Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention

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Washington, DC 20420

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Executive Summary

Introduction

The purpose of this review was to assess the implementation of action items that pertain to suicide prevention within the Veterans Health Administration's (VHA's) Mental Health Strategic Plan (MHSP).

There are approximately 25 million veterans in the United States and 5 million veterans who receive care within VHA. Based on Centers for Disease Control and Prevention data indicating suicide rates in men between the ages of 20 and 65 approximating 20 per 100,000 persons per year, VHA mental health officials estimate 1,000 suicides per year among veterans receiving care within VHA and as many as 5,000 per year among all living veterans. To better understand the characteristics of suicide in veterans, we reviewed studies on suicide in the general population. These studies can be summarized as follows.

- In the United States there are approximately 30,000 suicide deaths and 1.4 million suicide attempts per year. This generates many hospital admissions as well as visits to hospital emergency rooms.
- On average there are four male suicide deaths for each female death by suicide; however, there are three female suicide attempts for each male suicide attempt.
- Firearms were the most frequent means of completed suicide death in each adult age range, accounting for 51 percent of overall completed suicides.
- Numbers are somewhat different with regard to attempted suicide. Whereas firearms, hanging, or jumping are the more common methods in attempted male suicides, females are more likely to attempt by taking an overdose of medication or ingesting a poison.
- Among the population of those who commit suicide, there is a greater incidence of impulsivity in other settings, which is a tendency also associated with closed head injury and patients at risk for alcohol and substance abuse.
- The best single indicator that a patient is at increased risk of suicide may be a history of a prior suicide attempt. Up to 40 percent of depressed patients who commit suicide have made a previous attempt. The risk of a patient making a second attempt is highest within the 3 months following the first attempt. Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death. Among the older adult male sub-population, the majority tend not to seek mental health treatment. However, studies indicate that many who commit suicide have seen their primary care provider within the month of their death.

This report also briefly summarizes relevant findings and types of recommendations from related reports addressing prevention of suicide. These reports have been produced

during the last decade by the Surgeon General of the United States, the Institute of Medicine, and the President's New Freedom Commission on Mental Health. VA's Under Secretary for Health charged a work group to review the 2002 report of the President's New Freedom Commission on Mental Health and to develop an action agenda tailored to the mental health needs of veterans enrolled for care in VA. In December 2003, VHA published an Action Agenda which, along with other reports, led to the development of VHA's MHSP, which was finalized in November 2004.

The purpose of the 2004 MHSP was to present a new approach to mental health care, an approach which was focused on recovery rather than pathology, and to integrate mental health care into overall health care for veteran patients. This 5-year action plan with more than 200 initiatives includes timetables and responsible offices identified for each action item. Among these action items were a number specifically aimed at the prevention of suicide. Other factors that influenced the MHSP Work Group included the return of veterans from Iraq and Afghanistan, the challenge to deliver quality mental health services to a growing number of women veterans, and the changing and future mental health service needs of aging Vietnam Era veterans.

In response to a request from a member of the U.S. House of Representatives, Committee on Veterans' Affairs, the Office of Inspector General undertook an assessment of VHA's progress in implementing the MHSP initiatives for suicide prevention. Specifically, those initiatives that pertain to suicide prevention include the following.

- Develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care.
- Develop a plan to educate all staff who interact with veterans, including clerks and telephone operators, about responding to crisis situations involving at-risk veterans. This would include suicide protocols for intake, telephone operators, and other first contact personnel.
- Develop mandatory education programs for VA health care providers about suicide risks and ways to address these risks. Incorporate best practices for suicide prevention.
- Promote evidence based strategies for suicide assessment and prevention including emphasis on special emphasis groups.
- Develop and test an electronic suicide prevention database.
- Develop a national systematic program for suicide prevention.
- Endorsement and implementation of the *National Strategy for Suicide Prevention* (2001) and the Institute of Medicine's report, *Reducing Suicide: A National Imperative* (2002).
- Develop a plan for 24-hour mental health care availability through VHA.
- Medical centers establish contacts through the Chaplain Service with faith-based organizations and community resources to assist with culturally competent suicide prevention and other mental health issues at local and national levels.

- Support for a new Mental Illness, Research, Education Clinical Center (MIRECC) with focus on suicide prevention, in collaboration with other MIRECC's working in this area.

