We've Got Your Back: IAVA's Campaign to Combat Suicide

Policy Division White Paper

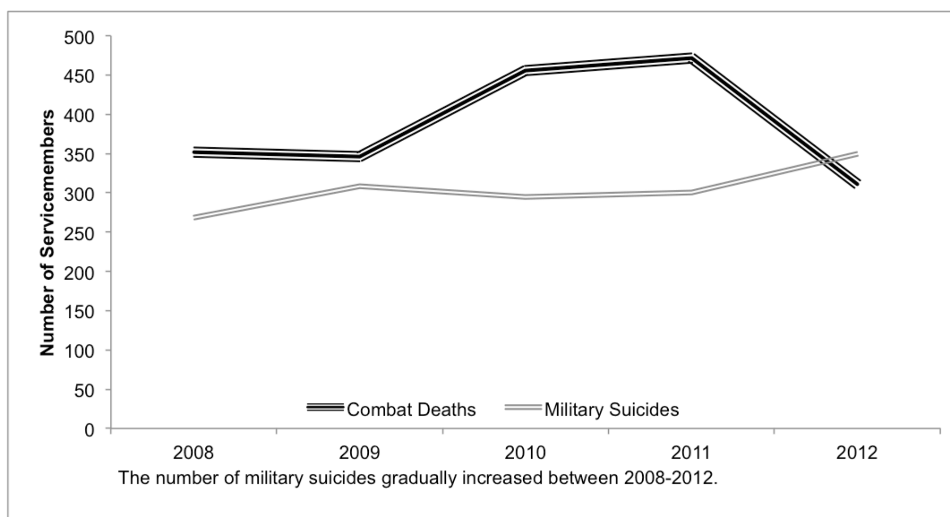
Jacqueline Maffucci, PhD

INTRODUCTION

Over 2.6 million men and women in the United States military have deployed to Iraq and Afghanistan since September 11, 2001.[1] Many of these individuals deployed more than once during their service. As of March 18, 2014, nearly 52,000 have been wounded in action and over 5,800 killed in action.[2] But these numbers do not begin to capture the invisible costs of these wars.

Tracking the number of veteran suicides is difficult because there is no central registry of veterans that identifies them as such, and not all veterans are registered with the Department of Veterans Affairs (VA). The VA, the Department of Defense (DoD) and the U.S. Centers for Disease Control and Prevention partnered to share databases to more accurately estimate this number, but it's still an imperfect system. The best estimate to date is that 22 veterans die by suicide daily[3] and more recent data suggests that the rate may be higher for veterans under 30.[4]

For those still serving on active duty, the DoD has a more accurate count of suicide numbers because they investigate all of these events. Over the last decade, the number of suicides among servicemembers slowly increased, hitting a high of 349 in 2012[5] and surpassing the number of servicemembers lost to combat.[6] Among IAVA survey respondents, nearly half reported knowing a veteran who had attempted suicide and 40 percent know a veteran that has died by suicide.[7]



The number of military suicides gradually increased between 2008-2012.

Reversing the number of suicides is a top priority for IAVA and should be the top priority of the entire American public. Combating military and veteran suicide requires a dynamic, comprehensive, community-based strategy, anchored around this simple fact: research shows that asking for and receiving help works. The same data that suggest at least 22 veterans a day take their own lives also show that those enrolled in VA healthcare have a lower rate of suicide than non-VA users.[8] Yet only 58 percent of new veterans are enrolled in VA healthcare[9] and some veterans are not eligible for care at the VA. Studies also show that the weeks immediately following a suicide attempt are a critical period for decreasing the risk for another attempt.[10] In short, veterans and their families need access to quality care that will support them when they are at their most vulnerable, the knowledge to know when to use that care, and the network available to ensure continuous care no matter what their status. And the solutions lie not only with the VA, but with community partners, private providers and other government agencies (federal, state and local) as well.

