Policy to lower veteran suicide rates

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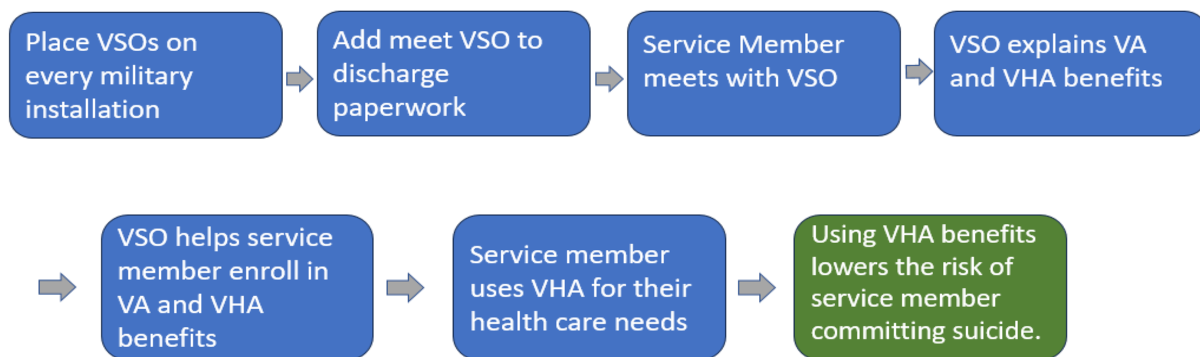
Description of the policy problem

In 2020, an average of 16.8 Veterans died by suicide daily (VA, 2020). In 2022, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults. Veterans are dying by suicide at higher rates than the average American (DeAneglis, 2022). Male veterans have a suicide rate of 36.0 per 100,000 compared to the male non-veteran population of 21.4 per 100,000. For female veterans, the rations are 34.6 per 100,000 commit suicide compared to 5.4 per 100,000 (Hoffmire et al., 2015), meaning female veterans are 84.4% more likely to commit suicide than non-female veterans.

Veterans enrolled in and using their health care benefits provided by the Veteran Health Administration (VHA) have a significantly lower risk of suicide (Dursa et al., 2016; VA, 2022). When comparing the VA hospital to outside resources such as private doctors or private counseling services, the VHA still outperforms these sources in lowering suicide rates (Basham et al., 2011; O'Hanlon et al., 2016). VHA healthcare providers have a better understanding of military culture, as all employees must understand military culture training (U.S. Department of Health & Human Services, 2023). The VHA ranks high in mental health can and outperforms many private hospitals in patient safety in avoiding illness and injury during and after surgical operations. The VHA also outperforms many private hospitals in outpatient care, medication management, and availability of services for cancer care and women's health (O'Hanlon et al., 2016). The most common reason (48.5%) veterans do not seek treatment at the VHA is that they do not know they are eligible or qualified for care and services at the VHA, claiming they were never told. An additional 26% mentioned they did not know how to apply (Dursa et al., 2016; Washington et al., 2006; Wittrock et al., 2014).

Since being enrolled in and using VHA benefits lowers a veteran's chance of committing suicide, I propose that increasing enrollment in VA services will lower suicide rates even more. My intervention takes place at the point when a service member becomes a veteran.

Theory of change



My theory of change starts with placing Veteran Service Officers (VSOs) on all military installations. No VSOs are currently working on military bases (VA, 2020). A VSO is a veteran's primary point of contact when dealing with the Department of Veterans Affairs (VA). A VSOs job is to explain the benefits the VA has available to you; How long you served in the military and discharge conditions determine your benefits. VSOs can also assist you in trying to increase the VA benefits you receive; A VSO will assist you in enrolling for VA health benefits and can put you in contact with a VA hospital and help you find a doctor. VSOs operate at many VA hospitals, so they can physically walk you to the appropriate departments you require for the best care access.

Service members transitioning into civilian life experience the highest rates of suicide during the first four years (Reger et al., 2014). Meeting with a VSO and finding the resources

available for new veterans can help alleviate many difficulties a new veteran might experience during their transition to civilian life.

The VA employs VSOs, and it is their job to represent a veterans case and claims to the VA. Placing VSOs on every military installation will allow service members and veterans easy access to a VA representative who can answer their questions and assist them with VA inquiries. Currently, no VSOs are operating from a military installation (VA, 2020).

The next step in my theory of change is requiring service members transitioning out of military service to attend a meeting with a VSO; to achieve this, I will add a VSO meeting to the out-processing paperwork required to leave military service.

The out-processing paperwork consists of a checklist of departments and steps the service member must visit before exiting the service. Typical steps are turning in your military gear and updating your banking information with the finance department.