Methodology

In order to assess VHA's progress in implementing initiatives for suicide prevention, we surveyed all VA medical centers between December 2006 and February 2007. Surveys were sent to facility Chiefs of Staff, to be done in collaboration with clinicians from mental health, primary care, and quality management. Follow-up questions within the survey captured descriptions of applicable programs or implemented strategies. It was possible for facilities to describe local innovations. One-hundred-ten facilities from 17 Veterans Integrated Service Networks (VISNs) responded; 4 VISNs had no facility responses. During the survey time frame, we conducted extensive personal interviews of VHA leadership, researchers, and subject matter experts in the field to assess the extent of progress, learn about innovations, and validate survey responses. We assessed implementation of MHSP initiatives along a spectrum of five stages: (1) we could find no evidence of plans for implementation, (2) we found evidence of planning but not piloting or local implementation, (3) we found evidence of ongoing or completed pilot or demonstration projects, (4) we found implementation throughout an entire VISN or in multiple facilities in multiple VISNs, and (5) we found system-wide implementation. (The extent of implementation for each suicide prevention initiative unique to the MHSP can be seen in the chart on page 54.)

Conclusions

MHSP initiatives pertaining to 24-hour crisis availability, outreach, referral, and development of methods for tracking veterans at risk have been implemented throughout an entire VISN or in multiple facilities in multiple VISNs but not yet system-wide. Initiatives focused on the development of methods for screening, assessment of veterans at risk, emerging best practice treatment interventions, and an electronic suicide prevention database have been piloted or are in the process of being piloted at select facilities. Development of mandatory education programs for VA health care providers about suicide risks and ways to address these risks, and a plan to educate first contact personnel about responding to crisis situations involving at-risk veterans have been piloted or are in the process of being piloted at select facilities. The VISN 19 MIRECC has been established with a focus on suicide prevention and has been providing leadership in collaboration with other MIRECCs working in this area.

Since 2004, progress has been made toward the implementation of the MHSP initiatives for suicide prevention. The progress is ongoing, with greater integration and at an accelerated pace. However, more work remains to ensure a coordinated effort in achieving system-wide implementation. Central to this effort is the ongoing need for

greater integration of local, network, and national level projects and innovations; a readiness to make difficult choices among best available options; and the impetus to translate this readiness into widespread and sustained implementation.

In the near term, system-wide implementation of a set of promising and/or emerging best practices, coupled with their ongoing evaluation and modification, would facilitate provision of a single standard of preventative care for all veterans seen at VHA facilities. A national system-wide suicide prevention plan is intended to provide proactive strategies for identifying, screening, assessing, referring, tracking, and treating veterans at risk. At present, MHSP initiatives for suicide prevention are partially implemented. It is therefore incumbent upon VHA to continue moving forward toward full deployment of suicide prevention strategies for our Nation's veterans.

Recommendations

We concluded that significant progress had been made, but more work remains to be done to achieve system-wide implementation. We recommended that:

- VHA facilities should make arrangements for 24-hour crisis and mental health care availability, either in person or by a VA facility or a non-VA crisis/suicide hotline staffed by trained personnel. In addition, an on-call mental health specialist should be available to crisis staff either in person or by phone.
- All non-clinical staff who interact with veterans should receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.
- All health care providers should receive mandatory education about suicide risks and ways to address these risks.
- A requirement of sustained sobriety should not be a barrier to treatment in specialized inpatient post-traumatic stress disorder (PTSD) programs for returning combat veterans.
- VHA should facilitate bi-directional information exchange between VA and Department of Defense, both for patients with mental illness entering VHA health care and/or leaving VHA for re-deployment to active duty status.
- VHA should establish a centralized mechanism to select emerging best practices for screening, assessment, referral, and treatment and to facilitate system-wide implementation, in order to ensure a single VHA standard of suicide prevention excellence.

Under Secretary for Health Comments

The Acting Under Secretary for Health reviewed the draft report and concurred with the recommendations to ensure a more coordinated effort of implementing proactive suicide prevention strategies throughout VHA. VHA's goal is to ensure continual awareness and prevention of suicide among veterans.

VHA has recently designated Suicide Prevention Coordinators in each medical center. Beginning on March 1, 2007, VHA established an annual Veteran Suicide Prevention Awareness Day. This will enhance suicide prevention education for clinicians and non-clinical staff, throughout the VA health care system. Each Vet Center, VISN, and medical center will hold Veterans Suicide Prevention Day annually to conduct suicide prevention programs and activities, to include educational presentations that are extended during the year through a number of VHA Employee Education System programs.

VHA is also in the process of developing additional awareness and training protocols at the local level that involve training of front-line patient contact personnel on the concepts of suicide recognition, early interventions, and the steps necessary in responding to crisis and obtaining assistance for veterans at risk of suicide. Awareness training on suicide prevention for clinical personnel is also under development. Although these efforts are already outlined with target dates in the MHSP, they have expedited these initiatives to limit any remaining gaps in service delivery involving suicide prevention.