There are actions that can be taken right now to help address suicide in the military and veteran communities, and there are actions that will require further research, careful planning, and strategic execution. Those actions center on *IAVA's Six Principles of Excellence for Combating Suicide (AC5)*:

1. **Access** to high quality care.
2. **Capacity** to support the demand of U.S troops and veterans.
3. **Care** that is based in evidence and of the highest quality.
4. **Crisis** recognition to proactively identify those at risk and provide immediate intervention.
5. **Continuity** that ensures no servicemember or veteran is lost in the system on the road to recovery.
6. **Community** support to ensure that the troops and veterans have a network of care and a nation behind them during their journey and throughout their lives.

THE POPULATION

Of the more than 2.6 million men and women who have deployed in support of the wars in Iraq and Afghanistan, most coming home transition back into the civilian population with minimal challenges; approximately 44 percent report experiencing some transition difficulties, ranging from difficulties in finding employment to struggling with invisible injuries.[11] IAVA's survey respondents reported employment and mental health issues as among their top challenges when transitioning out of the military.[12] While these invisible injuries can improve with medical intervention, they can pose a challenge to employment, education and social interactions.

Challenges from deployment can lead some troops and veterans to consider suicide, but approximately one third of military suicides are completed by servicemembers who have never deployed.[13] New research suggests that one in five soldiers had a mental health issue even before entering military service.[14] Multiple studies suggest that the factors that put a person at risk for suicide in the civilian world are similar to those that put a servicemember or veteran at risk. These include relationship challenges, financial concerns, law enforcement encounters and mental health injuries.[15]

Some populations of troops and veterans face unique challenges. The wars in Iraq and Afghanistan relied heavily on members of the reserve component with nearly 33 percent of the deployed forces made up of the Reserve Component.[16] Reserve component servicemembers often lack the continued access to care that active duty service members have. When they return home, they might experience a greater sense of isolation returning directly back into their community rather than returning to a military installation with their unit. Programs like the Yellow Ribbon Reintegration Program have helped to fill these gaps, and community-based programs and providers can help to do this too.

Additionally, about 15 percent of military personnel are female.[17] the highest number to date and the number of female servicemembers will only continue to grow. For female servicemembers transitioning out of the military, seeking care at the VA can be daunting given that VA services have only recently begun to focus in on the specific needs and injuries of women veterans. While much improved over the last few years, there are still gaps in care, particularly for mental health needs and there remain challenges for veterans seeking care who also require child care services. As the VA works to improve their women's health care, community and private providers should also step in to fill the gaps.

Regardless of these unique challenges, the entire veteran population deserves high quality, timely access to care to support the injuries that they sustained as a result of their service. Suicide is a complex issue that requires a comprehensive, community-based approach for prevention. And it begins with six principles.

IAVA'S SIX PRINCIPLES TO COMBAT SUICIDE

ACCESS: Servicemembers and Veterans need access to quality mental health care whenever they seek it.

When troops or veterans are ready to seek help, they must have access to services that will support them. While some veterans may have healthcare insurance from their employers or may choose to seek care from private or community providers, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) provide services for a significant proportion of the military and veteran community. Among IAVA survey respondents, only 21.5 percent use private insurance exclusively. Seventy-seven percent stated they used TRICARE, VA care, or one of these options supplemented by private healthcare.[18]

Current law allows combat veterans to enroll for free health care through the VA for five years from their date of discharge as long as they were discharged under other than dishonorable conditions.[19] This may not be long enough to protect veterans who may present with symptoms later, may not recognize symptoms immediately, or might delay care due to stigma. Studies support that delayed onset of post-traumatic stress disorder (PTSD) frequents about 25 percent of PTSD cases.[20] For Vietnam era veterans, research suggests that diagnosis may be delayed anywhere from 7-12 years.[21] In other cases, it might take time for the veteran to recognize that they either have a mental health injury or are ready to seek help for that injury. Extending access to VA care from five to fifteen years will ensure that veterans have access to care when they seek it.