Once the service member completes the task, they will receive a stamp or signature on their checklist showing it is complete. I would add an extra step to this paperwork requiring a visit with a VSO who will explain what the VA is, what benefits are available to them, and how to access these benefits.

A service member meeting with a VSO will presumably help reduce the lack of education or knowledge that they are eligible for benefits. Lack of knowledge is the leading cause of veterans not enrolling in their VHA benefits (Dursa et al., 2016; Washington et al., 2006).

When a VSO meets with a service member, they can take the time to explain all the benefits available to them. The benefits will vary from one service member to another based on length of service and discharge rating. Service members who receive a dishonorable discharge are ineligible to receive benefits from the VA. Most service members receive honorable discharge ratings and can access VHA and education benefits such as the GI Bill and the VA Home Loan.

If you are looking for a doctor at a VHA hospital, a VSOs can connect you to a primary care team. VSOs operate from VHA hospitals and can personally walk with you so you can meet your new doctor and primary care team.

By meeting with a VSO, the service member can enroll in the VA system. Service members can file their own claims with the VA; however, in 2019, the VA processed 1,289,274 claims for compensation and pension benefits. Of those, 515,891 claims were denied, resulting in a denial rate of approximately 40% (VA, 2019). The most common reasons for the denial are failure to provide adequate evidence, failure to provide nexus to service-connected injury, failure to complete required forms correctly, and the wrong or outdated forms (VA, 2020). The VA claims website states that It is essential to consult with a Veterans Service Officer (VSO) or a legal professional specializing in veterans' benefits to understand the specific requirements and evidence needed for a successful claim (VA, 2020).

This initial appointment sets the foundation for the soon-to-be veteran in their first steps outside of the military. Many service members move back home or to a new location after separating from the military. Knowing this, the VSO can contact another in the area where the veteran is moving.

The best way to find a VSO is by using the VA.gov website or a local state veteran affairs website. Word of mouth by another veteran is also a common way to find and connect with a VSO. Once a service member has met with a VSO and enrolled in the VHA, they have a much lower chance of suicide. Non-VHA veterans comprise 60.3% of all veteran suicides (VA, 2022).

Assumptions/Scope Conditions

The scope conditions for this policy will be for all service members transitioning out of military service. While service members receiving a dishonorable discharge rating will be ineligible

to enroll in VA benefits, I would not leave them out of the scope conditions as they must undergo the same checkout procedures as any other transitioning service members.

For this to happen, the Department of Defense and the Department of Veteran Affairs need to transition services for their outgoing service members better. Veteran suicide rates are at their highest within four years of a service member's transition into civilian life (Reger et al., 2014). Allowing for a merger of services can close the gap between the transition from service member to veteran.

Process evaluation approach

My policy heavily focuses on the interaction between the transitioning service member and the VSO; this interaction is essential for my policy to succeed. VSOs operate in the Department of Veterans Affairs and are essential in implementing my policy. A VSO is your first point of contact at the VA; they provide you with all the VA's information and services. Most VSOs are veterans who have a good understanding of the issues facing the veteran population. Getting in touch with a VSO is the first step in getting into the VA system.

A VSOs primary goal is to help veterans understand all the benefits the VA offers them based on their military service. My policy will increase the workload VSOs typically have. Each year 200,000 servicemembers exit the military (GAO, 2019). Each of these 200,000 servicemembers must have a VSO visit before they are eligible to leave military service. If VSOs are overwhelmed with the number of appointments they receive, they may face pressure to keep up with demand at the cost of service; this may result in VSOs just rubber-stamping paperwork to meet demand. If VSOs cannot meet the demand, the VA will need to hire more VSOs, especially in areas around sizeable active-duty military bases.

To ensure the implementation of my policy correctly, I will verify that the meeting between the service members and the VSO is constructive. I will spot-check the quality of the meeting by interviewing service members after they meet with their VSO.

I will randomly ask 10% of service members after their meeting with the VSO. During these interviews, I will ask the service members questions about The length of their meeting; If the VSO explained the following benefits health, education, and home loan; explained how to access these benefits; If they enrolled in any of these benefits during their meeting; Did the VSO answer any questions you had; If you are moving out of the area did the VSO put you in contact with another VSO in your new location.

VSOs must understand what federal benefits are available, including disability and compensation, education benefits, VA home loans, and state benefits each state provides, and be able to keep up with any changes to benefits at the federal and state levels. Many VSOs must complete three hours of qualifying CLE within 12 months and pass a written exam administered by the VA (Salazar & Breslauer, 2020); this training allows the power of attorney authority to represent you in your VA claims and appeals.