Assistant Inspector General for Healthcare Inspections Comments

The Acting Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendix B, pages 58–65 for the full text of the comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Under Secretary for Health (10)

SUBJECT: Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention

Purpose

In response to a request from a member of the U.S. House of Representatives, Committee on Veterans' Affairs, the Office of Inspector General (OIG) undertook an assessment of Veterans Health Administration's (VHA's) progress in implementing initiatives for suicide prevention from *A Comprehensive VHA Strategic Plan for Mental Health Services*. Centers for Disease Control and Prevention (CDC) data indicate that in 2004 there were 32,439 known completed suicides in the United States, which accounted for 1.4 percent of overall deaths. Suicide ranked as the 11th leading cause of death in 2004, with an overall rate of 11.1 suicides per 100,000 U.S. population.[1] Suicide was the 2nd leading cause of death in people ages 25–34, the 3rd leading cause of death in ages 15–24, and the 4th leading cause of death in ages 35–44.[2] It is estimated that each suicide intimately affects at least six other people. Based on the 754,570 reported suicides from 1980–2004, approximately 4.5 million, or 1 in every 65, Americans in 2004 was a survivor of suicide (that is, family members and friends of a loved one who died by suicide).[3]

There are approximately 25 million veterans in the United States, and 5 million veterans who receive care within VHA. Based on CDC data indicating suicide rates in men between the ages of 20 and 65 approximating 20 per 100,000 persons per year and not controlling for VHA population specific epidemiologic factors, VHA mental health officials estimate 1,000 suicides per year among veterans receiving care within VHA and as many as 5,000 per year among all living veterans.[4]

In this report we review what is known about the characteristics, nature, and rates of suicide. We also summarize related reports from the Surgeon General of the United States, the Institute of Medicine, and the President's New Freedom Commission on Mental Health, as well as *A Comprehensive VHA Strategic Plan for Mental Health Services,* known generally as VHA's Mental Health Strategic Plan (MHSP).

The 2004 MHSP is a plan for the transformation of VA mental health care. It is an action plan that presents goals and objectives that convey a set of proposed strategies to support the mental health needs of the enrolled veteran population. The action plan includes over 200 proposed initiatives or action items. The initiatives are grouped in alignment with mental health strategies aimed at ultimately achieving the goals and recommendations set forth in the President's New Freedom Commission on Mental Health report of 2003.[5] The purpose of this OIG Office of Healthcare Inspections (OHI) review is to assess the nature, progress, and extent of VHA's implementation of those action items within the MHSP that pertain to suicide prevention.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Background

A. Epidemiology

Suicide is the behavior of actively seeking self-destruction. The degree of life threatening intensity varies among those who display suicidal behavior. Essentially all of these individuals are suffering from one or another psychiatric condition that predisposes them to the behavior. Recent life events that provoke feelings of loss and hopelessness as well as sociocultural and demographic factors add to a person's suicidal risk.

In any particular suicide, individual and collective proclivities tend to combine. Consequently, the attempt to make sense of the multiple potential contributions from identifiable psychiatric disorder(s), co-morbid medical illness, specific personal events, and sociocultural factors has been the work of and an ongoing challenge to mental health professionals, sociologists, and epidemiologists for several decades. This effort has increased knowledge about suicidal patients and provided information for utilization in their treatment. However, there has been little if any reduction in overall suicide rates through the years, a discouraging fact indicating there is more to learn.[6]

In the United States there are nearly 30,000 suicide deaths and 1.4 million suicide attempts per year, resulting in 1.3 million years of life lost.[7] In 1999, more than 152,000 hospital admissions and more than 700,000 visits to the hospital emergency rooms were for self-harming behaviors.[8] Overall, suicide was the 11th leading cause of death in 2004 but the 2nd leading cause of death in the 25-34 age group, as shown in the following data from the Centers for Disease Control and Prevention (CDC).[9]