Further, our most vulnerable veterans should not be left without access to care at their moment of need. Those discharged under dishonorable conditions do not have the option of this five-year eligibility period. However, in some cases they might be the ones with the most need. Between 2001-2011, an estimated 30,000 servicemembers were dishonorably discharged due to a possible misdiagnosis of personality disorder.[22] An additional unknown number have been discharged for disciplinary problems that could have been related to an undiagnosed mental health condition. For example, symptoms such as dizziness and trouble sleeping that commonly appear with mental health issues might interfere with the ability to perform job functions, including attention to detail, standing at attention or other normally simple tasks. There are also those suffering with post-traumatic stress disorder, depression, or traumatic brain injury who might also self medicate with alcohol to lessen the symptoms. We need to first determine how many fall into this category, and then correct this wrong to make sure they have access to care.

CAPACITY: Mental health services must be able to meet the demand of troops and veterans.

Access to care is meaningless if the system does not have the capacity to support veterans that are seeking care. Currently 58 percent of Iraq and Afghanistan veterans are enrolled in VA care. Fifty-five percent of those enrolled have been diagnosed with a mental health injury.[23] Between FY 2006-2010, the number of veterans receiving mental health care increased from an annual 900,000 veterans to 1.2 million, with Iraq and Afghanistan veterans making up an increasing number of that demand.[24]

With the nearing end of the war in Afghanistan and expected troop drawdowns, the population of new veterans over the next few years will continue to increase and demand on the VA system and non-VA systems will grow. We need scalable, high quality solutions now to ensure that these veterans will have access to care when they most need it.

There is an urgent shortage of mental health care providers, not just in the VA, but also across the entire U.S. healthcare system. Currently, the VA has approximately 1,000 mental health care positions open.[25] As of January 1, 2014, nationwide there were over 3,900 designated mental health shortage areas, defined as areas or populations that have a shortage of mental health professionals identified.[26] Such an extensive nationwide shortage is already affecting the veteran population.

Not all veterans seek care from the VA, nor are all veterans eligible for care at the VA. In part, some veterans choose not to seek care from the VA because the VA system has its own set of challenges. Shortages in providers can lead to lengthy wait times for an appointment. Of IAVA's survey respondents reporting they sought mental health care from the VA, 64 percent reported challenges with scheduling appointments.[27] The VA has set a goal of a maximum 14-day wait time for a first-time patient to receive a mental health evaluation. A 2012 Inspector General (OIG) report found that the VA met this goal for only 49 percent of its first-time patients. The average wait time for the remaining 51 percent was 50 days.[28] The network of care needs to be able to support demand, and support it in a timely way.

In order to meet the demands of the veteran population, the VA needs to fill its open positions and strive to meet the growing demand for mental health specialists. Psychiatrists are among the most in demand; the 2012 OIG report found that 71 percent of mental health professionals said that their facility did not have enough mental health staff to meet the needs of their patients, and the greatest challenge was hiring and retaining psychiatrists.[29] Congress can help to address this shortage by funding additional psychiatric residency slots. The President can help by issuing a national call to action to rally public and private resources to address military and veteran suicide, including a specific call to action for civilians to pursue careers in mental health professions. Beyond this, the VA is competing with other Federal agencies and private providers that can offer more generous incentives for new hires. A variety of incentives, including bonuses, competitive salaries and loan repayment plans can all help to recruit talented providers, and the VA should be able to offer these competitive incentives.

Expanded peer-to-peer programs can also help combat the shortage of mental health professionals. Particularly with mental health challenges, peer mentoring is fast becoming an effective mechanism to combat stigma and encourage help seeking.[30] Vet centers are an often-underutilized VA resource, but one where peer-to-peer support is often offered and generally well received. A program that encourages and supports veterans entering mental health professions would help grow the field with providers who are culturally sensitive and can relate even further with veterans seeking help.

It's important that TRICARE can also support the mental health needs of our servicemembers.[31] Currently the number of civilian mental health providers that offer TRICARE and are accepting new patients is limited.[32] For civilian providers not accepting new TRICARE patients (61 percent for the mental health providers surveyed), the most common reason is that they don't know that it exists. For those who take TRICARE but aren't accepting new patients, it's primarily because of reimbursement concerns.[33] This is particularly important for National Guard and Reserve servicemembers, who may not have access to an on base facility. Additionally for this population, the program to embed behavioral health professionals is not funded completely.

