

# CRS Report for Congress

## Suicide Prevention Among Veterans

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# Suicide Prevention Among Veterans

## Summary

Numerous news stories in the popular print and electronic media have documented suicides among servicemembers and veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In the United States, there are more than 30,000 suicides annually. Suicides among veterans are included in this number, but it is not known in what proportion. There is no nationwide system for surveillance of suicide specifically among veterans. Recent data show that about 20% of suicide deaths nationwide could be among veterans. It is not known what proportion of these deaths are among OIF/OEF veterans.

Veterans have a number of risk factors that increase their chance of attempting suicide. These risk factors include combat exposure, post-traumatic stress disorder (PTSD) and other mental health problems, traumatic brain injury (TBI), poor social support structures, and access to lethal means.

Several bills addressing suicide in veterans have been introduced in the 110<sup>th</sup> Congress. On November 5, 2007, the Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110) was signed into law, requiring the Department of Veterans Affairs (VA) to establish a comprehensive program for suicide prevention among veterans. More recently, the Veterans Suicide Study Act (S. 2899) was introduced. This bill would require the VA to conduct a study, and report to Congress, regarding suicides among veterans since 1997.

The VA has carried out a number of suicide prevention initiatives, including establishing a national suicide prevention hotline for veterans, conducting awareness events at VA medical centers, and screening and assessing veterans for suicide risk.

This report discusses data sources and systems that can provide information about suicides in the general population and among veterans, and known risk and protective factors associated with suicide in each group. It also discusses suicide prevention efforts by the VA. It does not discuss Department of Defense (DOD) activities, or VA's treatment of risk factors for suicide, such as depression, PTSD, and substance abuse.

This report will be updated when legislative activity warrants.

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# Suicide Prevention Among Veterans

## Introduction

Considerable public attention has been drawn toward the mental health care needs of veterans, especially those returning from combat in Iraq and Afghanistan. Numerous news stories in the popular print and electronic media have documented suicides among servicemembers and veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).<sup>1</sup> Some veterans advocacy groups have filed a class-action lawsuit claiming that the Department of Veterans Affairs (VA) is not providing adequate and timely access to mental health care, and that this has led to an “epidemic of suicides.”<sup>2</sup>

However, most often the data cited in these press reports do not differentiate between suicides among veterans and active duty servicemembers.<sup>3</sup> It is important to make this distinction, because two separate health care systems — at the VA and the Department of Defense (DOD), respectively — are responsible for providing mental health care to these two distinct populations. This report explains the difficulties in determining the incidence of suicide among veterans, summarizes what is known about suicides in the general population and among veterans, and discusses known risk and protective factors associated with suicide in each group. It also discusses recent congressional action to address suicide among veterans, and suicide prevention efforts by the VA. The report does not discuss DOD activities, or VA’s treatment of risk factors for suicide, such as depression, post-traumatic stress disorder (PTSD), and substance abuse.

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<sup>1</sup> Ken Fuson and Jennifer Jacobs, “Iowans Lauded for Anti-suicide Efforts,” *The Des Moines Register*, January 26, 2008; Dana Priest, “Soldier Suicides at Record Level,” *Washington Post*, January 31, 2008, Page A01; “Soldier, After Bipolar Treatment and Suicide Attempts, Sent Back to War Zone,” *Editor & Publisher*, February 11, 2008; “Suicide Epidemic Among Veterans — A CBS News Investigation Uncovers a Suicide Rate for Veterans Twice That of Other Americans,” aired November 13, 2007. OEF, which began in October 2001, conducts combat operations in Afghanistan and other locations. OIF, which began in March 2003, conducts combat operations in Iraq and other locations.

<sup>2</sup> *Veterans for Common Sense and Veterans United for Truth, Inc., v. James B. Peake, Secretary of Veterans Affairs, et al.*, Plaintiffs Trial Brief, Case No. C-07-3758-SC, filed April 17, 2008.

<sup>3</sup> Within the context of the VA, a veteran is defined as a “person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.” [38 U.S.C. § 101(2); 38 C.F.R. § 3.1(d)]. The VA largely bases its determination of veteran status upon military department service records.