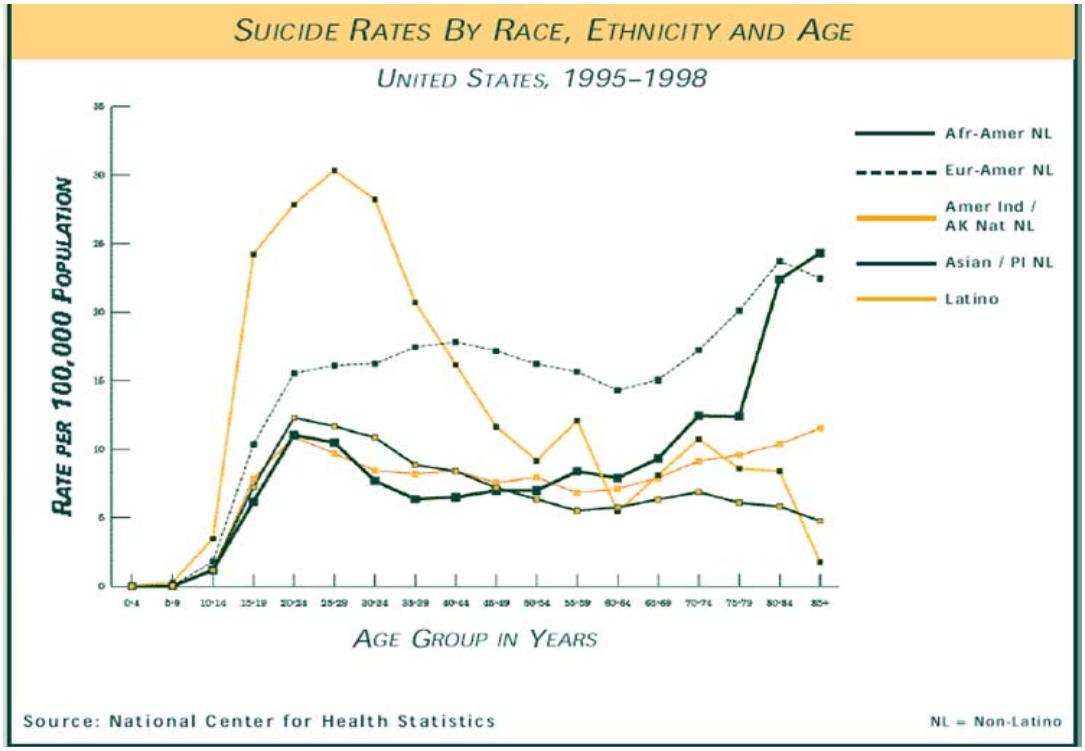
Leading Causes of Death in the United States for All Races, Both Sexes in 2004

	Age Groups										
R	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
	Congenital Anomalies 5,622	Unintentional Injury 1,641	Unintentional Injury 1,126	Unintentional Injury 1,540	Unintentional Injury 15,449	Unintentional Injury 13,032	Unintentional Injury 16,471	Malignant Neoplasms 49,520	Malignant Neoplasms 96,956	Heart Disease 533,302	Heart Disease 652,486
	Short Gestation 4,642	Congenital Anomalies 569	Malignant Neoplasms 526	Malignant Neoplasms 493	Homicide 5,085	Suicide 5,074	Malignant Neoplasms 14,723	Heart Disease 37,556	Heart Disease 63,613	Malignant Neoplasms 385,847	Malignant Neoplasms 553,888
	SIDS 2,246	Malignant Neoplasms 399	Congenital Anomalies 205	Suicide 283	Suicide 4,316	Homicide 4,495	Heart Disease 12,925	Unintentional Injury 16,942	Chronic Low. Respiratory Disease 11,754	Cerebro-vascular 130,538	Cerebro-vascular 150,074
	Maternal Pregnancy Comp. 1,715	Homicide 377	Homicide 122	Homicide 207	Malignant Neoplasms 1,709	Malignant Neoplasms 3,633	Suicide 6,638	Liver Disease 7,496	Diabetes Mellitus 10,780	Chronic Low. Respiratory Disease 105,197	Chronic Low. Respiratory Disease 121,987
	Unintentional Injury 1,052	Heart Disease 187	Heart Disease 83	Congenital Anomalies 184	Heart Disease 1,038	Heart Disease 3,163	HIV 4,826	Suicide 6,906	Cerebro-vascular 9,966	Alzheimer's Disease 65,313	Unintentional Injury 112,012
	Placenta Cord Membranes 1,042	Influenza & Pneumonia 119	Chronic Low. Respiratory Disease 46	Heart Disease 162	Congenital Anomalies 483	HIV 1,468	Homicide 2,984	Cerebro-vascular 6,181	Unintentional Injury 9,651	Diabetes Mellitus 53,956	Diabetes Mellitus 73,138

Source: CDC, National Center for Injury Prevention and Control, http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html.
Note: On the CDC website, you can click on any of the colored boxes for detailed causes and ICD[A] codes.