This adds another challenge for the Reserve Component because without an embedded provider readily available, servicemembers may have more challenges gaining access to care and may be less likely to seek care.

CARE: Troops and veterans deserve evidence-based, high quality mental health programs

Veterans deserve the highest quality of mental health care and yet, there is little to no evidence to show that the programs set up to prevent suicide or support psychological health are actually working.[34] Quality care is: (1) based in evidence (research), (2) safe (benefits far outweigh the risk), (3) timely (delays are avoided), (4) efficient (avoids wasting resources) and (5) equitable (available to all). [35] In 2008, the RAND Corporation published a groundbreaking report emphasizing the need for quality care for the invisible wounds of war, highlighting the gaps in existing care and projecting the cost if the U.S. opted not to make changes to the system to provide this care.[36] In 2013, the Defense Suicide Prevention Office announced that it had identified over 900 DoD programs related to suicide prevention.[37] In a parallel effort, the RAND Corporation identified 226 DoD programs involved with addressing psychological health and Traumatic Brain Injury (TBI).[38] Regardless of the actual number, what is clear is that although there are hundreds of DoD programs and billions of dollars being spent to support these programs, there is little to no data to show whether these programs are effective.[39] Far too many of these programs have neither established goals, nor outcomes to measure their success. Unfortunately, the inability to measure the effectiveness of programs in the DoD is mirrored by the inability to measure effectiveness of programs at VA.[40]

Part of the challenge in determining whether existing programs are effective is determining exactly what effective means and standardizing it across the board. The DoD, VA, and the Department of Health and Human Services, should lead the charge in using established research to standardize measures that evaluate existing programs to support psychological health, suicide prevention and intervention efforts. Further, future funding for programs should require that programs regularly evaluate their efforts and continually integrate improvements based on new research and these evaluations.

The private sector can also pave the way through example and philanthropy by funding programs that are evidence-based and rigorously evaluated. This will not only show the effectiveness of this process, but can also contribute quality programs to support veterans that can then be shared with and adopted by public agencies. Vets Prevail is a great example of this. It began as a small, privately funded initiative to deliver cognitive based therapy to veterans online, and through proven effectiveness expanded to partner with other organizations, including the VA. IAVA's Rapid Response Referral Program (RRRP) is another example of a privately funded program with the potential to expand as a proven model of service. This program, started in December 2012 in New York and recently expanded to California, provides free, confidential case management and referral services to new veterans navigating transition challenges in those areas.

These private sector initiatives also highlight potential best practices outside the DOD and VA. Sharing best practices across the network of care and between the DoD and VA is vital to providing high quality, evidence-based care. But no proven, proactive mechanisms exist within the VA and DoD to do this easily.

Currently, the VA and DoD use an internal website that programs can access to share and review best practices. The DoD and VA must develop more interactive mechanisms with a more proactive approach. This can be through a combination of solutions, including internal "sabbaticals" where employees can travel to other VA centers to train staff, more proactive use of technology and relationship building between the public and private sector such as funding the joint DoD/VA Suicide Prevention Conference to ensure that researchers, policymakers and the private sector have opportunities to interact and exchange ideas.

This is about coming together as a community to provide scalable solutions and improve the quality of care offered to our veterans. Research and evaluation is required to identify quality care; once identified, partnerships are necessary to expand those practices to the veteran that need the support.

CRISIS: Troops and veterans in crisis deserve proactive, effective support programs

A proactive approach to identifying and caring for troops and veterans in crisis can help lower the suicide rate. Since 2007, the Veterans Crisis Line has answered 1.1 million calls and saved 35,000 lives.[41] It has expanded to support online chats and texting capabilities, and continues to expand its partnerships to become the default crisis line for veterans. This program is a great example of effective identification and support of troops and veterans in crisis.