## Data and Data Systems for Tracking Suicide

Suicide is the act of intentionally ending one's life, attempted suicide is an effort that does not have a fatal outcome, and suicidal ideation is thinking about or wanting to end one's life. Because completed (versus attempted) suicide results in death, national statistics on suicide come from death certificate data.<sup>4</sup> These data are collected by state and territorial health officials, under their authority, and are voluntarily reported to the Centers for Disease Control and Prevention's (CDC's) National Vital Statistics System. The CDC analyzes the data and publishes information on numbers and rates of death, and important trends, in the United States.<sup>5</sup> The CDC also publishes a U.S. standard death certificate, which states and territories can modify. Most U.S. deaths are not investigated by government officials. Possible suicides may be investigated, however, pursuant to state and territorial authorities. To the extent that a death is recognized as a suicide, the standard death certificate provides the means to report suicide as the manner of death, but it has limited options for noting other information that may be relevant to the suicide.

In 2003, CDC launched the National Violent Death Reporting System (NVDRS), an active surveillance system that provides detailed information about the circumstances of violent deaths, including suicide.<sup>6</sup> The NVDRS augments death certificate data by linking it to death investigation reports filed by coroners, medical examiners, and law enforcement officials. These added layers of information allow the NVDRS to identify suicide risk factors, such as depression; to gather additional information, such as toxicology results; and to more reliably capture information that could have been, but was not, completed on the standard death certificate. At this time, the NVDRS is not in operation nationwide, but only in 17 states, and NVDRS data might not be generalizable to the entire U.S. population. Also, because protocols for death investigation vary from one state to the next, NVDRS data might not be comparable between those states in which it is in operation. CDC's goal is to expand the system to all 50 states, all U.S. territories, and the District of Columbia, and to continue efforts to standardize data collection and analysis across states.

*At this time, there is no nationwide system for surveillance (i.e., tracking) of suicide among all veterans. As with all suicides in civilian jurisdiction, suicides among veterans may be investigated, and the death certificates completed, by state and territorial authorities. Unless a veteran's suicide occurs in a VA facility, opportunities for the VA to become aware of the incident may be limited. Three*

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<sup>4</sup> In reference to fatal suicides, the public health community prefers to use the term "completed," rather than "committed" or "successful," to recognize the frequent association of suicide with mental illness, and reduce the accompanying stigma.

<sup>5</sup> For more information, see Centers for Disease Control and Prevention (CDC), Mortality Data from the National Vital Statistics System, at [<http://www.cdc.gov/nchs/deaths.htm>], visited May 2, 2008.

<sup>6</sup> See CDC, National Violent Death Reporting System, at [<http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm>].

approaches are being used to track the incidence of suicide among veterans, though each of them has serious shortcomings.

First, CDC's standard death certificate allows officials to note if a decedent *has ever served*<sup>7</sup> in the U.S. Armed Forces. However, the fact that a decedent is a veteran is not always known when the certificate is completed. Although suicides among veterans are a part of total national suicide statistics, it is not known what proportion of that total is made up of veterans.

Second, VA data may be linked to CDC's vital statistics data through the National Death Index (NDI). This CDC data system allows authorized researchers to link national death data to other data systems, identifying the fact that an individual had died of suicide, and that a death certificate has been filed.<sup>8</sup> This would allow the VA to identify suicide deaths among its enrollees. (Subsequent research steps are cumbersome. For example, researchers typically must contact state officials to access the actual death certificates.) The NDI is not an ongoing data linkage that would constitute surveillance for suicide. It can be used, however, to support special studies by linking specific data sets. For example, researchers from the VA and the University of Michigan conducted a study in which they linked data from VA's National Registry for Depression (NARDEP) to the NDI, allowing VA to match its patient registry to certified suicide deaths even when the decedent's veteran status had not been noted on the death certificate.<sup>9</sup> However, because only about one-third of veterans receive their health care from the VA, using VA health systems data for linkage would not capture the complete experience of suicide among veterans.

