



Testimony

Before the Subcommittee on National Security, Committee on Oversight and Reform, House of Representatives

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DOD AND VA HEALTH CARE

Suicide Prevention Efforts and Recommendations for Improvement

Statement of Alyssa M. Hundrup, Director, Health Care

GAO@100 Highlights

Highlights of [GAO-22-105522](#), a testimony before the Subcommittee on National Security, Committee on Oversight and Reform, House of Representatives

Why GAO Did This Study

In its Annual Suicide Report, DOD reported that the suicide rate for active-duty servicemembers increased over the past 6 years, reaching 28.7 per 100,000 individuals in 2020. VA has also reported rising rates of suicides among veterans, totaling 31.6 per 100,000 individuals in 2019. This rate of suicides was almost two times higher for veterans than non-veterans.

DOD and VA have taken steps to help prevent suicides among servicemembers and veterans. For example, DOD and VA both established suicide prevention strategies and created offices to oversee their suicide prevention efforts. Additionally, VA has identified suicide prevention as its highest clinical priority in its strategic plan for fiscal years 2018 through 2024.

This statement describes GAO's recent work examining DOD and VA suicide prevention efforts, including recommendations GAO made on (1) DOD's efforts to assess its non-clinical suicide prevention efforts and report data on suicides; (2) VA's use of and staffing for suicide prevention teams; and (3) VA's collection and analysis of data on suicides that occur on its campuses.

This statement is primarily based on three GAO reports issued between September 2020 and April 2021 ([GAO-20-664](#), [GAO-21-300](#), and [GAO-21-326](#)). GAO also reviewed documents from DOD and VA related to initial steps the agencies have taken to address GAO's recommendations.

View [GAO-22-105522](#). For more information, contact Alyssa M. Hundrup at (202) 512-7114 or hundrup@gao.gov.

November 17, 2021

DOD AND VA HEALTH CARE

Suicide Prevention Efforts and Recommendations for Improvement

What GAO Found

Suicide is a public health problem facing all populations, and has been a persistent and growing issue for the nation's servicemembers and veterans. The Department of Defense (DOD) and the Department of Veterans Affairs (VA) have multiple efforts underway to help prevent suicide among military servicemembers and veterans. For example:

- **DOD's** suicide prevention approach includes both clinical and non-clinical efforts intended to reduce the risk of suicide. Clinical efforts include, for example, depression and suicide-specific screening in primary care and during periodic health assessments. Non-clinical efforts include activities such as educating commanders about safe and effective messaging and reporting regarding suicide and help-seeking.
- **VA** uses suicide prevention teams at facilities to implement its Suicide Prevention Program. Such teams perform programmatic, administrative, and clinical activities ranging from tracking and reporting on veterans at high risk for suicide to conducting training, collaborating with community partners, and consulting with providers.

Since September 2020, GAO has made three recommendations to DOD and six recommendations to VA to improve the agencies' suicide prevention efforts. As of November 2021, the agencies reported that they have taken initial steps to implement most of these recommendations and GAO continues to monitor their progress. Below are examples of GAO's findings and related recommendations.

- **DOD non-clinical suicide prevention.** In 2020, DOD published a framework for assessing the collective effect of the department's suicide prevention efforts by measuring outcomes linked to specific prevention strategies. However, this framework did not provide DOD with information on the effectiveness of individual non-clinical prevention efforts, such as training. GAO recommended that DOD develop a process to ensure that individual non-clinical suicide prevention efforts are assessed for effectiveness. DOD concurred and has begun to assess how to standardize its approach for evaluating program effectiveness.
- **VA suicide prevention teams.** VA uses a benchmark to help determine facilities' suicide prevention staffing needs; however, the benchmark may not accurately reflect facilities' staffing needs and has not accounted for increasing workloads. GAO recommended that VA incorporate key practices for staffing model design into its determination of facilities' suicide prevention staffing needs. VA concurred and has taken steps to revise its existing staffing model.
- **VA on-campus suicides.** VA's process for identifying veteran suicides on its campuses (e.g., VA medical facilities) does not include a step for ensuring the accuracy of the number of suicides identified. As a result, GAO found that VA's counts of on-campus veteran suicides were inaccurate. GAO recommended that VA improve its process to accurately identify all on-campus veteran suicides. VA concurred and has initiated a process to improve its data collection efforts.

