GAO Highlights

Highlights of GAO-20-664, a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

September 2020

VETERAN SUICIDE

VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides

Why GAO Did This Study

VA established suicide prevention as its highest clinical priority. In recent years, there have been reports of veterans dying by suicide on VA campuses—in locations such as inpatient settings, parking lots, and on the grounds of cemeteries.

GAO was asked to review veteran deaths by suicide on VA campuses. This report examines (1) VA's process to track the number of veterans that died by suicide on VA campuses, and (2) steps VA has taken to address these types of suicides.

GAO reviewed the sources of information VHA uses to identify and analyze on-campus veteran suicides, VA and VHA strategic plans and policies related to suicide prevention and reporting, and federal internal control standards. GAO also interviewed VA and VHA central office officials, and officials from three medical facilities that GAO selected because they reportedly had on-campus veteran suicides between fiscal years 2018 and 2019.

What GAO Recommends

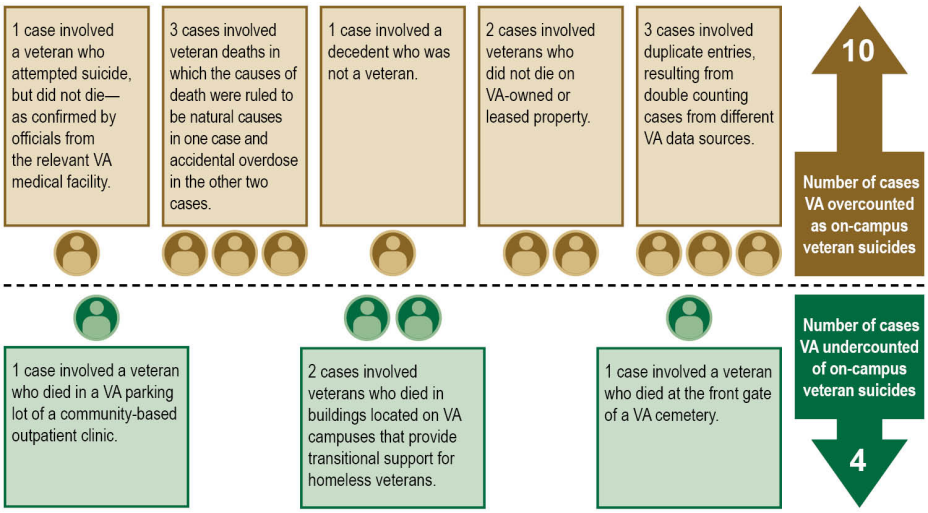
GAO is making three recommendations, including that VA improve its process to accurately identify all on-campus veteran suicides and conduct more comprehensive analyses of these occurrences. VA did not concur with one of GAO's recommendations related to conducting root cause analyses. GAO continues to believe that this recommendation is valid, as discussed in the report.

View GAO-20-664. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Veterans Affairs' (VA) process for identifying on-campus suicides does not include a step for ensuring the accuracy of the number of suicides identified. As a result, its numbers are inaccurate. VA's Veterans Health Administration (VHA) first started tracking on-campus veteran suicides in October 2017, and uses the results to inform VA leadership and Congress. GAO reviewed the data and 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).

Examples of Errors on the Department of Veterans Affairs' (VA) List of 55 On-Campus Veteran Suicides for Fiscal Years 2018 and 2019 (as of September 2019)



Source: GAO analysis of VA data. | GAO-20-664

VA has taken some steps to address on-campus veteran suicides, such as issuing guidance and staff training. However, GAO found that the analyses informing these efforts are limited. Specifically, 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 suicides. According to VHA officials, only 25 percent of on-campus suicides from October 2017 to April 2019 met the criteria for a root cause analysis.
- does not make use of all relevant information VA collects about these deaths, such as clinical and demographic data collected through other VA suicide prevention efforts. VHA officials said they could not link the different sources of information, but GAO found that selected medical facilities could do so.

Without accurate information on the number of suicides and comprehensive analyses of the underlying causes, VA does not have a full understanding of the prevalence and nature of on-campus suicides, hindering its ability to address them.