Third, the NVDRS resolves many of the problems discussed above. Through ongoing active surveillance, NVDRS substantially improves the likelihood that a suicide victim's veteran status will be captured, and it provides additional useful information about suicide incidents. But NVDRS is in operation in only 17 states. Though CDC intends it to become a nationwide system, expansion would depend on appropriations. Congress first provided funding for NVDRS in FY2002 and has expressed support for the program in annual appropriations report language. The program has not received a specified appropriation in recent years, but rather is funded through CDC's budget for intentional injury prevention and control.

## Suicide in the U.S. General Population

There are *risk factors* that increase the likelihood that someone will attempt suicide, and *protective factors* that decrease that likelihood. This section provides

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<sup>7</sup> This definition captures current and former U.S. military servicemembers.

<sup>8</sup> See CDC, National Death Index, at [<http://www.cdc.gov/nchs/ndi.htm>].

<sup>9</sup> Zivin et al., "Suicide Mortality among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics," *American Journal of Public Health*, Vol. 97, No. 12, pp. 2193-8, December 2007, hereafter referred to as Zivin et al., study of depression and suicide in veterans.

some context for suicide among veterans by discussing the incidence, and risk and protective factors, for suicide in the U.S. general population.<sup>10</sup>

## Incidence of Suicide

Suicide is a serious public health problem in the United States. According to CDC, there were more than 32,000 suicide deaths in the United States in 2004, making it the 11<sup>th</sup> leading cause of death that year. On average, there are four suicides among males for each one among females. Use of firearms is the most common method of suicide among males, while poisoning is the most common method among females. Suicide is the second leading cause of death among 25-34 year olds, and the third leading cause of death among 15-24 year olds. Although suicide is a leading cause of death in younger adults, the *rate* of suicide (number of suicides within the age group per 100,000 resident population in the age group) is actually highest in individuals aged 45 or older. **Table 1** presents suicide rates across age groups in the United States for 2004, as published by CDC. It is important to note that except in the youngest age group, these rates may, and probably do, include suicides among veterans, though in proportions that are not known.

**Table 1. U.S. Death Rates for Suicide, by Age, 2004**

Age Group	5-14 years	15-24 years	25-44 years	45-64 years	65 years and over	All age groups <sup>a</sup>
Suicide rate	0.7	10.3	13.9	15.4	14.3	10.9

**Source:** CDC, death rates for suicide, according to sex, race, Hispanic origin, and age: selected years, 1950-2004, "Health, United States, 2007," Table 46, at [<http://www.cdc.gov/nchs/data/hus/hus07.pdf>].

**Notes:** CDC does not calculate rates based on small numbers of suicides among those younger than five years of age, as such rates are not statistically reliable. In the source above, CDC also published rates for sub-intervals of the age intervals presented here (e.g., for those aged 25-34 years and 35-44 years).

a. This rate is age-adjusted, calculated using the year 2000 standard population.

There are no official national statistics on attempted suicide (i.e., attempts that were not fatal), but it is generally estimated that there are 25 attempts for each death by suicide. Also, it is reported that there are three suicide attempts among females for every one among males.

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<sup>10</sup> Unless otherwise noted, information in this section is drawn from CDC: "Suicide, Facts at a Glance," Summer 2007, and "Understanding Suicide, Fact Sheet," 2006, at [<http://www.cdc.gov/ncipc/dvp/suicide/>]; and "Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2005," *MMWR*, vol. 57(SS03), April 11, 2008, hereafter referred to as NVDRS 2005 report, at [<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm>].

## Risk and Protective Factors

No single cause or factor leads to suicide. It is a “final common outcome with multiple potential antecedents, precipitants, and underlying causes.”<sup>11</sup> A number of factors are known to increase or decrease the likelihood that an individual will attempt suicide. Factors that increase this likelihood are called *risk factors*. Risk factors exist at multiple levels, involving individual, family, community, and societal factors. Conversely, factors that decrease a person’s inclination to attempt suicide are called *protective factors*, which also exist at multiple levels. It is important to note that none of these factors in isolation is known to cause or prevent suicide.