Chairman Lynch, Ranking Member Grothman, and Members of the Subcommittee:

Thank you for the opportunity to discuss our work on the Department of Defense (DOD) and Department of Veterans Affairs (VA) efforts to help prevent suicides among military servicemembers and veterans. Suicide is a public health problem facing all populations, and has been a persistent and growing issue for our servicemembers and veterans.

In its 2020 Annual Suicide Report, DOD reported that the suicide rate for active-duty military servicemembers increased over the past 6 years. From 2015 through 2020, the suicide rate among servicemembers increased by 41.3 percent, from 20.3 to 28.7 per 100,000 servicemembers.¹ Similarly, VA also reported that the suicide rate among veterans rose 35.9 percent from 2001 to 2019, from 23.3 per 100,000 veterans in 2001 to 31.6 per 100,000 in 2019.² This rate of suicide was almost two times higher for veterans than non-veterans. In total, more than 65,000 veterans have died by suicide since 2010—more than the total number of deaths from combat during the Vietnam War and the operations in Iraq and Afghanistan combined, according to a recent White House statement.³

DOD and VA have efforts underway to help prevent suicides among military servicemembers and veterans. For example, in 2011, DOD established the Defense Suicide Prevention Office (DSPO) to develop and oversee standardized policies, procedures, and surveillance activities aimed at reducing the risk of suicide in the military population; in turn, DSPO developed the Defense Strategy for Suicide Prevention in 2015,

¹See Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Annual Suicide Report: Calendar Year 2020* (Sept. 3, 2021).

²See Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report* (September 2021).

³On November 2, 2021, the White House released a national strategy that included five priority goals for reducing servicemember and veteran suicides, including increasing interagency coordination efforts. See The White House, *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy* (Washington, D.C. Nov. 2, 2021).

which established a public health approach for suicide prevention.⁴ In addition, VA has identified suicide prevention as its highest clinical priority in its strategic plan for fiscal years 2018 through 2024, and issued a National Strategy for Suicide Prevention in 2018, which identifies four areas of focus: (1) healthy and empowered veterans, families, and communities; (2) clinical and community preventative services; (3) treatment and support services; and (4) surveillance, research, and evaluation.⁵

However, our work has identified concerns with some of DOD's and VA's suicide prevention efforts. Since September 2020, we have made three recommendations to DOD and six recommendations to VA to help improve the agencies' suicide prevention efforts.⁶ The agencies have taken initial steps to implement most of these recommendations and we will continue to monitor their actions to fully address them, as well as conduct additional work related to DOD and VA suicide prevention

⁴DSPO was established in response to a recommendation from the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces to create a suicide prevention policy division. For the strategy, see Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Department of Defense Strategy for Suicide Prevention* (Washington, D.C.: Dec. 29, 2015).

⁵See Department of Veterans Affairs, Department of Veterans Affairs Fiscal Years 2018-2024 Strategic Plan (Washington, D.C.: May 31, 2019); and Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028* (Washington, D.C.: June 29, 2018).

⁶See GAO, *Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, [GAO-20-664](#) (Washington, D.C.: Sept. 9, 2020); *VA Health Care: Efforts Needed to Ensure Effective Use and Appropriate Staffing of Suicide Prevention Teams*, [GAO-21-326](#) (Washington, D.C.: Apr. 5, 2021); and *Defense Health Care: DOD Needs to Fully Assess Its Non-clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness*, [GAO-21-300](#) (Washington, D.C.: Apr. 26, 2021).

efforts.⁷ Specifically, we plan to issue three reports in 2022 related to these topics.

My testimony today summarizes key findings from our recent work examining DOD and VA suicide prevention efforts, including recommendations we have made related to:

1. DOD's efforts to assess its non-clinical suicide prevention efforts and report data on suicides;
2. VA's use of and staffing for suicide prevention teams; and
3. VA's collection and analysis of data on suicides that occur on its campuses—locations such as VA medical centers or other facilities, parking lots, and on the grounds of VA national cemeteries.