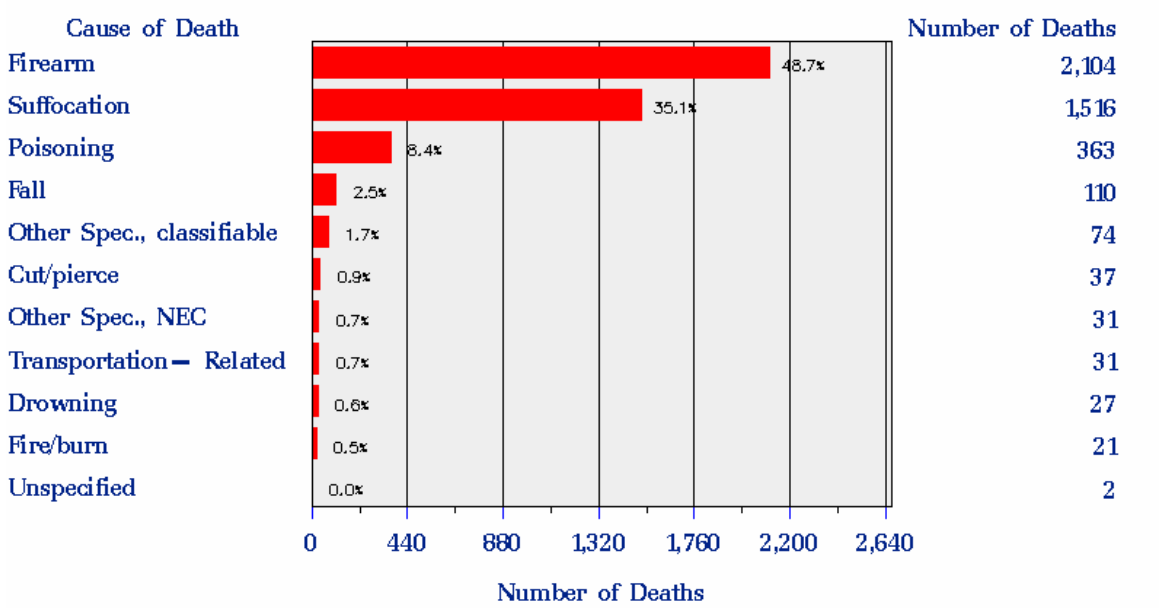
The overall U.S. suicide rate in 2004 was 11.1 persons per 100,000; but rates vary dramatically according to age and gender as shown in the following chart. Suicide rates are highest in white males (19.6 per 100,000) followed by Native Americans (12.9 per 100,000) and black males (9.0 per 100,000). The older end of the age range comprised 12.4 percent of the population in 2004 but represented 16 percent of the suicides. The rates among those ages 75–84 were 16.3 per 100,000. The younger age groups (15–34) comprised 14.2 percent of the 2004 population but 13.3 percent of the suicides. However, the greater absolute number of suicides occurred in the 35–54 age range.[10] In addition, the pattern of suicide rates by age varies for men and women.[11]

[A] ICD – the International Classification of Diseases is published by the World Health Organization and is used world-wide for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine.



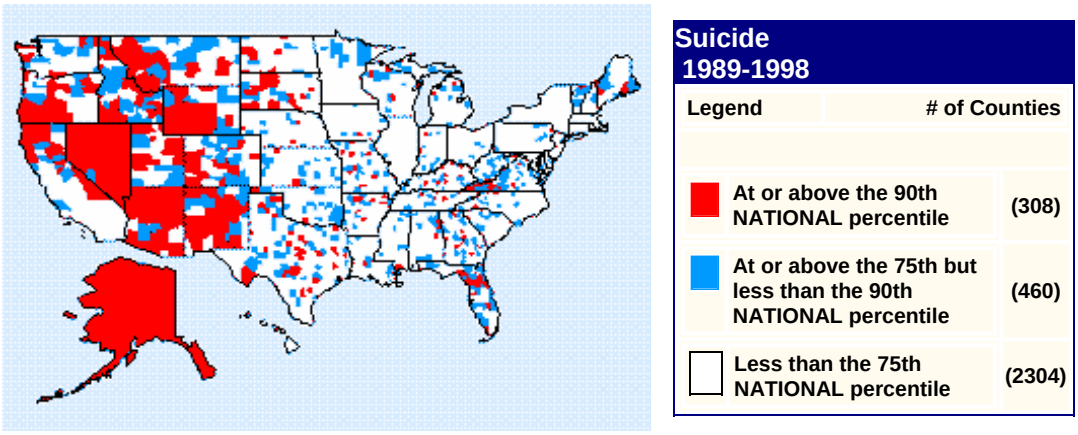
On average there are 4 male suicide deaths for each female death by suicide, but there are 3 female suicide attempts for each male suicide attempt—ratios which have been relatively stable over time. Of the 32,439 overall suicide death figure cited in the 2004 CDC National Center for Health Statistics, 25,566 suicides were among males and 6,873 were among females.[12] Firearms were the most frequent means of completed suicide death in each adult age range, accounting for 51 percent of overall completed suicides. Among the 15–24 age group, firearms were involved in 49 percent of suicides (see the following chart on Methods of Suicide Death).[13] In addition, firearms are the leading means of completed suicide among women as well as men. However, whereas firearms, hanging, or jumping are more common methods in attempted male suicides, females are more likely to attempt by taking an overdose of medication or ingesting a poison.