The single best predictor of an increased risk of suicide is a history of a prior suicide attempt. Other risk factors for suicide in the general population include certain mental illnesses such as depression, alcohol and substance abuse, history of trauma or abuse, family history of suicide, job or financial stress, the stigma associated with seeking mental health care, barriers to health care access, and easy access to lethal means. Protective factors include strong family or community connections; accessible and effective clinical care; skills in problem solving, conflict resolution, and nonviolent handling of disputes; and cultural and religious beliefs that discourage suicide.<sup>12</sup>

## Suicide Among Veterans

In the absence of national surveillance for suicide among veterans, information is limited to the findings of special epidemiological studies and surveys. These vary considerably in their design and in the sub-population of veterans studied, and they often yield conflicting results.

It is tempting to make comparisons between these studies, and with information about suicide in the general population. Such comparisons are often made, but they are not necessarily valid. Among other things, data about suicides in the general population includes suicides among veterans. Information about suicide in groups that exclude veterans is scant, as is information about the extent to which data for veterans may skew the data for the general population, if at all. An additional problem in interpreting the findings of these special studies is that they are often conducted on populations of veterans who are receiving treatment for suicide risk factors. On the one hand, this makes it difficult to determine whether study findings reflect the effects of risk factors, or the effects of interventions. On the other hand, it indicates that efforts to develop systematic surveillance of suicide among veterans may, with careful attention to design, also provide the means to evaluate the

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<sup>11</sup> Testimony of Michael Shepherd, M.D, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, in U.S. Congress, House Committee on Veterans’ Affairs, hearing on *Stopping Suicides: Mental Health Challenges Within the Department of Veterans Affairs*, December 12, 2007.

<sup>12</sup> Suicide Prevention Resource Center, “Risk and Protective Factors for Suicide,” at [<http://www.sprc.org/library/srisk.pdf>], visited April 30, 2008.



effectiveness of prevention and treatment programs. This section discusses the findings of some key studies of suicide among veterans.

## Incidence of Suicide

The true incidence of suicide among veterans is not known. This section discusses information from two recent published studies that yield a partial picture of the burden of suicide in this group.

In 2005, the NVDRS identified 1,821 suicides among former or current military personnel, comprising 20% of all suicides, in the 16 states in which the system was operational that year.<sup>13</sup> CDC's published findings about these 1,821 decedents include the following:

- 1,765 (96.9%) were male.
- 1,415 (77.7%) were 45 years of age or older.
- The most common method used was firearms (67.9%), followed by poisoning (12.7%), and hanging/strangulation/suffocation (11.5%).
- 47.2% were married, 25.0% were divorced, 13.0% were widowed, and 14.0% were never married.<sup>14</sup>

Researchers from the VA and the University of Michigan conducted a cohort study of 807,694 veterans who were diagnosed with depression in the VA health system, and registered in the VA's National Registry for Depression (NARDEP), between 1999 and 2004.<sup>15</sup> During the study period, 1,683 (0.21%) of the veterans in this high-risk group committed suicide. The researchers calculated a rate of 88.25 suicides per 100,000 person-years in this group, seven to eight times higher than the rate in the general population for the same time period. They noted that this rate was similar, though, to a more relevant comparison, namely, to suicides among those in the general population who were depressed.<sup>16</sup> They also found the rate among the group of veterans studied to be highest among those who were younger than 45 years of age, in contrast with the age trend in the general population.

In December 2007, VA testified that it had identified 144 known suicides among OIF/OEF veterans from the time the conflicts began through the end of 2005,

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<sup>13</sup> NVDRS 2005 report. The definition "current and former military personnel" is likely to include both current military personnel and veterans, but the publication does not provide information about each group separately, or about whether such separate information is available.

<sup>14</sup> The remaining small number of decedents were "married but separated," "single, not otherwise specified," or their marital status was not known. These findings were not cross-tabulated by age.

<sup>15</sup> Zivin et al., study of depression and suicide in veterans. The authors used CDC's National Death Index to link NARDEP registrants with death certificate data, in order to identify registrants who had died, and determine that they died of suicide, during the study period.