This statement is based on our recent work issued between September 2020 and April 2021 reviewing DOD and VA efforts to help prevent suicides among active-duty military servicemembers and veterans, including recommendations we made to help improve these efforts.⁸ Detailed information on the objectives, scope, and methodology of this work can be found in each issued report. This statement is also based on our review of DOD's 2020 Annual Suicide Report and VA's 2021 National Veteran Suicide Prevention Annual Report. Additionally, we reviewed documents from DOD and VA related to initial steps the agencies have taken to address our recommendations since the reports were issued. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate

⁷We currently have work underway examining topics such as the effectiveness of VA's efforts to identify veterans at high risk for suicide, VA's tracking of its suicide prevention and mental health memorandums of understanding and agreement, and suicide prevention at remote DOD installations. In addition, because of our long-standing concerns related to patient safety—the prevention of harm to patients—in the VA health care system, we placed VA health care on GAO's High-Risk List in 2015. This list identifies various recommendations we have made to help address risks to the safety, quality, timeliness, and cost-effectiveness of veterans' health care. See our most recent related report, GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas* [GAO-21-119SP](#) (Washington, D.C.: Mar. 02, 2021). In designating VA health care as high-risk, we categorized our concerns into five broad areas: inadequate oversight and accountability; ambiguous policies and inconsistent processes; information technology challenges; inadequate training for VA staff; and unclear resource needs and allocation priorities.

⁸See [GAO-20-664](#), [GAO-21-300](#), and [GAO-21-326](#).

evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

DOD Efforts to Help Prevent Suicide among Servicemembers

DOD's suicide prevention efforts are guided by its Defense Strategy for Suicide Prevention, which establishes a public health approach for suicide prevention.⁹ This approach includes both clinical and non-clinical efforts intended to reduce the risk of suicide.

- **Clinical efforts** include, for example, depression and suicide-specific screening in primary care and during annual periodic health assessments.¹⁰
- **Non-clinical efforts** include activities such as facilitating training for servicemembers in problem-solving, coping skills, and financial literacy; educating commanders and media outlets about safe and effective messaging and reporting regarding suicide and help-seeking; and disseminating fact-based suicide related information, such as the connection between access to lethal means of suicide and incurred risk of dying by suicide.

Within DOD, multiple entities are involved in suicide prevention efforts, including the reporting and surveillance of suicide data. For example:

- DSPO performs a range of policy and operational functions, including leading, guiding, and overseeing DOD's non-clinical suicide prevention efforts; and

⁹See Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Department of Defense Strategy for Suicide Prevention* (Washington, D.C.: Dec. 29, 2015).

¹⁰DOD and VA developed joint clinical practice guidelines for the assessment and management of patients at risk for suicide. See Department of Defense and Department of Veterans Affairs, *Assessment and Management of Patients at Risk for Suicide (2019)*.

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- each of the military services (Army, Navy, Air Force, and Marine Corps) develops and implements its own service-specific suicide prevention efforts that incorporate DOD-wide suicide prevention policies and requirements.

We and DOD have previously reported that perceived stigma creates an impediment to servicemembers seeking mental health care—a key component of DOD’s suicide prevention efforts. Specifically, this stigma may discourage servicemembers from seeking help for themselves or for their colleagues, including help from mental health providers, as well as from chaplains, counselors, or other non-clinical supports. For example, in 2016, we reported that a DOD-wide survey found that about 37 percent of active-duty servicemembers and 39 percent of reservists surveyed during 2010 and 2011 thought seeking mental health care through the military would probably or definitely damage a person’s career.¹¹ Specific concerns included the fear of losing a security clearance or the ability to carry a weapon, and living up to the competitive military image. DOD reports that it has efforts underway to improve perceptions about mental health care for servicemembers, such as programs that provide training to reduce stigma and public awareness campaigns to encourage help-seeking behavior.¹²

VA Efforts to Help Prevent Veteran Suicides

In 2007, the Joshua Omvig Veterans Suicide Prevention Act mandated that VA develop and implement a comprehensive program to reduce the incidence of suicide among veterans. The program was to include mandatory training for staff working with veterans to recognize suicide risk factors and respond appropriately in crisis situations, among other things.¹³ Following the enactment of this law, VA implemented various suicide prevention activities under different offices within its Veterans Health Administration (VHA).

