



Twenty Veterans Die by Suicide Each Day – We Can Not Accept the Status Quo

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COVID-19 and Suicide Risk

It is hard to address any topic today, without somehow relating it to the COVID-19 pandemic. We all struggle to define the “new normal”, or identify the lasting effects on how we work, how we relate to each other, or simply determine what life will be like when the pandemic has passed. The authors don’t have the answers, but we do know that this pandemic, and our response to it, will impact the emotional wellbeing of millions of Americans. We also know that unemployment, social disconnectedness, and uncertainty is adding, and will continue to add, stress to our lives. In some, this elevation in stress levels will lead to increased behavioral health issues, including the risk of increased suicidesⁱ.

DoD and VA Suicide Prevention Historical Perspectives

In order to understand why we would make such a prognosis, we must look back nearly ten years. In 2011, the two authors of this article were responsible for the Suicide Prevention efforts for the U.S. Navy and the Marine Corpsⁱⁱ. Budget pressures abounded and military suicides were forefront in each Service Chief’s mind.

Congressional inquiries into the suicide rate seemed to come on a nearly daily basis. DoD was in the early stages of understanding the complexity of suicide as it continued to grow as a significant public health challenge across all the military services and components. Moreover, on the occasion that individual services were able to achieve reductions in suicide rates in any particular year, these reductions were never lasting and never reversed the ominous trend in the growth in suicide rates. Thusly, our early efforts could be summed up as follows: 1) We did not know precisely what suicide prevention efforts made an actual difference; and 2) We could not establish a direct relationship between level of effort (money, programs, number of people) and the number of suicides. And although we did not have the needed answers, we all took solace in the fact that the DoD suicide rate was less than the corresponding civilian rate. Put simply, we were doing better than society at large!ⁱⁱⁱ. During this same period, the Department of Veteran Affairs was struggling with a growth in the number of Veteran suicides. Complicating matters, the two departments track their associated suicides much differently, making comparison difficult and complicating policymakers understanding of the data. However, in 2006, Veteran suicide rates were lower than the adult civilian suicide rates, after accounting for age and sex differences in the populations^{iv}.

In the intervening years, attention on this problem has only grown more intense and resources continue to flow to stem the tide. In 2012, the DoD created the Defense Suicide Prevention Office (DSPO), a direct result of a recommendation by the DoD Task Force on the Prevention of Suicides by the Members of the Armed Forces^v. The creation of DSPO reflected the Department's commitment to address the rise in suicides among our active duty population. And in a good first step, DSPO published the seminal Defense Strategy for Suicide Prevention (DSSP) in 2015, and the first-ever Department of Defense Instruction in 2017 (guiding policy document). These foundational documents brought the DoD programming in line with the National Strategy for Suicide Prevention (published under the auspices of the National Action Alliance for Suicide Prevention). While these foundational documents provided a comprehensive framework to advance suicide prevention across the Department, some have argued that the policies did not go far enough in instilling sufficient accountability or direct prescription for the military services.

Regarding other progress, DSPO drove transition from a reactive medical model to a public health approach focused on early intervention and widespread suicide prevention efforts. DSPO's suicide prevention strategy sought to advance training competencies while identifying and addressing underlying risk and socio-demographic factors and simultaneously enhancing protective factors^{vi}.

During this same period, the VA, for its part, established Veteran suicide prevention as its number one clinical priority under Secretary Shulkin, and this emphasis has continued to this day under Secretary Wilkie. And in an attempt to ensure an integrated national response, President Trump has issued two Executive Orders, one in January 2018 and one in March 2019, focused on Veteran suicide prevention^{vii}.

Suicide Resource Allocations

As you would imagine, resources have followed this focus on military and veteran suicides. The fiscal year 2020 Presidential Budget Request includes \$9.3 million to fund the DoD program charged with preventing suicide, up from \$8.7 million in fiscal year 2019. In addition, the military services, components, and activities, also fund suicide prevention and resiliency efforts through their respective service budgets.

Funding levels for the VA suicide prevention program have increased steadily over the past decade. The most current Presidential Budget Request earmarks \$80 million for mental health and suicide prevention related capabilities, \$76 million for the Veterans Suicide Crisis Hotline, and an additional \$50 million to fund PREVENTS, a new executive level task force. These investments represent perennial funding increases for suicide prevention programs at a time that we continue to struggle with historic rates of suicide.

Current Approaches

With these resources, each institution has evolved its approach to suicide prevention. DoD and VA have made significant investments to build databases to collect comprehensive data regarding each and every suicide of service members and veterans. This data is used to conduct discreet analysis based on selected characteristics aggregated from these individual events. Findings from such analysis has led to significant policy and programmatic changes such as increasing service delivery for Reserve and Guard populations through the nationwide system of Veteran Centers. Similarly, a review of the data led to policy changes that now allow every Veteran unfettered access to behavioral health care for the first year after leaving military service. Analysis of suicide data was also instrumental in the VA's decision to open up mental health care for those veterans leaving the military with dishonorable discharges. Regarding access to care, the VA has made significant progress eliminating administrative barriers in large part due to data analysis.