Method of Suicide Death in 2004 for Ages 15–24, All Races, Both Sexes



Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System
NEC = Not otherwise classifiable

There are regional and state-by-state variations in suicide rates, with higher rates reported in the Mountain and East South Central sub-divisions and lower rates reported in the East North Central and Middle Atlantic sub-divisions. Suicide rates are highest in the Rocky Mountain States. Some data indicate higher rates in rural areas.[14]



Source: National Center for Health Statistics

Data from the 1990–92 National Co-Morbidity Survey, a face to face survey of a sample of participants ages 18–54, who were queried about suicidal ideation in the prior 12 months, found that 2.8 percent of the replication group reported having experienced suicidal ideation, 0.7 percent reported having had a suicide plan, 0.3 percent reported having made a suicide gesture, and 0.4 percent reported having made a suicide attempt.

Thirty-nine-point-three percent of attempters reported having made a serious life threatening attempt, 13.3 percent a serious but not foolproof method, and 47.3 percent reported making a "cry for help," but not wanting to die. The cumulative probability for transition from ideation to plan was 34 percent, from plan to attempt was 72 percent, and from ideation to unplanned attempt was 26 percent. The survey found a prevalence of major depression of 34–42 percent among the four categories of suicidality and a prevalence of anxiety of 63–78 percent among participants in the four categories. The study was replicated in 2001–2003 with similar results.[15]

Psychological autopsy studies from the U.S., Finland, Sweden, and the United Kingdom have found that as many as 90 percent of people who kill themselves have a diagnosable mental or substance abuse disorder. Follow-up studies of adults with mental or substance abuse disorders also reveal a high risk of suicide associated with these disorders. Studies have indicated that the lifetime risk for suicide is 6 times higher for persons with diagnosable depression than for those without depression. Among persons with schizophrenia, the risk for suicide is between 4–6 percent over the life-long course of the illness but with higher risk earlier in the course of the illness. It is estimated that approximately 7 percent of those with alcohol dependence will die by suicide. Adult patients who report high rates of suicide attempts also include women with borderline personality disorder; men and women with depression who also abuse drugs or alcohol; and men and women with bipolar depression. In addition, co-morbid alcohol and substance use further complicates suicide risk in those with co-morbid psychiatric diagnosis, especially in the younger age ranges.[16]

Investigators have noted that suicide involves aggression and is often carried out impulsively. Among the population of those who commit suicide, there is a greater incidence of impulsivity in other settings, which is a tendency also associated with closed head injury and patients at risk for alcohol and substance abuse. In addition, research studies have demonstrated a lower level of the serotonin metabolite 5-HIAA in the cerebrospinal fluid of a sample of patients who had made or completed serious suicide attempts and also in studies of groups of other individuals with histories of impulsive, externally directed aggression. Further highlighting the potential contribution of impulsive or aggressive personality factors to some cases of suicide is study data that found that 25 percent of 153 survivors of near lethal suicide attempts acted within 5 minutes of the impulse and 71 percent acted within 1 hour.[17] Additionally, the presence of alcohol use or a history of traumatic brain injury may cause or exacerbate impulsivity and disinhibited behavior.

Perhaps the best indicator that a patient is at increased risk may be a history of a prior suicide attempt. For example, some studies have shown that up to 40 percent of depressed patients who commit suicide have made a previous attempt. The risk of a patient making a second attempt is highest within the 3 months following the first attempt. Some studies indicate that up to two-thirds of patients who commit suicide have

seen a physician in the month before their death. Among the older adult male sub-population, the majority tend not to seek mental health treatment. However, studies indicate that many who commit suicide have seen their primary care provider within the month of their death.[18]

