

Overemphasizing Communities in the National Strategy for Preventing Veteran Suicide Could Undercut VA Successes

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In June 2018, the US Department of Veterans Affairs (VA) issued its National Strategy for Preventing Veteran Suicide, 2018-2028. Its 14 goals—many highly innovative—are “to provide a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention.”¹

The National Strategy recognizes that suicide prevention requires a 3-pronged approach that includes universal, selective, and targeted strategies because “suicide cannot be prevented by any single strategy.”¹ Even so, the National Strategy does not heed this core tenet. It focuses exclusively on universal, non-VA community-based priorities and efforts. That focus causes a problem because it neglects the other strategies. It also is precarious because in the current era of VA zero sum budgets, increases in 1 domain come from decreases in another. Thus, sole prioritizing of universal community components could divert funds from extant effective VA suicide prevention programs.

Community-based engagement is unquestionably necessary to prevent suicide among all veterans. Even so, a 10-year prospective strategy should build up, not compromise, VA initiatives. The plan would be improved by explicitly bolstering VA programs that are making a vital difference.

UNDERCUTTING VA SUICIDE PREVENTION

As my recent review in *Federal Practitioner* documented, VA’s multiple levels of evidenced-based suicide prevention practices are pre-eminent in the field.² The VA’s innovative use of predictive analytics to identify and intervene with at-risk individuals is more advanced than anything available in the community. For older veterans who constitute the majority of veterans and the majority of veteran suicides, the VA has more comprehensive

and integrated mental health care services than those found in community-based care systems. The embedding of suicide prevention coordinators at every VA facility is unparalleled.

But one would never know about such quality from the National Strategy document: The VA is barely mentioned. The report never advocates for strengthening—or even maintaining—VA’s resources, programs, and efforts. It never recommends that eligible veterans be connected to VA mental health services.

The strategy observes that employment and housing are keys that protect against suicide risk. It does not, however, call for boosting and resourcing VA’s integrated approach that wraps in social services better than does any other program. Similarly, it acknowledges the role of family involvement in mitigating risk but does not propose expanding VA treatments to improve relationship well-being, leaving these services to the private sector.

The National Strategy expands on the recent suicide prevention executive order (EO) for supporting veterans during their transition from military to civilian life. Yet the EO has no funding allocated to this critical initiative. The National Strategy has the same shortcoming. In failing to advocate for more funds to pay for vastly enhanced outreach and intervention, the plan could drain the VA of existing resources needed to maintain its high-quality, suicide prevention services.

FIRST STEP: DEFINE THE PROBLEM

The National Strategy wisely specifies that the initial step in any suicide prevention effort should be to “define the problem. This involves collecting data to determine the ‘who,’ ‘what,’ ‘where,’ ‘when,’ and ‘how’ of suicide deaths.” Then, “identify risk and protective factors.”

Yet the report doesn’t follow its own advice. Although little is known about the

14 of 20 veterans who die by suicide daily who are not recent users of VA health services, the National Strategy foregoes the necessity of first ascertaining crucial factors, including whether those veterans were (a) eligible for VA care; (b) receiving any mental health or substance use treatment; and (c) going through life crises, etc. What's needed before reallocating funds to community-based programs is for Congress to finance a post-suicide, case-by-case study of these veteran decedents who did not use VA.

Proceeding in this manner has 2 benefits. First, it would allow initiatives to be targeted. Second, it could preserve funds for successful VA programs that otherwise might be cut to pay for private sector programs.

A POSITIVE STARTING POINT

There are many positive components of the National Strategy for Preventing Veteran Suicide that will make a difference. That said, they fall short of their potential. The following are suggestions that could strengthen the VA's plan.

First, given the overwhelming use of firearms by veterans who die by suicide, the National Strategy acknowledges that an effective prevention policy must attend to this factor. It prudently calls for expansion of firearm safety/suicide prevention collaboration with firearm owners, firearm dealers, shooting clubs, and gun/hunting organizations. This will help ensure that lethal means safety counseling is culturally relevant, comes from a trusted source, and has no antifiarm bias.

Nothing would be more useful in diminishing suicide than correcting the false belief among many veterans that "the VA wants to take away our guns." If that misperception were replaced with an accurate message, not only would more at-risk veterans seek out VA mental health care, more veterans/families/friends would adopt a new cultural norm akin to buddies talk to vets in crisis about safely storing guns. Establishing a workgroup with gun constituency collaborators could spearhead such a shift.

Second, although, the National Strategy emphasizes the benefits of using peer supports, peers currently express qualms that they have too little expertise intervening with this vulnerable population. Peers could be given extensive

training and continued supervision in suicide prevention techniques.

Third, the National Strategy calls for expanded use of big data predictive analytics, whose initial implementation has shown great promise. However, it fails to mention that this approach depends on linked electronic health records and therefore best succeeds for at-risk veterans within VA but not in insulated community care.

Fourth, the National Strategy recognizes that reshaping media and entertainment portrayals could help prevent veteran suicide. Yet it ignores the importance of correcting the sullied narrative about the VA. The disproportionate negative image contributes to veterans' reticence to seek VA health care. One simple solution would be to require that service members readying to transition to civilian life be informed about the superior nature of VA mental health care. Another is to provide the media with positive VA stories more routinely.

Fifth, the National Strategy suggests that enhanced community care guidelines be developed, but it never recommends that community partners should equal VA's standards. Those providers should be mandated to conduct the same root cause analyses and comprehensive documentation of suicide risk assessments that VA does.

CONCLUSION

With zero sum department budgets, the National Strategy's exclusive priority on public health, community-based initiatives could undercut VA successes. An amended plan that explicitly supports and further strengthens successful VA suicide prevention programs is warranted.

Author disclosures

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