One of the most important pieces to preventing suicide is being able to identify the risk factors. Research into suicide prevention is still in its infancy. The DoD and VA have allotted over $100 million for its suicide prevention research portfolio, including $65 million for the five year long Army Study to Assess Risk and Resilience in Servicemembers (STARRS) project to identify suicide risk factors in Army soldiers.[42] This kind of research is necessary to enable better recognition of risk factors before an individual chooses suicide.

This research also informs training, so that first responders can better intervene. Among servicemembers and veterans, between 75-80 percent have sought care from a provider within four weeks of attempting suicide.[43] This is a critical time to identify those at risk and informed suicide prevention training is a necessity for doing that successfully. At the VA, from the moment a veteran walks in the door, every staff member should be trained to identify warning signs and have a standard operating procedure to ensure that veteran gets immediate care. Further, every veteran coming to the VA in crisis should be immediately identified and given support.

CONTINUITY: No troop or veteran should fall in the cracks between programs and services

The VA system requires voluntary participation and not all veterans use the VA system. While systems are in place to educate separating servicemembers on VA benefits and healthcare, there is no mechanism to proactively identify a servicemember in treatment for a mental health injury and transition them to the VA.

The challenge to continuity is two-fold. First, for those transitioning who opt not to seek VA care, there is a challenge to ensure that the community, or the VA, is empowered to proactively reach out to them and support them. Second, for those who do transition to the VA, they might experience challenges in maintaining quality mental health care through the transition.

IAVA's 2014 policy survey respondents ranked difficulty transitioning to VA benefits/services as the third biggest challenge they experienced when transitioning out of the military.[44] The DoD and VA can smooth these processes immensely, in part through more efficient information sharing.

Currently the DoD and VA use different systems to manage electronic medical health records. Creating an integrated system of electronic health records is one way to ease the transition between these systems of care. After spending over a billion dollars, the DoD and VA abandoned this effort in 2013 to pursue separate, interoperable technologies.[45] Achieving even this will be delayed for years, as the DoD announced that it will not be launching its new electronic health system until FY 2017.[46] Further, a recent GAO report found that the proposed separate technologies do not appear to be on track to accomplish the initial goal to enable an easier transition from the DoD to VA.[47]

Even cost saving mechanisms, such as coordinating the DoD and VA drug formulary so that servicemembers transitioning to the VA can transition with the same prescription drugs, are not in place. This is particularly important for anti-anxiety medications, anti-depressants and other prescription drugs that support mental health. Finding a drug that works to relieve symptoms associated with these conditions can take time and changing that regimen once established can be risky and decrease the quality of care. Continuity of care is vital as the servicemember transitions to the VA.

Finally, all too often veterans anecdotally report high turnover among mental health providers at the VA. Veterans may lose their provider with little to no warning and often there is no system in place to transfer their care. It's important for patients to feel comfortable with their doctors. Because of the nature of invisible injuries, it might take multiple tries for a veteran to even find a provider with whom they are comfortable. Procedures should be put in place to require a minimum 30-day notice as a provider is leaving and a warm handoff should be established between the current and future provider to ensure continuity of care.

COMMUNITY: The entire American community must be involved in encouraging troops and veterans to seek care

Veterans struggling with mental health issues should not struggle alone. Recognizing symptoms and asking for help can be difficult, but that step can be made much easier with a network of support. Seventy-seven percent of IAVA members who had someone close to them recommend they seek help took the advice and sought out mental health care as a result.[48] The entire community must be able to recognize the signs and proactively rally around these individuals to let them know that getting help is a sign of strength and it works. That community must also have services to support the veteran. This falls to private providers and hospitals to educate themselves on veteran specific issues; non-profit agencies and the private sector to provide additional resources outside of the VA to contribute to the network of care; employers to actively seek veterans for employment, recognizing this population for the leaders that they are and the talent that they bring; and the government to appoint an official to lead the efforts to coordinate suicide prevention and mental health programs across agencies and proactively develop that network of high quality care that our veterans deserve.