Providing the VSO with current information on how VA health care can lower suicide rates vs. non-VA health care options and how the VA outperforms private hospitals in general quality of care is essential for the VSOs to explain to departing servicemembers (Basham et al., 2011; O'Hanlon et al., 2016;). VSO will need to explain the VHA priority groups, what each group means regarding your health care benefits, and how to raise in the groups based on disability and financial need.

During the first few years of implementation, VSOs should develop a list of things that went well and did not go well during their appointment to better prepare for each new meeting. To better understand each servicemember, a VSO should create a preparation guide that would

include questions such as the location of where the servicemember will reside; this will allow for the VSO to connect with another VSO to where the servicemember will relocate and schedule an appointment; these items will vary from VSO to VSO and region to region.

A crucial aspect of my policy is adding the extra step of a VSO meeting to all out-processing paperwork. This step forces service members to meet with the VSO. My policy includes adding VSOs to all active-duty installations; doing so will make meeting with a VSO as easy as possible.

To achieve these steps, The Department of Defense (DoD) must make all the current out-processing paperwork obsolete and create a new checklist, including the VSO meeting.

Allowing the VA to establish a presence on a military base would in essence, the DoD will give up a small piece of its sovereignty to allow for an outside department to operate on all of its bases. The DoD and the other government departments must compete for the limited budget resources Congress can allocate each year. To allow the VA to operate on DoD bases, the DoD may ask for something in return that Congress might have to accept to enable full implementation of the policy. But ultimately, Congress and the president have the final say in the matter.

My policy will bring more veterans into the VHA. The VHA operates 1,454 healthcare facilities, including 171 hospitals and 1,283 outpatient facilities, and employs 15,000 doctors and 61,000 nurses (Veterans Affairs, 2021). The VA Health Care system can provide necessary care to those who need it. The VA has a patient-to-physician ratio of 356 to 1, meaning that there is one physician for every 356 veteran patients (Vajracharya, 2017). This number is well below the World Health Organization (WHO) goal of a 1000 to 1 patient-to-doctor ratio (Kumar & Pal, 2018). With 15,000 doctors, The VHA system can expand to cover 15 million veterans under the WHOs recommendation for a doctor-to-patient ratio meaning that the VHA can provide health care to 83% of the 18.5 million veterans in the United States.

Impact evaluation approach

For my policy to succeed, I want to see one less veteran suicide each day which is a 15% decrease. The expected decrease is reasonable because veterans who use the VHA for their healthcare needs are 17.3% less likely to commit suicide. On average, 16.8 veterans commit suicide daily (VA, 2022). 60.3% of those veterans do not use the VA for their health care (VA, 2022), making up 10.1 of daily suicide rates. Since 48% of all veterans use the VHA for their health care, we would expect 48% of the 16.8 would be 8.1 suicides a day. However, since 39.7% of all suicides occur to veterans enrolled in the VA, this number would be 6.7 per day or 1.4 fewer suicides per day.

I will pilot my policy to 10% of all active-duty military installations with no more than one base per state, allowing for the most diverse treatment group, eliminating single-state biases, and increasing the external validity allowing reduplication of my policy. I will exclude overseas bases as no service member separates from the military from an overseas base; these servicemembers are reassigned to a base in the United States to separate from service. National Guard and Reserve component bases will also be exempt from the piloting stage of my policy.

By selecting 10% of all active-duty military installations, I expect a treatment group of roughly 20,000 service members annually based on the 200,000 service members who exit the military service annually (GAO, 2019).

The selection will consist of Eight Air Force bases, Six Army bases, Six Navy bases, two Coast Guard bases, and one Marine base for a total of 23 bases in the pilot project. These bases will receive the treatment of having transitioning service members visit a VSO during their separation from service. All other active-duty bases will be in my control group and will not receive the pilot treatment of forcing service members to visit a VSO during separation. The demographics

between the treatment and control groups will be identical as my target population is service members exiting military service.

To track if my intervention worked, I will work with the VA and have them provide me with the records of all veteran suicides. I will then see if these veterans took part in my intervention. To know if the veteran participated in my treatment group, I will see which military installation they transitioned out of service. By knowing this, I can see if trends on specific bases in my treatment have an unusually higher or lower rate of suicide. This knowledge is instrumental in seeing why some bases may outperform or underperform compared to others. I will see what went well on some bases and try to duplicate their success on others. For installations with an unusually higher number of suicides, I can use this information to understand the reason behind their increase and what needs addressing.

If my intervention succeeds, I will roll it out to all military installations in the United States.

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