

Commentary: Suicide and Incarcerated Veterans—Don't Wait for the Numbers

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Using indirect evidence, Wortzel and his colleagues raise the likelihood that the rates of suicide will increase among incarcerated veterans, given past trends and current information about veterans returning from Iraq and Afghanistan. Although it might be argued that the data are inadequate for the formulation of public policy, there is sufficient information to begin creating programs for veterans now. Wortzel and colleagues suggest screening in jails to identify veterans at risk, with increased monitoring in the first weeks of incarceration, and use of the Critical Time Intervention during important transitions. While these recommendations are worthy, a better understanding of the factors associated with suicidality may help policy-makers to support programs for returning veterans before they develop the serious problems that can lead to suicide. Also promising is the Substance Abuse and Mental Health Administration's recent funding of six jail diversion programs with a focus on veterans.

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With great interest, we read the review by Wortzel and colleagues¹ of the literature on the risk of suicide among incarcerated veterans. Lacking past published studies specific to the topic, the authors have wisely approached it by considering related research on veteran suicide, suicide among incarcerated individuals, and the characteristics of incarcerated veterans. These findings are enhanced with recent observations about veterans returning from Iraq and Afghanistan, and likely connections that cannot be directly studied from existing published reports, such as evidence of high rates of brain injury. The authors make a compelling case that the rate of suicide among incarcerated veterans is probably high because of the higher incidence of suicide among both veterans and incarcerated individuals, compared with that in the general population. A more dire projection (without as much evidence) is that the rate will grow because of the documented problems among veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

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This article raises the question of whether this indirect evidence is enough reason to act now, or whether we first need to establish the actual rates of suicide risk among incarcerated veterans. We believe that we can begin to create and use appropriate screening tools and develop programs without waiting for epidemiological studies. Although it is probably wise to avoid very large investments until models of screening and intervention are tested, we argue that we have to act now on this information. The troops returning from Iraq and Afghanistan are large in number, and we have a moral obligation to reintegrate them into society. Although we don't have all the information that might be desired, we do have an emerging picture.

Consider the nature of the population. While single studies may be limited by restricted populations, design, and/or available data, this review of multiple studies offers consistent data about those veterans at highest risk of completing suicide. Most of the studies point to younger white males who are depressed and substance-abusing. Similar characteristics are highlighted among incarcerated populations, with additional evidence indicating past violent behavior as a risk factor. Indeed, mood disorders, substance abuse, and impulsive or aggressive behaviors are frequently cited as suicide risk factors in the general

population. To some extent, increasing the routine use of standard suicide assessments at jail admission should help to identify veterans (and other inmates) at highest risk.

Do we even need to know whether these inmates are veterans? On the one hand, if veteran suicide is similar to suicide among other populations, there may be no need to establish veteran status as a separate risk factor. But we agree with Wortzel and colleagues that veteran status should be part of intake screening in jail. Recent research shows that brain injuries, post-traumatic stress disorder (PTSD), and cognitive deficits are likely to be related to deployment to Iraq and Afghanistan, and that OEF and OIF veterans' symptoms include irritability, anger, depression, anxiety, and increased use of substances.² While the past literature reviewed by the authors (much of which is focused on Vietnam veterans) is unclear with respect to the specific role of PTSD in suicide risk, trauma is strongly associated with myriad health and symptoms of soldiers returning from Iraq.³ Head trauma can cause impulsive and violent behavior, including offenses such as domestic violence and driving while intoxicated.

Jails may have the capacity to screen for PTSD, traumatic brain injury, and cognitive problems, but perhaps veteran status (or deployment) alone can be more easily established. Other reasons that veterans are more likely to commit suicide include lack of connectedness to nonmilitary society⁴ and the military culture. The transition from military service to civilian life may prove quite difficult for the returning serviceperson. Returning veterans are reported to feel isolated and out of place in the community. Civilian life may introduce difficulties not previously experienced by the veteran, such as unemployment and marital conflict. For healing purposes, they need to share their experiences of war with their families and communities, but they are greeted with pleas to stop talking about the war. Because nonveterans cannot appreciate the veterans' experience, the veterans develop feelings of hopelessness that are related to suicidality.^{5,6} OEF and OIF veterans have also recently been immersed in a military culture that stigmatizes seeking help. Those with mental health disorders resist treatment partly because of attitudes toward mental health treatment.⁷ Moreover, it seems likely that soldiers' self-image may be shattered by their own postdeployment behavior, although research has not yet made this link. Altogether, being a

veteran is associated with risk factors above and beyond what standard assessments typically measure because of the deployment experience itself.