The community as a whole needs to change the way it thinks and talks about mental health. According to the World Health Organization, 25 percent of Americans right now have a mental health diagnosis and 50 percent will have one at some point in their lifetime.[49] Mental health care should be a part of our normal care regimen. While the VA is an important contributor to providing care for veterans, it should not take on the burden alone. There needs to be a cohesive, comprehensive, and well funded network of care between VA, private health care and community based non-profits who supplement the care provided by the VA.

The stigma of seeking help can be difficult to overcome. Of those respondents to IAVA's policy survey who said that they had a mental health injury but were not seeking care, the majority was concerned about the perceptions of their peers and loved ones as well as the impact on their jobs.[50] In FY 2012, veterans represented 30 percent of the federal workforce.[51] For those servicemembers and veterans whose jobs require security clearance, there remains a misperception that seeking mental health care for a service-connected injury might impact this process. Federal employers must play a more active role in ending this misconception once and for all.

Further, while most states in the U.S. have decriminalized suicide attempts, recognizing that these individuals need medical care not incarceration, the military has yet to do the same. While rarely acted upon, the language in the Uniform Code of Military Justice criminalizing suicide attempts has yet to be removed. This adds to the stigma of help seeking when suicidal thoughts arise.

Prevention and intervention relies on a nationwide acceptance that mental health and mental health care are a part of an every day health regimen. Daily preventative maintenance is key. It's time to change the conversation surrounding mental health and recognize that just like we go to the doctor for a flu shot because there is a risk each year that we might get the flu, seeing a doctor to check in on our mental health is a way to identify and prevent more serious issues later on, including suicide risk.

CONCLUSION

It is important to recognize that the DoD and VA have put a good deal of effort into suicide prevention efforts over the last few years. When IAVA asked its members to rate how DoD and VA are handling the issue of suicide, only 10 percent of IAVA survey respondents felt the DoD was not playing a role and only eight percent said the same for the VA. Approximately a third felt both agencies were being proactive in their efforts.[52] However, there is still *enormous* work to be done, and that work requires a strategic, comprehensive and community based approach to combating suicide. Some of these changes can happen now, some require a more long-term approach, but all of these solutions fall within IAVA's six principles of excellence: access, capacity, care, crisis, continuity and community. Congress, the President, the DoD, the VA and the nation overall must commit to these principles and together work to support our servicemembers and veterans as they transition home.