<sup>16</sup> The authors cited only one study on which to base this comparison, though, which likely reflects the limited availability of studies in groups that are meaningful for comparison. It is not clear whether the comparison group included or excluded veterans.

and that this number translated into a rate that is not statistically different from the rate for age, sex, and race matched individuals from the general population. These data have not been published.<sup>17</sup>

## Risk and Protective Factors

While there have been a number of studies to identify risk and protective factors for suicide in the general population, few studies have looked at factors specific to veterans. In the general population, suicide risk factors include male gender; older age; diminished psycho-social support (e.g., homelessness or unmarried status); availability and knowledge of firearms; and the co-existence of medical and psychiatric conditions. This profile describes a large portion of the veteran patient population, making suicide risk management particularly challenging in the VA health care system.<sup>18</sup> A study that screened 703 patients from a general medical outpatient clinic at a VA hospital found that 7.3% of the patients had suicidal ideation.<sup>19</sup> Younger and white patients were found to be at increased risk. The risk was higher in patients with self-described fair or poor mental health, a history of mental health treatment, and fair or poor perceived physical health. When major depression was controlled for, anxiety and substance abuse disorders continued to show an association with suicidal ideation.

CDC's NVDRS data identified the following associated circumstances among a group of 1,622 former or current military personnel who died by suicide in 2005:<sup>20</sup>

- Although almost half of them (47.2%) were depressed at the time of death, only about a fourth (26.7%) were receiving mental health treatment.
- 17.2% had an alcohol problem, and 7.7% had a problem with other substances.
- 24.5% had a problem with an intimate partner.
- 38.4% had a physical health problem.
- 28.0% had experienced an acute crisis during the prior two weeks.
- 33.9% had left a suicide note, 13.3% had made a previous suicide attempt, and 29.0% had disclosed their intent to commit suicide with enough time for someone to have intervened.

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<sup>17</sup> Testimony of Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer, Office of Mental Health, Veterans Health Administration, Department of Veterans Affairs in U.S. Congress, House Committee on Veterans' Affairs, *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs*, hearings, 110<sup>th</sup> Cong., 1<sup>st</sup> sess., December 12, 2007.

<sup>18</sup> Lambert et al., "Suicide Risk Factors among Veterans: Risk Management in the Changing Culture of the Department of Veterans Affairs," *Journal of Mental Health Administration*, Vol. 24, No. 3, pp. 350-8, Summer 1997.

<sup>19</sup> Lish et al., "Suicide Screening in a Primary Care Setting at a Veterans Affairs Medical Center," *Psychosomatics*, Vol. 37, No. 5, pp. 413-24, 1996.

<sup>20</sup> NVDRS 2005 report. This group is a subset of the 1,821 former or current military personnel whose suicides were recorded in NVDRS in 2005, for whom these additional types of information were collected.

The VA/University of Michigan study of suicide among veterans with depression found that having a service-connected disability was associated with a lower risk of suicide in this group.<sup>21</sup> The authors suggest that greater access to VA health facilities and regular compensation payments may explain the protective effect.

## **The Effects of PTSD, TBI, and Depression on Suicide Risk**

This section describes three suicide risk factors that are common among veterans: Post-traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and depression. PTSD and TBI are common consequences of war, with distinct symptoms, treatment modalities, and long-term effects. PTSD has been recognized in various forms throughout military history. It is an anxiety disorder, with symptoms of varying severity, that can occur following experiences, such as military combat, in which grave physical injury occurred or was threatened. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. TBI occurs when a sudden physical trauma causes damage to the brain. Improvised explosive devices (IEDs), which have been used extensively in the current conflict in Iraq, can cause TBI, sometimes in the absence of obvious external signs of injury. Symptoms of TBI can be mild, moderate, or severe, depending on the extent of the brain injury. When symptoms of TBI or PTSD are mild, they may go undiagnosed, or be confused with conditions with similar symptoms, such as other mental illnesses, including depression, or substance use disorders. Either PTSD or TBI may co-occur with depression or substance abuse. Finally, some veterans have both a TBI and PTSD.