In 2002, the VA National Center for Patient Safety (NCPS) looked at a convenience sample of 400 suicide and parasuicide[B] root cause analysis (RCA)[C] reports from VA medical centers, relying heavily upon narrative detail in each RCA. The review, which included 10 inpatient suicides, 293 outpatient suicides, 47 inpatient parasuicides, and 45 outpatient parasuicides, indicated that 34 percent of patients had made a previous attempt. Of these patients, 42 percent had a history of alcohol dependence, 19 percent a history of street drug dependence, and 16 percent a history of prescription medicine dependence. For the total 400 patients, the last contact was with outpatient mental health for 42 percent, inpatient mental health for 25 percent, and outpatient primary care for 25 percent. More specifically, for outpatient suicides 78 percent had contact with a provider (either mental health or primary care provider) within the month prior to suicide.[19]

In a Danish study that made use of data registries containing information on the Danish population from 16–78 years of age in the period from 1980–1994, researchers matched 811 suicides that occurred with 79,871 control subjects and performed multiple statistical analyses to identify key variables associated with suicide. In this population, the strongest risk factor by far was a history of admission to a psychiatric hospital; regardless of diagnosis, the greatest period of risk was during hospital admission and in the first week following discharge.[20]

Additionally, suicide of a care recipient while in a staffed, round-the-clock care setting has been the most frequently reported type of sentinel event since the inception of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Sentinel Event Policy in 1996. As a result, the JCAHO's 2007 National Patient Safety Goals require that organizations identify patients at risk for suicide. The requirement applies only to patients admitted within psychiatric hospitals and patients being treated for emotional or behavioral disorders in the general hospital. The requirement (15A) includes the expectations that risk assessment includes identification of specific factors that may increase or decrease risk for suicide; the patient's immediate safety needs and most appropriate setting for treatment are addressed; and the organization provides information such as a crisis hotline to individuals and their family members for crisis situations.[21]

[B] Parasuicide refers to a suicidal gesture or a suicide attempt which does not result in death (a completed suicide). NCPS defines it as "Any suicidal behavior, with or without physical injury, short of death including the full range of known or reported attempts, gestures, or threats."

[C] The goal of a root cause analysis or RCA is to find out what happened, why it happened, and to determine what can be done to prevent it from happening again. RCAs are used to focus on improving and redesigning systems and processes, rather than to focus on individual performance.

Environmental and sociocultural risk factors also include job or financial loss, relational or relationship loss, easy access to lethal means, lack of social support and sense of isolation, stigma associated with help-seeking behavior, barriers to accessing health care, certain cultural or religious beliefs, and exposure to, including through the media, and influence of others who have died by suicide.[22]

VA is one of the largest integrated health systems in the world, and the largest provider of mental health care. Although the demography is changing as the number of women veterans increases, veterans in general are fairly representative of the overall U.S. male population. However, only a small proportion of veterans seek care from VA. As a whole, those veterans who do seek care through VA are poorer and sicker than the general population of veterans. In particular, they are more likely to be disabled and to have a psychiatric disorder.[23]

Using data (with methodological limitations) from studies that predate Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), some VHA researchers had previously estimated suicide rates among VHA facility users to be as high as 83 per 100,000 in the less-than 65 age group and 45 per 100,000 in the older-than age 65 age group; this reflects a higher at-risk population (or higher relative proportion of at-risk patients) than the overall general population.[24] At-risk patients seen in VHA and non-VHA settings include patients with schizophrenia and other psychotic illness, recurrent major depression, bipolar spectrum disorder, panic disorder and post-traumatic stress disorder (PTSD), substance abuse disorders, dual diagnosis (serious mental illness and substance abuse) and aging adults. Sub-populations particular to the VA who are or may be at increased risk include patients with combat zone related PTSD, traumatic brain injury (TBI), traumatic amputation and/or disfigurement, spinal cord injury, those who have experienced military sexual trauma (MST), and combinations of the above.[25]

The following introductory sections will review the development of the VHA Mental Health Strategic Plan and will briefly highlight the public health approach to suicide prevention presented in the Surgeon General's *National Strategy for Suicide Prevention* (NSSP) report; the Institute of Medicine (IOM) report, *Reducing Suicide: A National Imperative*; and the report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*.