The Department of Defense has also lead the development of and relied on sound data analysis to inform its suicide prevention approach. Historically, the military services have focused on resilience-building efforts by training troop populations on resiliency and ensuring military spouses and other gatekeepers are familiar with the signs of suicide risk. Leveraging suicide data after decades of war, DoD implemented a number of community programs including Military One Source and the Military and Family Life Counseling Program which are both upstream interventions designed to help service members and their families get the support they need before the risk becomes too high or complex. Data analysis in DoD also led to significant improvements in the military transition process over the last five years. These institutional advancements ensure that transition from the military is not a single event, but a process that begins the day a service member enters the service and continues long after separation from the Service. These examples of data-informed policies demonstrate the importance of proactive, upstream interventions for suicide prevention. Just as importantly, however, each of these examples highlight the importance of data in developing sound and efficient policy prescriptions for large healthcare systems such as DoD and VA.

So, there has been, and is, no lack of attention and resources aligned to the issue of military and veteran suicide for at least the past decade. And it is unquestionable that this influx of attention and resources has driven meaningful policy and system improvements across DoD and VA. The question remains, however; What has this extraordinary focus and attention delivered in terms of reducing the number of suicides? Are we better off today than we were in 2011? Statistics abound, but we find two pieces of data very enlightening. First, for DoD, the CY 2018 military suicide rates were roughly equivalent to CY 2017 U.S. population rates. This holds true for all Components, except the National Guard (which is higher)^{viii}. Second, for VA, in 2017 (latest data available), Veterans were 22 percent more likely to die by suicide compared to their adult civilian peers, adjusting for age and sex^x. We do not seek to debate statistics as the nuances are profound and add rich context to this issue. However, we think it is clear that, even with a national focus and significant flow of resources over the past decade, the DoD and VA suicide rates have grown relatively WORSE compared to the comparable U.S. population! The problem is not getting better...and, it is time for the national efforts to focus on innovation that advances methods that have yet to be fully leveraged. If what we have been doing worked – we would have seen sustained reductions by now.

We should note at this point that we both hold great respect and admiration for all the mental and behavioral health providers, medical professionals, and suicide prevention workers across the federal and civilian enterprise – these staff on the front lines are true heroes. They have worked tirelessly to develop, implement, analyze, and benchmark suicide prevention interventions in an effort to reverse the pernicious trends in suicide rates amongst our military and veteran populations. More moving though is the heart-warming support and concern these professionals demonstrate to our military members, veterans, and their families. In this same vein, the well-intentioned strategies and programs they have put in place over the past decade are GOOD. Building resiliency

(financial, social, physical, spiritual, mental) is GOOD. Bringing all elements of society (whole of government approach) to bear is GOOD. A public health approach is GOOD. Each of these, in and of themselves, has benefited military members, veterans, and their families. However, thus far they have also collectively failed to move the needles in the required direction. In full disclosure, the authors count ourselves amongst those who have been in accountable positions, but failed to stem the tide of suicide. The question is why, or better yet, is there another approach that may yield the insight(s) we so far lack?

Now What?

Our central thesis is that most of the analysis on military and Veteran suicides has been conducted from the bottom up. In short, we place each suicide event under a microscope, gather all known data and facts, and build the mosaic of “what happened” from the thousands of after action reports. From that vast trove of data, we try to answer questions such as: what triggered the event; were there early signs of distress that were missed; what intervention would have been effective; and, why didn’t they seek help? Yet, by the very nature of the event, we can’t go back in time and obtain answers to these questions. While, on a case-by-case basis, some answers may be clear in hindsight, we haven’t gained enough insight into the problem to accurately identify those at increased risk, or at least identify the risk population down to a level actionable by today’s resources.

To break this reactive and feckless quest for answers using a bottom-up approach, we advocate for a “top down” model. Those of us whom have worked in both the DoD and VA on these issues know that both agencies have access to vast amounts of data. The data is incredibly detailed and already captured in multiple databases. How we leverage this vast data is key. If we are willing to utilize modern technology to synthesize big data and produce accurate and real-time analysis regarding suicide amongst our active duty and veteran populations, we would not only help provide more targeted information about “who” specifically is at risk within the military and veteran community but likely drive a national conversation on other public health challenges as well. Real time data aggregation on the macro level is required across military health systems, personnel data (available through the Defense Manpower Data Center – DMDC), GENESIS data alongside the veterans electronic health data, financial data, social media data, publicly available information like commodity purchase data, and maybe even location data^x.

