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Preventing Suicide in Veterans Through Access to Primary Care

Suicide prevention and the mental wellbeing among our military veterans has recently become a national priority. Traditionally, the US military has appreciated lower suicide rates compared with the civilian US population. However, over the last decade, these rates have nearly doubled and now far exceed that of the general population.^{1,2}

Healthy People 2020 has identified a need to reduce the rates of suicide and improve mental health. In the general US population, there were 11.3 suicides per 100,000 people in 2007, with rates increasing over the past decade.³ Currently, veterans are twice as likely (adjusted hazard ratio 2.13, 95% CI 1.14 to 3.99) to die of suicide compared with non-veterans in the general population.⁴ This influx has drawn a great deal of attention from a public health standpoint. Healthy People 2020 has set out to improve rates in the general population by 10%, equating to 10.2 suicides per 100,000 population.³

The wellness model surmises that some of the limiting factors to reaching this goal are: limited access or utilization of primary care, a lack of healthcare providers who display competence in mental health needs, and the social stigma and culture around mental health.⁵ The veteran community is no exception to these limitations. In fact, studies have shown that they may be even more vulnerable to these barriers- and others. Research has begun to analyze this troubling trend over the last decade. While looking at the above stated barriers, as well as the possible association with combat deployments with Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF), we must identify areas to improve the delivery of mental health care- and develop an aggressive plan of action.¹

In further specifying my target audience, research has shown that the veteran population is at a higher risk for suicide and mental health disorders than the active duty military population. A recent study looked at whether previous combat deployments were directly linked to the heightened rates of suicide. Astonishingly enough, and contrary to popular assumption, there was no significant correlation between prior deployment status and increased suicide rates. The most significant predictor of mental health disorders and increased suicide risk was if the member had simply been separated from military service.^{1,6}

Furthermore, veterans that have most recently been discharged, or those that are currently going through civilian reintegration, appear to be the most vulnerable population.⁷ Civilian re-entry is one of the strongest predictors of mental health disorders and suicide.^{1,7} The burdens of re-entry have been particularly problematic for America's post-9/11 veterans. Seventy-six percent say their military experience helped them get ahead, yet half (51%) say they had some difficulty readjusting to civilian life.⁷ A majority of these Veterans report strained family relations, frequent incidents of depression, irritability, or anger-with nowhere to turn.⁸

Local organizations like Lift For the 22 offers community support and solidarity for veterans experiencing this transition. By offering free gym memberships to recently discharged veterans, its mission is to provide support and community to veterans that are having difficulties adjusting to their new life. This is a great way to focus on maintaining both a healthy physical and mental lifestyle. Groups such as these are the frontlines for identifying individuals at high risk, or those that may benefit from a little extra support.⁸ Suicide awareness education and prevention should be available to groups such as these so that they may continue to support their comrades should the situation arise.

This identifies a much more specific veteran population than is normally addressed; it raises questions as to why, during this transitional time, are veterans increasingly susceptible?

When a service member is discharged from the military, to embark on the journey of civilian reintegration, the Department of Defense has developed extensive programs to ease separation and transition. The most well-known and implemented program is the Transition Assistance Program (TAP), which every member must complete before discharge from active duty service.⁹ However, programs such as these have only a strong focus on reestablishing family connections, securing housing, and finding employment.^{9, 10} Very little attention is paid to ease the transition of health care needs. There is no emphasis on the importance of establishing a new primary care provider that will pick up where military medicine has left off.

While on active or reserve duty, members need pay little attention to the management of their primary health care needs. They are required to stay up to date with immunizations, physicals, and annual screenings in order to comply with unit readiness. Every component of the military has a medical department that ensures that its unit's members are compliant at all times. In accordance with HA Policy 06-006, Periodic Health Assessment Policy for Active Duty and Selected Reserve Members, all service members are required to receive a Periodic Health Assessment (PHA) annually.¹¹ This ensures medical readiness and helps improve the health status of military personnel. The PHA includes: a current self-reported health status, review of medical records, referral for current health problems, assessment for mental health problems, identification and management of occupational health risks, preventive health needs, and identification and development of a plan to manage health risks.¹¹

This annual screening is a proactive approach to health care. It saves lives of service members by identifying concerns early on. This proactive approach is recommended in the

civilian health care setting as well, yet it is loosely adhered to- especially by members of this age and demographic. This is largely due to the fact that many people simply don't have a primary care provider. Healthy people 2020 has identified that about 25% of the US population is without a primary care provider, and thus going without these important screenings. It is suspected that this number is even higher when isolated to the young adult and veteran populations.¹²

The National Association of Community Health Centers (NACHC) has released a report that shows 62 million Americans have no or inadequate access to primary care, for varying reasons. The majority of these people have health insurance. In fact, just 21% of these 62 million are uninsured.¹³ Establishing a relationship with a primary care provider is a much different concern than just "being covered" by insurance. It means more than getting care in an ER for an acute event. Having a primary provider means having a regular, reliable source of quality preventive care, fewer Emergency room visits, and timely referrals to specialty care.