¹¹See GAO, *Human Capital: Additional Actions Needed to Enhance DOD’s Efforts to Address Mental Health Care Stigma*, [GAO-16-404](#) (Washington, D.C.: Apr. 18, 2020). Additionally, in 2019, the Army conducted an internal epidemiological study in response to a cluster of suicides at a military installation and found that addressing concerns related to perceived stigma in seeking mental health care was important to inform risk mitigation and health promotion strategies.

¹²See Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Annual Suicide Report: Calendar Year 2020* (Sept. 3, 2021).

¹³Pub. L. No. 110-110, § 3, 121 Stat. 1031, 1031-32 (2007), codified at 38 U.S.C. § 1720F(a),(b).

In May 2017, VHA established the Office of Mental Health and Suicide Prevention (OMHSP) to consolidate mental health and suicide prevention under one office. OMHSP is responsible for (1) monitoring and supporting the implementation of mental health and suicide prevention policies and the performance of mental health programs in VHA facilities, and (2) conducting ongoing evaluations of mental health services and policies. OMHSP manages VHA's Suicide Prevention Program, which includes a variety of initiatives related to screening for suicide risk and increasing access to mental health care.

VHA's Suicide Prevention Program has grown over time, as the agency has undertaken several initiatives, including:

- **Suicide prevention teams.** Since 2007, VHA has used suicide prevention coordinators at its medical facilities to support implementation of its suicide prevention program, which was mandated by law.¹⁴ Facilities may also use suicide prevention case managers and others who share or support the duties of coordinators, which along with the coordinators collectively represent local suicide prevention teams. Although VHA's approach to veteran suicide prevention involves commitment from across the agency—including clinical providers from a variety of specialties—local suicide prevention teams serve as a focal point for suicide prevention efforts at their respective facilities.
- **Veterans Crisis Line.** In 2007, VA established the Veterans Crisis Line. The crisis line provides confidential support 24 hours per day to veterans and their families and friends through phone calls, online chat, or text message.
- **Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET).** In 2016, VA established REACH VET. This initiative uses predictive modeling to analyze existing data from veterans' health records to identify veterans at increased risk for adverse outcomes, such as suicide, hospitalization, or illness. REACH VET coordinators staffed at VA medical centers are

¹⁴The Joshua Omvig Veterans Suicide Prevention Act required VA to develop and carry out a comprehensive program designed to reduce the incidence of suicide among veterans, including designating a suicide prevention counselor at each VA medical facility other than a Vet Center. A Vet Center is a facility that is operated by VA for the provision of health care services, but is situated apart from VA general health care facilities. Pub. L. No. 110-110, § 3, 121 Stat. 1031 (2007), codified at 38 U.S.C. § 1720F. VHA provides care through various types of medical facilities, including medical centers and outpatient clinics.

to notify the appropriate VHA mental health or primary care provider when a veteran has been identified as being at high risk for suicide, using a list of high-risk veterans, which is generated monthly by REACH VET's predictive model. After REACH VET identifies veterans at high risk for suicide, VA health care providers are to contact them to determine whether they need additional care or services.

- **Standardized suicide risk identification.** In 2018, VHA began implementing a standardized suicide risk identification process (which VHA refers to as Risk ID) for all veterans receiving VHA health care. Risk ID is a two component process that includes an annual mental health screening, and a more comprehensive screening for veterans with positive initial screens.

Assessing DOD's Non-clinical Suicide Prevention Efforts and Improving Suicide Data Reporting

In our April 2021 report, we made three recommendations to address issues we identified with DOD's assessment of its non-clinical suicide prevention efforts, as well as its reporting of data on suicides among servicemembers.¹⁵

Framework for assessing suicide prevention efforts. We found that DOD had taken steps towards assessing its suicide prevention efforts, but that DOD's process does not assess the extent to which individual non-clinical prevention efforts are effective in the military population. DSPO officials estimated that most of the non-clinical suicide prevention efforts for which they have oversight are evidence based, although this has not been formally determined. DSPO officials stated that their newer efforts and pilot programs are generally considered to be "evidence informed," which means that they have demonstrated effectiveness in the civilian population, but are still being assessed in the military population. They explained that the effectiveness of suicide prevention efforts may be different for servicemembers than for civilians because servicemembers have different risk factors, including frequent moves, occupational specialties with higher likelihood of experiencing or seeing trauma, as well as exposure to actual combat.

