factors, including depression, posttraumatic stress disorder (PTSD), problem drinking, traumatic brain injury (TBI), military sexual trauma (MST), and pain; veterans who screen positive must be offered follow-up evaluations and, if appropriate, treatment.⁵²

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.⁵³ In particular, the evaluation finds that evidence-based treatments (both pharmacotherapy and psychotherapy), while widely available, are not usually provided.⁵⁴ 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).⁵⁵ 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.

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%).⁵⁶ Evidence supports restricting access to lethal means (e.g., firearms, gas, drugs) as a way to reduce suicide rates.⁵⁷ The VHA has a gun safety program (as both a child safety initiative and a suicide prevention initiative), which includes distribution of gun safety literature and gun locks. The VHA also encourages demonstration projects and research on blister packaging medications as a way to reduce the incidence of medication overdoses.⁵⁸ Means restriction is a promising area still under investigation.⁵⁹

⁵¹ *The War Within*.

⁵² *VHA Strategic Plan*, Element 6.2.

⁵³ *VHA Mental Health Program Evaluation*, p. 153.

⁵⁴ *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).

⁵⁵ *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).

⁵⁶ 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-cd10.html>.

⁵⁷ 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.

⁵⁸ *VHA Strategic Plan*, Elements 10.4 and 10.6; and VA, *Blister Packaging Medication to Increase Treatment Adherence and Clinical Response: Impact on Suicide-Related Morbidity and Mortality*, <http://www.mirecc.va.gov/> (continued...)

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.⁶⁰ The main line (1-800-273-8255) is the National Suicide Prevention Lifeline, operated by SAMHSA.⁶¹ 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 identity in order to allow the COE staff to access their VA medical records during the call. Since the Veterans Crisis Line began in 2007, it has received over 500,000 calls, resulting in over 73,000 referrals to Suicide Prevention Coordinators for same-day or next-day service. The Veterans Crisis Line is supplemented by an online chat service (<http://www.VeteransCrisisLine.net/chat>) and support via text messaging (text 838255).⁶²

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.⁶³ 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.

Media Restrictions

Exposure to a suicide—whether through a personal relationship with the decedent or through media coverage—is a risk factor for suicide.⁶⁴ In this way, suicide sometimes seems to act as a contagion, resulting in suicide clusters as one suicide is followed by other imitative suicides. Following a completed suicide, news media may restrict how suicides are reported (e.g., not glamorizing suicide or not reporting the specific means), in an effort to reduce the likelihood of imitative suicides. Evidence has shown that this may reduce suicide at a particular site (e.g., a bridge); however, more evidence is needed to determine whether this approach reduces the overall rate of suicide.⁶⁵ The VA monitors depictions of suicide in the media and (working with

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[projects/blisterpack/index.asp](#).

⁵⁹ 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.

⁶⁰ *VHA Strategic Plan*, Element 6.10.

⁶¹ Substance Abuse and Mental Health Services Administration, *National Suicide Prevention Lifeline*, <http://www.suicidepreventionlifeline.org/>.

⁶² U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Understanding and Preventing Veteran Suicide*, 112th Cong., 1st sess., December 2, 2011, testimony of Jan E. Kemp, RN, Ph.D., National Mental Health Director for Suicide Prevention, Veterans Health Administration, U.S. Department of Veterans Affairs.

⁶³ 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.

⁶⁴ *National Strategy for Suicide Prevention*, p. 63.

⁶⁵ 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.

other federal agencies and partners in academia) encourages both news and entertainment media to depict suicide in a manner that is ethical and responsible.⁶⁶

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 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.⁶⁷ 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 VA, 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.⁶⁸

Potential Issues for Congress

A recurring theme in recommendations regarding VHA suicide prevention efforts is the need for the VHA to work in concert with other federal, state, and local government agencies; private for-profit and not-for-profit health care providers; veterans, their families, and their communities; and other individuals or organizations that might be able to help. Specific recommendations are organized in the following subsections, according to the public health framework for suicide prevention: surveillance, risk and protective factors, and interventions. Public laws addressing suicide prevention among veterans are described in the **Appendix**.

Potential Issues in Surveillance

As discussed earlier, three challenges in suicide surveillance are (1) timeliness of data, (2) accurate identification of decedents as veterans, and (3) consistent classification of deaths as suicides. Addressing these three challenges requires the involvement of entities other than VHA.

The Center for a New American Security (CNAS)⁶⁹ offers three recommendations related to the timeliness of data. First, CNAS recommends that “Congress should establish reasonable time requirements for states to provide death data to the CDC.”⁷⁰ It should be noted that states,

⁶⁶ *VHA Strategic Plan*, Elements 11.1 and 11.2.

⁶⁷ 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, <http://www.va.gov/oig/54/reports/VAOIG-09-00326-223.pdf>; 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.

⁶⁸ 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.health.mil/dhb/subcommittees-tfpsmaf.cfm>; hereinafter referred to as *The Challenge and the Promise*.

⁶⁹ CNAS is a 501(c)3 tax-exempt nonprofit organization located in Washington; it describes itself as independent and non-partisan. See <http://www.cnas.org/about>.