ENDNOTES

[1] The Institute of Medicine. (2014). Preventing Psychological Disorders in Servicemembers and their Families. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2013/Returning-Home-Iraq-Afghanistan/Returning-Home-Iraq-Afghanistan-RB.pdf
[2] https://www.dmdc.osd.mil/dcas/pages/casualties.xhtml
[3] Kemp, J., & Bossarte, R. (2013). *Suicide Data Report: 2012*. Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program. Retrieved from http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf
[4] Kemp, J. (2014). *Suicide rates in VHA patients through 2011 with comparisons with other American and other veterans through 2010* [Powerpoint Slides]. Retrieved from http://www.mentalhealth.va.gov/docs/Suicide_Data_Report_Update_January_2014.pdf
[5] Zoroya, G. (2014, January 31). Suicides in the Army decline sharply. *USA Today*. Retrieved from http://www.usatoday.com/story/news/nation/2014/01/31/suicide-----military----army----numbers-----decline/5057337/
[6] https://www.dmdc.osd.mil/dcas/pages/main.xhtml
[7] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[8] Kemp, J. (2014). *Suicide rates in VHA patients through 2011 with comparisons with other American and other veterans through 2010* [Powerpoint Slides]. Retrieved from http://www.mentalhealth.va.gov/docs/Suicide_Data_Report_Update_January_2014.pdf
[9] Department of Veterans Affairs. (2013). Analysis of VA Health Care Utilization Among OEF/OIF/OND Veterans: Cumulative from 1st Qtr FY 2002 through 3rd Qtr FY 2013. Retrieved from http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2013-qtr3.pdf
[10] Department of Veterans Affairs Office of Inspector General. (2013). Evaluation of Mental Health Treatment Continuity at Veterans Health Administration Facilities (Report 13-01742-188). Retrieved from http://www.va.gov/oig/pubs/VAOIG-13-01742-188.pdf
[11] The Institute of Medicine. (2014). Preventing Psychological Disorders in Servicemembers and their Families. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2013/Returning-Home-Iraq-Afghanistan/Returning-Home-Iraq-Afghanistan-RB.pdf
[12] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[13] Schoenbaum, M. et al. (2014, March 3). Predictors of Suicide and Accident Death in the Army Study to Assess Risk and Resilience in Servicemembers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), *JAMA psychiatry*.
[14] Kessler, R. C. et al. (2014). Thirty-Day Prevalence of DSM-IV Mental Disorders Among Nondeployed Soldiers in the US Army: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA psychiatry*. Retrieved from http://archpsyc.jamanetwork.com/article.aspx?articleID=1835338&utm_source=Silverchair%20Information%20Systems&utm_medium=email&utm_campaign=JAMAPsychiatry%3AOnlineFirst03%2F03%2F2014
[15] Ibid.
[16] The Institute of Medicine. (2014). Preventing Psychological Disorders in Servicemembers and their Families. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2013/Returning-Home-Iraq-Afghanistan/Returning-Home-Iraq-Afghanistan-RB.pdf
[17] Ihttp://www.statisticbrain.com/women-in-the-military-statistics/
[18] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[19] Department of Veterans Affairs. (2013). Combat Veteran Eligibility (IB 10-438). Retrieved from http://www.va.gov/healthbenefits/resources/publications/IB-10-438_Combat_Veteran_Eligibility2-13.pdf
[20] Smid, Geert E. et al. (2009). Delayed posttraumatic stress disorder: Systematic review, meta-analysis, and meta-regression analysis of prospective studies. *J Clin Psych*. 70(11): 1572-1582.
[21] The Centers for Disease Control Vietnam Experience Study. (1988). Health status of Vietnam veterans. I. Psychosocial characteristics. *JAMA. 259(18):2701-7.*
[22] Ader, Cuthbert et al. (2012). ***Casting Troops Aside: The United States Military's Illegal Personality Discharge Problem***. Retrieved from http://www.vva.org/PPD-Documents/WhitePaper.pdf
[23] Department of Veterans Affairs. (2013). Analysis of VA Health Care Utilization Among OEF/OIF/OND Veterans: Cumulative from 1st Qtr FY 2002 through 3rd Qtr FY 2013. Retrieved from http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2013-qtr3.pdf
[24] Government Accountability Office. (2011). VA Mental Health : Number of Veterans receiving Care, Barriers Faced and Efforts to Increase Access (GAO 12-12). Retrieved from http://www.gao.gov/assets/590/585743.pdf
[25] Search on USAJobs.gov for mental health care providers at the VA, March 5, 2014.
[26] http://www.hrsa.gov/shortage/
[27] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[28] Veterans Health Administration Office of the Inspector General. (2012). Review of Veterans' Access to Mental Health Care (Report 12-00900-168). Retrieved from http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf
[29] Ibid.