In 2020, DSPO published a framework for assessing the collective effect of DOD's suicide prevention efforts. Specifically, the framework identifies measures for assessing outcomes linked to its prevention strategies, such as creating protective environments. Protective environments are created through activities such as providing counseling on access to lethal means and initiatives to create social norms for safe firearm storage. However,

¹⁵See [GAO-21-300](#).

this framework does not provide DOD with information on the effectiveness of individual non-clinical prevention efforts.

We recommended that DSPO collaborate with the military services to develop a process to ensure that individual non-clinical suicide prevention efforts are assessed for effectiveness, and DOD concurred with this recommendation. Having such a process would help DOD and the military services determine whether their non-clinical prevention efforts effectively reduce the risk of suicide and suicide-related behaviors.

Definitions. We also found that DOD’s military services use different definitions for key suicide-related terms, such as suicide attempt, which may result in inconsistent classification and reporting of data.¹⁶ These data are used to develop DOD’s annual suicide event report, as well as conduct surveillance on suicide and related behaviors, which can help the department develop more targeted prevention efforts. DOD officials stated that differing definitions could negatively affect the reliability and validity of the reported data, which may impede the understanding of the effectiveness of DOD’s suicide prevention efforts and limit its ability to identify and address any shortcomings. We recommended that DSPO collaborate with the military services to develop and use consistent suicide-related definitions; DOD concurred with this recommendation.

Annual suicide reports. DOD publishes two yearly suicide reports through two different offices that are based on some of the same data and provide some of the same information, resulting in the inefficient use of staff.¹⁷ While these reports serve different purposes, improved collaboration between the two offices could help minimize duplication of effort and improve efficiency, potentially freeing resources for other

¹⁶For example, the Army defines a suicide attempt as “A self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence that the individual intended to die, but the event resulted in no injuries.” The Air Force defines a suicide attempt as “Any nonfatal, self-directed, potentially injurious behavior accompanied by evidence of intent to die which as a result of the behavior, results in medical care/treatment (including mental health care) or evacuation from the Area of Responsibility. A suicide attempt may or may not result in injury.”

¹⁷The two annual reports on suicide published by the department are the DOD Suicide Event Report Annual Report and the Annual Suicide Report. See, for example, Department of Defense, *DoDSER Department of Defense Suicide Event Report Calendar Year 2019 Annual Report* (Mar. 15, 2021); and Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Annual Suicide Report: Calendar Year 2020* (Sept. 3, 2021).

suicide prevention activities. We recommended that DOD improve collaboration on its annual suicide reports to reduce duplication of effort; DOD concurred with this recommendation.

In June 2021, DOD stated that the agency had begun activities to address each of these recommendations, such as DSPO beginning discussions with the military services on how to standardize the approach for evaluating program effectiveness of service-level programs. DOD estimated that it would complete activities to address our recommendations between March and June 2022.

Ensuring Effective Use and Appropriate Staffing of VHA's Suicide Prevention Teams

In our April 2021 report, we made three recommendations to strengthen VHA's use of and staffing for its suicide prevention teams.¹⁸ Suicide prevention teams perform programmatic, administrative, and clinical activities in implementing VHA's Suicide Prevention Program, encompassing activities ranging from tracking and reporting on veterans at high risk for suicide to conducting training, collaborating with community partners, and consulting with providers.

Evaluation of and support for local suicide prevention teams. We found that VHA had added new initiatives to its Suicide Prevention Program since its inception—such as Risk ID—and as a result, suicide prevention teams' activities had increased, in particular as more veterans at risk of suicide were identified. This had created challenges, according to selected teams we interviewed. For example, team staff at one facility said they have experienced burnout and turnover due to new initiatives and a large caseload of veterans at high risk for suicide. We found that VHA had not conducted a comprehensive evaluation of suicide prevention teams, including an assessment of any challenges teams face in implementing VHA policies and the effects of program growth on teams' workload. Without such an evaluation, VHA does not have a good understanding of how its various activities and initiatives are affecting the teams, or how best to support those teams in meeting their responsibilities. This could put the suicide prevention teams—and ultimately the care they provide to the veterans they serve—at risk of falling short of the program's goal to reduce the incidence of suicide among veterans.

We recommended that VHA 1) conduct a comprehensive evaluation of its local suicide prevention teams that includes, among other things, an

¹⁸See [GAO-21-326](#).

identification of the effects of program growth on workload, as well as 2) use information obtained through such an evaluation to inform the support it provides to these teams (e.g., direction, guidance, and technical assistance). VA concurred with these two recommendations.