⁷⁰ Margaret Harrell and Nancy Berglass, *Losing the Battle: The Challenge of Military Suicide*, Center for a New (continued...)

territories, and cities voluntarily share vital statistics with the CDC. Congress may be able to facilitate or motivate more rapid data sharing by providing resources or incentives. Second, CNAS recommends ensuring that the CDC's ability to compile national death data expeditiously is not limited by a lack of resources.⁷¹ Third, CNAS recommends that the annual analysis of veteran suicide data be coordinated among VA, DOD, and HHS.⁷²

The VHA can identify decedents as veterans only if they are enrolled with the agency.⁷³ Identification of non-enrolled veterans relies on information gathered in the course of completing the death certificate or on supplemental information gathered as part of the National Violent Death Reporting System. 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.⁷⁴ Congress may consider whether the DMDC is a source of information that can be used for suicide surveillance among veterans regardless of enrollment.

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.⁷⁵ 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, territory, or city) has its own requirements for investigating deaths, leading to variability across jurisdictions. Congress may be able to facilitate or motivate more standardization by providing resources or incentives.

Potential Issues in Risk and Protective Factors

Recommendations in the area of risk and protective factors include collaboration and dialogue both among agencies involved in suicide prevention and across other areas of public health. CNAS suggests information sharing between the VA, DOD, and HHS⁷⁶ and recommends that the House and Senate Committees on Veterans' Affairs initiate discussions with the House and Senate

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American Security, Washington, DC, October 2011, p. 9; hereinafter referred to as *Losing the Battle*.

⁷¹ Ibid.

⁷² Ibid.

⁷³ The enrollment file includes veterans receiving benefits from the Veterans Benefits Administration, even if the veterans are not receiving care from VHA.

⁷⁴ 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. 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.

⁷⁵ 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.

⁷⁶ *Losing the Battle*, p. 9.

Armed Services Committees to develop provisions addressing veteran suicide in the National Defense Authorization Act.⁷⁷ *Charting the Future* notes that 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. It recommends collaboration and dialogue between the suicide prevention effort and other public health efforts, stating, “Strong dialogue will help prevent the field from endlessly recreating wheels and spreading the limited funds too broadly to make a sustainable difference.”⁷⁸

Congress may choose to assess whether current levels of collaboration and dialogue are sufficient to ensure rapid dissemination of knowledge and avoid unnecessary duplication of effort. (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.) Congress may mandate, facilitate, or incentivize additional interagency coordination.

Potential Issues in Interventions

Three issues in VHA suicide prevention interventions that have come before Congress during hearings are (1) collaboration and dialogue, as discussed above; (2) an apparent gap between policy and practice; and (3) perceptions about mental illness and mental health care.⁷⁹

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. The recommendations above regarding information sharing and collaboration pertain to intervention research as well.⁸⁰ *Charting the Future* advocates 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.⁸¹ Moreover, congressional testimony has repeatedly called for increased use of non-VA resources, including other federal, state, and local government agencies; private for-profit and not-for-profit health care providers; veterans, their families, and their communities; and other individuals or organizations.⁸² The use of non-VA resources might help suicide prevention interventions reach the majority of veterans who do not use VHA services.

A recurring theme in the area of suicide prevention interventions is the apparent gap between policy and practice. Examples of such a gap include the timeliness of mental health appointments and the use of evidence-based treatment. Increasing the timeliness of appointments may require congressional action in the form of additional resources in order to hire more providers, expand

⁷⁷ Ibid.

⁷⁸ *Charting the Future*, p. 40.

⁷⁹ U.S. Congress, Senate Committee on Veterans’ Affairs, *VA Mental Health Care: Closing the Gaps*, 112th Cong., 1st sess., July 14, 2011; U.S. Congress, Senate Committee on Veterans’ Affairs, *VA Mental Health Care: Addressing Wait Times and Access to Care*, 112th Cong., 1st sess., November 30, 2011; U.S. Congress, House Committee on Veterans’ Affairs, Subcommittee on Health, *Understanding and Preventing Veteran Suicide*, 112th Cong., 1st sess., December 2, 2011.

⁸⁰ *Losing the Battle*, p. 9; and *Charting the Future*, p. 40.

⁸¹ *Charting the Future*, p. 40.

⁸² U.S. Congress, Senate Committee on Veterans’ Affairs, *VA Mental Health Care: Addressing Wait Times and Access to Care*, 112th Cong., 1st sess., November 30, 2011; U.S. Congress, House Committee on Veterans’ Affairs, Subcommittee on Health, *Understanding and Preventing Veteran Suicide*, 112th Cong., 1st sess., December 2, 2011.

office space, or implement technologies such as telemedicine. Other gaps between policy and practice, such as the infrequent use of evidence-based treatment, may be possible for the VHA to address without additional resources; Congress may choose to continue exercising oversight in such areas.

Perceptions about mental illness and mental health care may affect whether veterans make use of treatment available to them. The belief that mental illness is a sign of weakness or something shameful may inhibit individuals or those around them from reaching out. Additionally, the belief that mental health care is not available, not appropriate, or not effective may discourage veterans from seeking care. Both stigma and mistaken beliefs may be reduced through discussions that address the facts of mental illness and mental health care. Thus congressional hearings on suicide, mental illness, or mental health care may have the unintended—but beneficial—consequence of reducing stigma and correcting misunderstandings about treatment.⁸³

⁸³ U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Closing the Gaps*, 112th Cong., 1st sess., July 14, 2011. Senator Murray mentioned stigma in her opening statement, and it was discussed at several points.

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.⁸⁴ 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.

⁸⁴ 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.⁸⁵

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). As of this writing, the study has not been completed.

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⁸⁵ 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.