[30] Keller, R. T., Greenberg, N., Bobo, W. V., Roberts, P., Jones, N., & Orman, D. T. (2005). Soldier peer mentoring care and support: bringing psychological awareness to the front. *Military Medicine*, *170*(5). Retrieved from http://www.kcl.ac.uk/kcmhr/publications/assetfiles/deployment/Keller2005-soldierpeermentoring.pdf
[31] TRICARE is the health care program that covers service members and their families, both within military treatment facilities and across private providers.
[32] Government Accountability Office. (2013). TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries (GAO13-364). Retrieved from http://www.gao.gov/products/gao-13-364
[33] Ibid.
[34] The Institute of Medicine. (2014). *Preventing Psychological Disorders in Servicemembers and their Families*. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2013/Returning-Home-Iraq-Afghanistan/Returning-Home-Iraq-Afghanistan-RB.pdf
[35] Taneilian, T. and Jaycox L.H. (Eds.). (2008). *Invisible Wounds of War*. Santa Monica, CA: Library of Congress.
[36] Ibid.
[37] Testimony before the House Armed Services Committee Subcommittee on Military Personnel, 113th Congress (2013, March 6) (testimony of Ms. Jacqueline Garrick, LCSW-C). Retrieved from http://docs.house.gov/meetings/AS/AS02/20130321/100277/HHRG-113-AS02-TTF-GarrickJ-20130321.pdf
[38] Ramchand, R. et al. (2011). The War Within: Preventing Suicide in the U.S. Military. RAND Corp.: Santa Monica, CA. Retrieved from
[39] The Institute of Medicine. (2014). Preventing Psychological Disorders in Servicemembers and their Families. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2013/Returning-Home-Iraq-Afghanistan/Returning-Home-Iraq-Afghanistan-RB.pdf
[40] Bagalman, E. (2013, January 10). *Suicide Prevention Efforts of the Veterans Health Administration*, Congressional Research Service. Retrieved from http://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG953.pdf
[41] http://veteranscrisisline.net/About/Default.aspx
[42] Gutierrez, P.M. (2012, April 20) Status of Department of Defense Funded Suicide Research [Powerpoint Presentation]. American Association of Suicidology. Retrieved from http://www.mirecc.va.gov/visn19/presentations/docs/Status_of_Department_of_Defense_Funded_Suicide_Research_Dr_Fitek.pdf
[43] Suicide Data Report 2012, Medical Surveillance Monthly http://www.afhsc.mil/viewMSMR?file=2012/v19_n02.pdf
[44] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[45] *Testimony before the Joint House Armed Services Committee and Veterans' Affairs Committee,* 113th Cong. (2013, July 10) (Testimony of The Honorable Frank Kendall).
[46] Bruin, B, (2013, November 19). Pentagon health records not ready until 2017… at least. Retrieved from http://www.defenseone.com/management/2013/11/pentagon-electronic-health-records-not-ready-until-2017-least/74153/?oref=d-skybox?oref=d-interstitial-continue.
[47] Government Accountability Office. (2014). VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans and Improve Collaboration (GAO 14-302). Retrieved from http://www.gao.gov/products/GAO-14-302
[48] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[49] Center for Disease Control and Prevention. Retrieved from http://www.cdc.gov/Features/MentalHealthSurveillance/
[50] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.
[51] United States Office of Personnel Management. (2013). Employment of Veterans in the Federal Executive Branch, FY 2012. Retrieved from http://www.fedshirevets.gov/hire/hrp/reports/EmploymentOfVets-FY12.pdf
[52] IAVA 2014 Member Policy Survey Preliminary Findings, Unpublished.

About IAVA
Iraq and Afghanistan Veterans of America (www.IAVA.org) is the nation's first and largest nonpartisan, nonprofit organization representing veterans of Iraq and Afghanistan and has more than 270,000 Member Veterans and civilian supporters nationwide. Celebrating its tenth year, IAVA recently received the highest rating – four stars – from Charity Navigator, America's largest charity evaluator.

About IAVA's Campaign to Combat Suicide
Every year IAVA asks its members through an annual policy survey to rank the issues most important to them, and mental health and suicide continue to top the list. The Campaign to Combat Suicide is a result of the priorities of our members, ten years of experience as advocates for this new generation of veterans and programs like IAVA's Rapid Response Referral (RRRP) that arose as a result of an identified need in the veteran community. For more information on the campaign and IAVA's Storm the Hill 2014, please access www.IAVA.org. For a more comprehensive list of IAVA's policy priorities to combat suicide, and other areas, please refer to IAVA's 2014 Policy Agenda.

About the Author
Jacqueline Maffucci, PhD is the Research Director at Iraq and Afghanistan Veterans of America. She holds a Bachelor of Science from Cornell University and a Doctorate of Philosophy in Neuroscience from The University of Texas at Austin. Prior to her position at IAVA, Dr. Maffucci spent nearly four years as a consultant for the Pentagon focusing on behavioral health policy for the Army, including two years as a liaison for the Army Health Promotion, Risk Reduction, Suicide Prevention Task Force. She is also the former Editor-in-Chief for The Journal of Washington Academy of Sciences.