In April 2008, the RAND Corporation published a study of mental health problems in servicemembers and veterans.<sup>22</sup> From their review of the literature, the authors found that in the general population, depression, PTSD, and TBI are each independent risk factors for suicide. More limited information from studies of servicemembers or veterans generally shows the same effect of these three risk factors in specific groups that were studied. This information also typically shows trends comparable to those in the general population with respect to other risk factors for suicide, though the demonstrated effects of interactions of these factors with depression, PTSD and TBI may differ. For example, studies have found that while males are at greater risk of death from suicide than are females, the effects that depression, PTSD and TBI have on increasing this risk is greater in females. Among the general population, substance abuse, prior nonfatal suicide attempts, severity of PTSD symptoms, and certain types of TBI are more predictive for suicide, and may signal areas of greater suicide risk among military and veterans populations as well. Researchers also found that combat exposure increases the risk of suicide, as well as the likelihood of PTSD, which itself also increases the risk of suicide.

The VA/University of Michigan study of suicide among veterans with depression found that PTSD was associated with a lower risk of suicide in this

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<sup>21</sup> Zivin et al., study of depression and suicide in veterans.

<sup>22</sup> Tanelian and Jaycox, "Invisible Wounds of War," RAND, 2008, at [[http://rand.org/pubs/monographs/2008/RAND\\_MG720.1.pdf](http://rand.org/pubs/monographs/2008/RAND_MG720.1.pdf)], visited April 28, 2008.

group.<sup>23</sup> The authors suggest that this unexpected finding may reflect the effect of treatment for PTSD, rather than a protective effect of PTSD itself.

## Congressional Action

In the 109<sup>th</sup> Congress, two measures (H.R. 5771 and S. 3808) were introduced regarding the prevention of suicide among veterans. However, these bills did not see further legislative action.

In the 110<sup>th</sup> Congress, the Joshua Omvig Veterans Suicide Prevention Act (H.R. 327) was introduced in the House, and a companion version (S. 479) was introduced in the Senate.<sup>24</sup> The House passed H.R. 327 on March 21, 2007, and the Senate passed the House measure with an amendment on September 27. The bill was signed into law (P.L. 110-110) on November 5, 2007.<sup>25</sup> The act, among other things, requires the VA to establish a comprehensive program for suicide prevention among veterans. In carrying out this comprehensive program, the VA must designate a suicide prevention counselor at each VA medical facility. Each counselor is required to work with local emergency rooms, police departments, mental health organizations, and veterans service organizations to engage in outreach to veterans. The act also requires the VA to provide for research on best practices for suicide prevention among veterans, and requires the VA Secretary to provide for outreach and education for veterans and their families, with special emphasis on providing information to veterans of OIF and OEF. The act requires VA to provide for the availability of 24-hour mental health care for veterans and to establish a 24-hour hotline for veterans to call if needed.

Also in the 110<sup>th</sup> Congress, the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181) requires the Secretaries of DOD and VA to develop a comprehensive care and transition policy for servicemembers who are recovering from serious injuries or illnesses related to their military service, and to specifically address the risk of suicide among these individuals in developing the required policy.<sup>26</sup>

More recently, the Veterans Suicide Study Act (S. 2899) was introduced. This measure would require the VA to study and report to Congress regarding suicides that have occurred among veterans since 1997. In carrying out this study, the VA Secretary would have to coordinate with the Secretary of Defense, Veterans Service Organizations, the CDC, and state public health offices and veterans agencies.

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<sup>23</sup> Zivin et al., study of depression and suicide in veterans.

<sup>24</sup> The Joshua Omvig Veterans Suicide Prevention Act is named for a veteran who completed suicide on December 22, 2005.

<sup>25</sup> Codified at 38 U.S.C. § 1720F. For a detailed legislative history of P.L. 110-110, see H.Rept. 110-55 and S.Rept. 110-132.

<sup>26</sup> See CRS Report RL34371, “Wounded Warrior” and Veterans Provisions in the FY2008 National Defense Authorization Act, by Sarah A. Lister, Sidath Viranga Panangala, and Christine Scott.