Many people, even those with insurance, overlook this valuable relationship or do not understand the importance of it. The NACHC has published extensive research that documents how accessing primary care results in better health outcomes, identifies mental health disparities before they escalate, and lowers the overall health care expenditures.^{13, 14, 15}

The USPSTF recommends mental health screening to be conducted with regular health maintenance in the general adult population- so long as there are adequate systems in place to ensure diagnosis, treatment, and appropriate follow-up.¹⁶ There is convincing evidence that the treatment of adults with mental health concerns, identified through screening in primary care settings, with antidepressants, psychotherapy, or both decreases clinical morbidity.^{14, 15} The Department of Veterans Affairs also recommends screening on an annual basis.¹¹ The World Health Organization has predicted that mental health illness, like depression, could jump from

the fourth leading cause of death and disability to second place by 2020.¹⁷ This is the role of primary care providers in combating mental illness and suicide.

When a military member is discharged from service, this strict accountability is lost—often at the most pivotal moment of their lives. One pillar of action in reducing the mental health burden and suicide among our nation's veterans includes education on the value of the patient/primary provider relationship after leaving military service. Last year there were an average of 20 veteran suicides reported each day. Of these 20 veterans, 14 were not under VA care, nor had an outside primary care provider established.⁷

The first step in combating preventable morbidity and mortality is taking charge of your own care. These young veterans are no longer in the military where their care is managed for them. They are experiencing a dramatic change in their life with civilian re-entry and likely have not yet figured out the complexities of VA healthcare. If you know of a fellow veteran who is struggling, and is unaware of the resources available to them, take the time to help them out—educate them. The following three basic steps can help inform someone and get them on the track to receiving care.

Step one is to find out if you have VA health benefits. If you served in the active military service and were separated under any condition other than dishonorable, you most likely qualify for VA health care benefits. The VA encourages all veterans to apply so that they may determine their enrollment eligibility. Many people think that you have to first establish a disability rating before you can start to make appointments, see doctors and receive medication. That is not the case. If you served in the military, even during peace time, and were honorably discharged, you likely qualify for VA care. Even if you don't meet those requirements, special circumstances, like low household income, might apply. Below is a link to the VA Health Benefit Explorer. It

takes less than 5 mins to fill out and tells you immediately if and what benefits you qualify for.

<http://hbexplorer.vacloud.us>

Step two is to establish care with a primary care provider. The VA's comprehensive medical benefits package offers care and services that are designed to promote your good health, preserve your current health, and/or restore you to better health. That includes treating illnesses and injuries, preventing future health problems, improving functional abilities and enhancing quality of life. A full spectrum of medical services are available to qualified veterans including but not limited to surgery, medications, mental health care, women's health care, and much more.¹⁸