In August 2021, VA stated that the agency plans to use information from an ongoing study to help address our recommendations. Specifically, it stated that OMHSP, which is responsible for managing VHA's Suicide Prevention Program, plans to analyze and leverage data resulting from an internal study to address our recommendations, with a January 2022 target completion date. Additionally, the agency said that OMHSP plans to pilot a site visit process through June 2022, which among other things, would provide OMHSP with information from local teams on how to enhance the support it provides.

Suicide prevention staffing model. We found that OMHSP uses a benchmark to help determine facilities' suicide prevention staffing needs. Although facilities are responsible for making their own staffing decisions, according to the benchmark, each facility should aim to have at least one coordinator or case manager for every 10,000 unique patients the facility serves. However, we found that the benchmark may not accurately reflect facilities' staffing needs and that it was not developed according to key practices for staffing model design.¹⁹ For example, the benchmark does not account for the increasing workload of teams, such as the addition of activities related to new initiatives over time. Additionally, it does not account for risk factors, like suicide rates, that may vary among facilities.

We recommended that OMHSP incorporate key practices for staffing model design into its determination of facilities' suicide prevention staffing needs. This would better ensure facilities have appropriate staffing for suicide prevention, which would in turn help its facilities be prepared to care for veterans at risk for suicide. VA concurred with this recommendation and in August 2021 reported that the agency had taken steps to improve the accuracy of existing staffing data and revise its existing staffing model for suicide prevention teams. We are in the

¹⁹See GAO, *Federal Protective Service: Enhancements to Performance Measures and Data Quality Processes Could Improve Human Capital Planning*, [GAO-16-384](#) (Washington, D.C.: Mar. 24, 2016). The report on the Federal Protective Service describes the key practices we identified for the design of staffing models. These key practices can be used to assess staffing models generally, including a benchmark for suicide prevention.

process of assessing whether VA's actions have addressed our recommendation.

Improving the Accuracy of Data on VA On-Campus Suicides

In our September 2020 report, we made three recommendations to improve VA's efforts to address suicides that occur on its campuses.²⁰ VA first started tracking on-campus veteran suicides in 2017, in part to help inform VA leadership and Congress. According to VA officials we interviewed, they identified the need to compile such information to identify incidents amidst concerns that there may be an increasing trend. VA has undertaken several efforts to address the issue of veteran suicides occurring on VA campuses such as expanding suicide prevention training for medical facility staff. However, based on our review, we identified the following issues:

Identification of suicides. We found that VA's process for identifying on-campus suicides does not include a step for ensuring the accuracy of the number of suicides identified. Specifically, VHA did not obtain complete information or corroborate the information it obtained with other sources. As a result, the agency's numbers were inaccurate. We found errors in the 55 on-campus veteran suicides VHA identified for fiscal years 2018 and 2019, including 10 overcounts (deaths that should not have been reported but were) and four undercounts (deaths that should have been reported but were not). Without accurate information on the number of on-campus suicides, VA does not have a full understanding of their prevalence, hindering its ability to make informed strategic decisions about efforts aimed at preventing future on-campus suicides.

We recommended that VA improve its process to accurately identify all on-campus veteran suicides by ensuring that it uses updated information and corroborates information with facility officials. VA concurred with this recommendation. In September 2021, VA told us that it had drafted changes to a VA directive, requiring OMHSP notification of all veteran deaths by suicide on VA property, and had created procedures for email notification of, and corroboration by local officials of veteran deaths by suicide. VA estimated publication of the updated directive and procedures by February 2022.

Root cause analyses. We also found that VHA requires root cause analyses—processes to determine what can be done to prevent recurrences of incidents—for some, but not all on-campus veteran

²⁰See [GAO-20-664](#).

suicides. According to VHA officials, 25 percent of on-campus suicides from October 2017 to April 2019 met the criteria for a root cause analysis. VHA policy requires root cause analyses for (1) any inpatient suicide, (2) all outpatient suicides within 72 hours of discharge from status as an inpatient, and (3) all outpatient suicides within 7 days of discharge from inpatient psychiatric treatment.²¹ However, we found that VHA facilities do not conduct root cause analyses for other on-campus suicides that do not meet this criteria, such as those in which the veteran was never an inpatient, because VHA policy does not require them to do so, and, according to officials, there is no potential for system or process improvements for a root cause analysis to identify for these incidents. Limiting root cause analyses and their potential links to improvements to veterans who are or have been recent inpatients may fail to identify other at-risk veterans.