## **VA's Suicide Prevention Efforts<sup>27</sup>**

In response to legislation and congressional oversight, the VA has initiated several suicide prevention activities. Following is a summary of major activities.

### **Mental Health Strategic Plan**

In 2004, the VA developed the Mental Health Strategic Plan (MHSP), which aimed to present a new approach to mental health care, to focus on recovery rather than pathology, and to integrate mental health care into overall health care for veteran patients. This five-year action plan, with more than 200 initiatives, includes timetables and responsible offices identified for each action item. A number of these action items are specifically aimed at the prevention of suicide. In 2006, following a request by the House Committee on Veterans Affairs, the VA's Inspector General (IG) undertook an assessment of VA's progress in implementing the MHSP initiatives for suicide prevention, and provided recommendations.<sup>28</sup> The IG's findings revealed that MHSP initiatives pertaining to 24-hour crisis availability, outreach, referral, and development of methods for tracking veterans at risk have been implemented in multiple facilities, but not yet systemwide. Initiatives focused on the development of methods for screening, assessment of veterans at risk, emerging best practice treatment interventions, education of VA health providers, and an electronic suicide prevention database have been piloted or are in the process of being piloted at selected facilities.

### **Mental Health Research**

VA's Mental Illness Research, Education and Clinical Center (MIRECC) at Denver, Colorado, and the Center of Excellence in Mental Health and PTSD at Canandaigua, New York, have been specifically focusing on research related to suicide prevention. According to the VA, ongoing studies at these centers are studying suicide risk factors, validation of suicide ideation screening instruments, quality of mental health care and its relationship to suicide prevention, and risk factors for suicide as it relates to depression.

### **Suicide Awareness**

In April 2007, VA held its first Suicide Prevention Awareness Day at all VA medical centers (VAMCs). The program included recognizing risk factors for suicide, and proper protocols for responding to crisis situations. VA held its second Suicide Prevention Awareness Day in September 2007. The program consisted of required training for all staff on general principles of suicide prevention, and the use of the national VA Suicide Prevention Hotline (see below).

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<sup>27</sup> Drawn from the Department of Veterans Affairs, Report to Congress, *P.L. 110-110, Comprehensive Program for Suicide Prevention Among Veterans*, February 2008.

<sup>28</sup> Department of Veterans Affairs, Office of Inspector General, "Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention," Report No. 06-03706-126, 2007.

VA has also appointed Suicide Prevention Coordinators who are located at each VA medical center. They were appointed in response to P.L. 110-110, which required VA to appoint suicide prevention counselors in each VA medical facility. The primary function of these coordinators is to support the identification of patients at high risk for suicide, and to ensure that their monitoring and care are intensified. Furthermore, they are involved in training and education, both within the VA and in the community. All the coordinators are licensed mental health professionals.

## Screening

A screening program aims to identify individuals who have mental or emotional problems that increase their risk for suicide.<sup>29</sup> VA has implemented a policy to screen all OEF/OIF veterans for depression, PTSD, and alcohol abuse upon their initial visit to VA medical centers or clinics. Furthermore, screening for depression and alcohol abuse is required on an annual basis for all veterans, and screening for PTSD is required annually for the first five years after enrollment, and every five years thereafter. Veterans who screen positive for one of these conditions are required to receive a follow-up clinical evaluation that considers both the condition(s) related to the positive screen, and the risk of suicide. When this process confirms the presence of a mental disorder or suicide risk, veterans are offered mental health treatment. When there is a referral or request for mental health services, veterans must receive an initial evaluation within 24 hours. If this evaluation identifies an urgent need, treatment is to be provided immediately. Otherwise, veterans must receive a full diagnostic and treatment planning evaluation and the initiation of care within two weeks.