Big Data Analytics

Put in the simplest terms, advanced predictive analytics using big data is the critical tool we must deliver to helping professionals in our fight against suicide. Predictive models must be developed using combined Metadata sources to identify early indicators of risk and this capability must be coupled with a mechanism to push alerts to helping professionals best positioned to engage in early intervention. These types of advanced analyses can be used to guide the “best care pathway” for service members and veterans. These are pathways that could be focused on non-clinical interventions, social support, financial boosters, substance abuse treatment, or mental health care while underpinned with seamless “warm handoffs” between healthcare entities. In circumstances involving active duty populations, these care pathways would logically include military leaders and should be built around existing evidence demonstrating the importance of peer support. And like their active duty counterparts, we know that veterans also thrive in situations incorporating peer support which facilitates social connectivity during a time of need.

While this may sound easy, there are significant barriers to the adoption of predictive analytics using big data. It has been tried previously, albeit with primarily medical data. Adding the various other data sources mentioned above does not guarantee success. However, we do know that the current method(s) have not worked, so

we have a responsibility as a nation to try something new. We must approach privacy in a new way for this to succeed. Normally, this would require navigating the system of System of Records Notice {SORN}, Privacy Act, Health Insurance Portability and Accountability Act {HIPAA} and Data Usage Agreements. But this system of statutes and regulations is so complex that successfully satisfying each is likely a far reach; a statute allowing for the use of this collective data may be the only avenue to success. But, the more sources of data, the more likely that patterns or risk factors become apparent. In fact, the more “Big Brother”, the higher chance of success.

We don’t discount the enormity of the challenge. Military and Veteran suicide is a national problem. Suicide prevention is a national problem. The problem is getting worse. Social distancing and the new normal will likely make the challenge more difficult. But, big problems require big solutions. What we have done for the past ten years has not produced results. One suicide is too many; 20 each day is a crisis! It is time to further harness the power of big data analytics. The price we’ll pay is some measure of privacy. The potential payoff, however, is being able to identify those at risk in ways we have not been able to thus far. If we can identify them, we can provide them the best resources this country has to offer in an attempt to reduce the number of suicides. Can we afford to just keep doing what we’ve been doing?

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- i. April 10, 2020
Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?
Mark A. Reger, PhD^{1,2}; Ian H. Stanley, MS^{1,3}; Thomas E. Joiner, PhD³
JAMA Psychiatry. Published online April 10, 2020. doi:10.1001/jamapsychiatry.2020.1060
Remarkable social distancing interventions have been implemented to fundamentally reduce human contact. While these steps are expected to reduce the rate of new infections, the potential for adverse outcomes on suicide risk is high.
Existing research suggests that sustained economic stress could be associated with higher US suicide rates in the future.
 - ii. Dr Keita Franklin was Director, USMC Suicide Prevention Office. Then RADM Kurta was Director, Military Personnel Plans and Policy for the Navy, with responsibility for the Navy Suicide Prevention Office.
 - iii. Department of Defense, Under Secretary of Defense for Personnel and Readiness, Annual Suicide Report, Calendar Year 2018, p. 34. In 2011, the annual suicide mortality rates standardized to the CY US Adult population rate data for Active Duty and Reserve components were below the US Adult population rate. The Guard rate was higher. In 2018, both the Active and Guard rates were above the US Adult population rate, with the Reserve rate roughly equal.
 - iv. Suicide Among Veterans and Other Americans 2001-2014, U.S. Department of Veterans Affairs, Office of Suicide Prevention, 3 August 2016 (Updated August 2017 by the Office of Mental Health and Suicide Prevention), p. 25.
 - v. DoD Annual Suicide Report, p.7.
 - vi. DoD Annual Suicide Report, p. 6.
 - vii. <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4064>. Signed by the president in January 2018, the executive order directs VA, the Department of Defense (DOD), and the Department of Homeland Security (DHS) to collaborate to provide, to the extent consistent with law, seamless access to mental health care and suicide prevention resources for Veterans, with a focus on the first year after separation from military service.
<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5272>. On March 5, President Donald J. Trump signed an executive order (EO) titled “National Roadmap to Empower Veterans and End Suicide.” The EO directed the Secretary of VA and the director of the White House Domestic Policy Council to co-chair and stand up an interagency task force to develop a plan implementing a roadmap for the prevention of Veteran suicide at the national and community level.
 - viii. DoD Annual Suicide Report, p. 15.
 - ix. Suicide Among Veterans and Other Americans, p. 25.
 - x. As opposed to today, where the VA classifies risk via the REACH VET protocol, which essentially bins Veterans based on medical record data only (e.g. how many appointments scheduled, how many appointments missed, etc...)

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