Our report recommended that VA expand the policy requirement for a root cause analysis to include all cases of on-campus veteran death by suicide, to help provide a fuller understanding of the prevalence and nature of on-campus suicides. VA disagreed with our recommendation. It stated that while it agreed with the importance of suicide surveillance, root cause analyses were not always the appropriate tool for analyzing cases of veteran death by suicide. We continue to believe that VA should perform root cause analyses for all cases of on-campus veteran death by suicide. By utilizing this existing process, VA could better ensure the consistent collection and analysis of information for on-campus suicides.

OMHSP analyses. We also reported that, according to VHA officials, OMHSP collects and analyzes information as part of its effort to identify on-campus veteran suicides and, on a monthly basis, reports information to VA leadership. OMHSP's analysis is based on VHA Issue Briefs, which we found include relevant information for analyzing on-campus veteran suicides such as the location and method of suicide and some of the veteran's clinical information. However, we found that OMHSP does not use other sources of relevant information VA collects about the veterans involved in these incidents that could strengthen its analysis, such as information from root cause analyses. It also does not use information collected through the Behavioral Health Autopsy Program—a quality improvement initiative by VHA to improve its suicide prevention efforts—among others. For example, through this program VHA conducts medical

²¹See Department of Veterans Affairs, *VHA National Patient Safety Improvement Handbook*, Veterans Health Administration Handbook 1150.01, (Washington, D.C.: Mar. 04, 2011).

chart reviews, which collect detailed information about veterans and their military and clinical histories that is not routinely collected through the VHA Issue Briefs.

We recommended that OMHSP expand its analyses of on-campus veteran deaths by suicide to include all relevant information VA collects for these incidents; VA concurred with this recommendation. In September 2021, VA stated that the agency has instituted a monthly reconciliation meeting to review data on veteran suicide deaths on VHA property from patient safety reporting, root cause analyses, and Issue Briefs. According to VA, these ongoing monthly reconciliation meetings include consideration of other opportunities for data integration and coordination to inform the agency's suicide prevention efforts. We are in the process of assessing whether VA's actions have addressed our recommendation.

In closing, suicide is an ongoing and persistent risk for military servicemembers and veterans that needs significant attention and action. Both DOD and VA have emphasized the prevention of suicide as a priority and implemented a number of steps to help prevent suicides among servicemembers and veterans. As these agencies continue their efforts, it is imperative that they fully address our recommendations. Going forward, we will continue to monitor the agencies' efforts to implement our recommendations and examine additional aspects of DOD's and VA's suicide prevention efforts.

Chairman Lynch, Ranking Member Grothman, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Alyssa M. Hundrup at (202) 512-7114 or hundrupa@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Rebecca Rust Williamson (Assistant Director) and Christina Ritchie (Analyst-in-Charge). Other contributors include Jacquelyn Hamilton and Drew Long.

Related GAO Reports

Health Care Capsule: Veterans' Growing Demand for Mental Health Services. [GAO-21-545SP](#). Washington, D.C.: May 17, 2021.

Defense Health Care: DOD Needs to Fully Assess Its Non-clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness. [GAO-21-300](#). Washington, D.C.: April 26, 2021.

VA Health Care: Efforts Needed to Ensure Effective Use and Appropriate Staffing of Suicide Prevention Teams. [GAO-21-326](#). Washington, D.C.: April 5, 2021.

High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas. [GAO-21-119SP](#). Washington, D.C.: March 2, 2021.

Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides. [GAO-20-664](#). Washington, D.C.: September 9, 2020.

VA Health Care: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation. [GAO-19-66](#). Washington, D.C.: November 15, 2018.

Veterans Crisis Line: Additional Testing, Monitoring, and Information Needed to Ensure Better Quality Service. [GAO-16-373](#). Washington, D.C.: May 26, 2016.

Human Capital: Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma. [GAO-16-404](#). Washington, D.C.: April 18, 2016.

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