In addition, the DOD administers a post-deployment health reassessment (PDHRA) 90-180 days after a servicemember's return from deployment, to identify health concerns, with an emphasis placed on screening for mental health conditions that may have emerged since returning home. Information gathered during this assessment helps DOD identify servicemembers who require referrals for further evaluation.<sup>30</sup> The Government Accountability Office (GAO) has stated that DOD shares information gathered through the PDHRA with the VA. According to GAO, "VA officials obtain PDHRA information about servicemembers referred to VA and individual servicemembers' [PDHRA] when they access VA health care. Each month, VA receives a report that provides monthly and cumulative totals of servicemembers referred, including servicemembers referred to VA facilities."<sup>31</sup> However, it is unclear at this time if VA uses this information to specifically screen those who may be potentially at risk of suicide.

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<sup>29</sup> For more information on screening tools and their effectiveness, see CRS Report RS22647, *Screening for Youth Suicide Prevention*, by Ramya Sundararaman.

<sup>30</sup> The PDHRA (DD Form 2900) includes questions about feeling down, depressed, or hopeless, the occurrence of nightmares, relationship issues with family and friends, and increased alcohol use.

<sup>31</sup> U.S. Government Accountability Office (GAO), *DOD's Post-Deployment Health Reassessment*, GAO-08-181R, January 25, 2008, p.7.

## Suicide Prevention Hotline

The VA has also partnered with the Lifeline Program, a grantee of the Substance Abuse and Mental Health Services Administration (SAMHSA), of the Department of Health and Human Services (HHS), to develop a VA suicide prevention hotline. Those who call 1-800-273-TALK are asked to press “1” if they are a veteran, or are calling about a veteran.<sup>32</sup> When they do so, they are connected directly to VA’s hotline call center, where they speak to a VA mental health professional with real-time access to the veteran’s medical records. The responders at the VA suicide prevention hotline have received American Association of Suicidology (AAS) credentialing and certification.

In emergencies, the hotline contacts local emergency resources such as police or ambulance services to ensure an immediate response. In other cases, after providing support and counseling, the hotline transfers care to the suicide prevention coordinator at the nearest VAMC for follow-up care.

From October 7 to November 10, 2007, 1,636 veterans and 311 family members or friends called the VA suicide prevention hotline. These calls led to 363 referrals to suicide prevention coordinators and 93 rescues involving emergency services.<sup>33</sup>

## Funding for Suicide Prevention

According to VA estimates, in FY2008, spending for the suicide prevention program will include \$970,000 to establish the suicide prevention hotline; \$1.97 million for the Center of Excellence in Canandaigua, New York; \$2.20 million for the Mental Illness Research, Education and Clinical Center in Denver, Colorado; \$90,000 for the Serious Mental Illness Research, Education and Clinical Center for monitoring of suicide rates and risk factors; and \$14.32 million for Suicide Prevention Coordinators.<sup>34</sup>

## Conclusion

There has been considerable recent interest in the burden of suicide among veterans, in particular those who have recently returned from military service in Operation Iraqi Freedom and Operation Enduring Freedom. This interest has thrown a spotlight on the fact that there is not, at this time, a system of surveillance for suicide among veterans.

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<sup>32</sup> VA is using the national suicide prevention hotline to provide this service to veterans.

<sup>33</sup> Testimony of Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer, Office of Mental Health, Veterans Health Administration, Department of Veterans Affairs in U.S. Congress, House Committee on Veterans’ Affairs, *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs*, hearings, 110<sup>th</sup> Cong., 1<sup>st</sup> sess., December 12, 2007.

<sup>34</sup> Department of Veterans Affairs, Report to Congress, *P.L. 110-110, Comprehensive Program for Suicide Prevention Among Veterans*, p. 7, February 2008.

Despite recent interest in comparing suicide rates between veterans and the general population, this may not be the most useful comparison. In numerous ways that affect their suicide risk, veterans are not like the general population. Also, the VA has an interest in decreasing the burden of suicide among veterans, whether this burden exceeds that of the general population or not. What may be more meaningful, and more important to achieve, is the establishment of data systems that support a more robust and reliable understanding of suicide among veterans. The ideal systems would describe a clear baseline, and provide a means to track changes going forward — with respect to such things as risk and protective factors, and the effects of treatment — in order to know which interventions work, and where to target them.