A more obvious reason to find out if an inmate is a veteran is to identify treatment options and other services that may be helpful. Specialized treatments for PTSD and brain injuries are more available to veterans than to other people with these disorders. Even if a veteran has been reluctant to seek treatment at a Department of Veterans Affairs (VA) health facility, this option should be explored and encouraged during jail discharge planning. Other community services, such as Vet Centers and state-operated programs for veterans, can offer counseling, social support, and economic support that may improve hopefulness. In addition to this specific type of discharge planning, jail administrators might consider developing jail-based veteran programs to capitalize on the mutual support that is part of the military culture. Recent news reports concerning Marines imprisoned in the Camp Lejeune brig highlight the rehabilitative value of giving these prisoners responsibility for training dogs as support animals for Marines injured in combat.

On the other hand, identifying veterans is not always straightforward. For many reasons, some veterans fail to self-identify. Other people may falsely declare veteran status in hopes of gaining access to associated services and benefits. As new procedures are developed, better methods of establishing veteran status must be identified. Unfortunately, it has been difficult to obtain official paper documentation of military service in a timely way. However, OEF and OIF veterans may now obtain their own separation document, the DD214, directly from the internet. Other people trying to establish whether an offender is a veteran cannot obtain this information so easily unless the veteran provides access.

If veteran status is difficult to establish, suicide risk is even harder. Wortzel *et al.*¹ restricted their review to completed suicide, but we may benefit more from consideration of the larger group of veterans with suicidal ideation. Because suicide is a relatively low-frequency event, large samples are needed to develop confidence in risk models for completed suicide. Even large samples cannot make up for invalid data, and some suicide deaths are likely to be incorrectly classified. An alternative for future research is to focus instead on suicidal feelings, especially after deployment, to develop interventions for the larger

population of returning veterans. The review by Wortzel and colleagues leads to the conclusion that jail admissions need screening, and veterans identified at high risk need to be carefully monitored following admission. These are excellent recommendations. But from a policy perspective, we would prefer to move upstream and help returning warriors connect to treatment and other types of support before they become suicidal. To do so will require studies that consider the entire population with suicidal ideation, rather than just those who have completed suicide.

Clearly, we need to evaluate the transition from war zone to home and active duty to military discharge. Can the postdeployment process be improved to identify PTSD, brain injury, and substance abuse? Wortzel and colleagues¹ point to the documented inverse relationship between receiving treatment and suicide and highlight the potential of applying the evidence-based critical time intervention (CTI), especially for veterans discharging from psychiatric units or jails. We applaud this idea, but it isn't enough. Perhaps the most important thing we can do is to communicate to returning veterans that their symptoms are very common and that treatment can be helpful. Families also need education about how to support the returning veteran.

Recently, the Substance Abuse and Mental Health Administration (SAMHSA) funded six states to support jail diversion programs for trauma survivors, with a focus on veterans. SAMHSA is doing the right thing, at the right time. Jail diversion includes prebooking programs (often consisting of police crisis intervention teams that can identify people in need of psychiatric services and connect them to care instead of arresting them) and postbooking programs

to link criminal defendants to treatment in lieu of sending them to jail. SAMHSA funded these programs to encourage states to try out models of linking veterans with trauma disorders who would otherwise be incarcerated or arrested to specialty services for trauma survivors and related services. Compared with mainstream jail diversion services, we expect that these programs will rely more on peer support models, offer more treatment for substance abuse, and involve families. Each state involved has an opportunity to create these programs collaboratively through a built-in strategic planning phase, and to perfect them in pilot sites to prepare for larger-scale model dissemination. We have witnessed extraordinary enthusiasm in Connecticut about this project, by court staff and police, probation, parole, and correction officers. This isn't surprising. They're veterans.

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