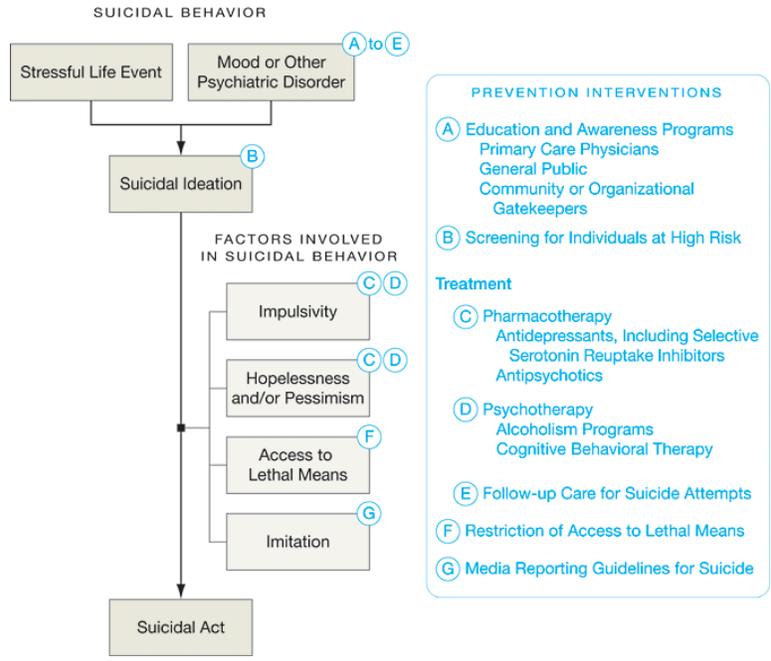
Step three is to follow-up regularly. Specialty services like mental health care are available based on the judgment of your VA primary care provider. It is imperative that patients have a regular and healthy relationship with their primary care provider in order to be seen by specialty providers in a timely manner. At the VA, if a patient is not seen for an annual health maintenance exam within a 2-year period of time, they are reassigned to a new PCP, or must at least complete a "new patient exam". New patient exams are significantly longer and more involved visits. Typically, there are considerably longer waits to get an appointment to establish care than there are for annual check-ups or episodic visits.¹⁸

Many veterans are unaware of this technicality. For this reason, there is a perceived barrier to accessing care in a timely manner. Complaints of outrageously long waiting periods to be seen by a mental health specialist are often related to the fact that the patient has no PCP to refer them. Therefore, they must first wait to be seen to establish or re-establish care before they can be sent to where they ultimately need to go.

Once they reach the specialty care level, patients are offered “Veterans Choice”, if appointments are too far out. Meaning, if a provider cannot see them within 3 months of referral they have the choice to be seen elsewhere by a specialist in their community. Often, when this system breaks and a patient has no PCP to refer them, the wait time is truly unreasonable for their condition. This leads to increased emergency room visits, exacerbation of manageable illnesses, and unfortunately in cases of mental health- suicide. This barrier to appropriate care access is too often just a misunderstanding of how the system works. This model is shared with the civilian healthcare delivery system as well, but there are typically more options for individuals within their network.

The cornerstone of suicide prevention education is recognizing red flag signs. In spite of the many difficulties with predicting suicidal behavior, there are structured approaches to suicide prevention that have been developed. The multifactorial nature of the problem of suicide has required the adoption of a multidimensional approach to intervention, combining population-based screening and education, with more targeted efforts for those that seem to be above baseline risk. One method that was reviewed by Mann et al. in the figure below uses a fairly basic conceptual model that organizes the interventions well.¹⁹

Figure 1. Targets of Suicide Prevention Interventions



In this model life stressors and psychiatric disorders combine to produce suicidal ideation. The majority of suicides, at least 90% by some studies, in the US are associated with a psychiatric disorder, usually a mood disorder.^{19, 20, 21} This is modulated by impulsivity, hopelessness/pessimism, access to lethal means, and imitation, leading to the final suicidal act. The appropriate interventions correspond to different points in this causal web. In the table below a stepwise set of interventions are considered.

Table 1. Set of interventions

Education and Awareness Programs
Primary Care Physicians
General Public/Population
Community or Organization Gatekeepers (lift for 22)
Screening for individuals at high risk
Pharmacotherapy or ECT
Psychotherapy
Follow-up care for suicide attempts

Restriction of access to lethal means
Media reporting guidelines for suicide

Education and awareness programs can have varying audiences. Earlier we discussed that primary care providers might benefit from awareness programs to improve detection of mental health issues or significant stressors, with the goal of referring to mental health clinicians early for diagnosis and treatment.⁵ Most importantly we must focus on educating the general public about suicide and the availability of resources for getting help. It is the non-clinical social support systems and communities in solidarity that will make first contact with veterans in need of support.²² Getting them to the help they need is everyone's responsibility.

As a veteran myself, I have seen and experienced first-hand the repercussions of this communication breakdown. Service members and fellow veterans have struggled with receiving appropriate care, not because it is not available to them, but because the services are not accessed appropriately. The vast majority of veterans that I have spoken with about this topic report that they do not have a primary care provider because they do not need one- at that time. Often the understanding is, since they have "coverage", the services should be available if and when an issue arises. Unfortunately, this reactive approach to accessing care is what frustrates both the healthcare system and the individuals alike. This leads to excessively long wait times for appointments and the perceived limited access to care.

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