B. Surgeon General's *National Strategy for Suicide Prevention: A Public Health Approach*

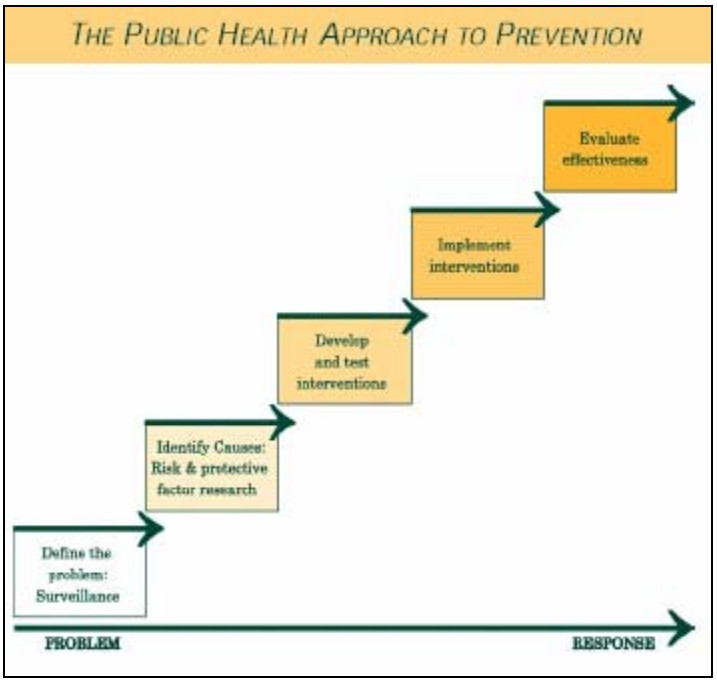
Recognizing that mental and substance abuse disorders confer the greatest risk for suicidal behavior, the Surgeon General's *Call to Action* (1999) suggested a blueprint for addressing suicide and injuries from suicidal behavior by addressing the problems of undetected and under treated mental health and substance abuse disorders in conjunction with other public health approaches. The *Call to Action* proposed a conceptual foundation designated "AIM." The elements of "AIM" were Awareness: Broaden the

public's awareness of suicide and its risk factors; Intervention: Enhance services and programs, both population-based and clinical care; and Methodology: Advance the science of suicide prevention. The AIM framework included 15 recommendations derived from consensus-based and evidence-based findings intended to serve as a foundation for a more comprehensive *National Strategy for Suicide Prevention*.[26]

The NSSP (2001) is intended as a highly ambitious, comprehensive, and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. The NSSP represents the first attempt in the United States to prevent suicide through a coordinated approach by both the public and private sectors. The editors noted that "suicide is an outcome of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental risk and protective factors…. Development of a national strategy can bring together multiple disciplines and perspectives to create an integrated system of interventions across multiple levels, such as the family, the individual, schools, the community, and the health care system…. An evidence-based national strategy can maximize success when recommendations are implemented locally. Sound evaluation of community programs, in turn, builds the evidence base."[27]

The NSSP articulates a set of 11 goals and 68 objectives intended as a roadmap for action to help guide an informed selection of activities for suicide prevention across the spectrum of the nation. The editors noted that the next step would be to develop a detailed plan that includes specific activities corresponding to each objective.

The NSSP roadmap is based on a public health approach adapted for suicide. In contrast to the clinical approach of exploring the clinical history, health, behavior, and life events of a single individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior throughout a group or population. The five basic steps of the public health approach are depicted in the following diagram:



From the *National Strategy for Suicide Prevention*, p. 29.

The steps depicted may occur in sequence but sometimes overlap. For example, information gained from evaluations may lead to new and promising interventions. Surveillance helps define a problem for a community. Collecting data on rates of suicide and suicidal behavior typically comprises surveillance. Surveillance data includes information on how suicide rates vary by time, geography, age, or special populations. In addition, surveillance may include collection of information on characteristics of individuals who suicide, circumstances surrounding suicide events, the presence and absence of possible precipitants, and the adequacy or accessibility of supportive factors and health services.[28]

Risk factors are those elements that may be thought of as leading to or being associated with suicide and were discussed in the preceding section. Protective factors tend to enhance resilience, and may serve to counterbalance risk factors and reduce the likelihood of suicide. Protective factors include effective clinical care for mental, physical, and substance use disorders; easy access to a variety of clinical interventions and support for help seeking; restricted access to highly lethal means; strong connections to family and community support; support through ongoing medical and mental health care relationships; skills in problem solving and conflict resolution; and cultural and religious beliefs that discourage suicide and support self-preservation. Understanding interactive relationships between multiple risk factors, between risk factors and protective factors, and how these interactions can be modified are challenges to suicide prevention.[29]

Suicide prevention interventions may be developed to attempt to influence some component or combination of psychological, physical, environmental or cultural

conditions. Alternatively, suicide prevention efforts may be divided into a universal approach intended for everyone in a population regardless of risk (e.g., reducing stigma in the community), a selective approach for subgroups at increased risk, and an indicated approach designed for patients such as previous suicide attempters, whose examination reveals factors that put them at very high risk.[30] The universal approach is consistent with the notion known as Rose's Theorem[D] that "a large number of people at small risk may give rise to more cases of disease than a small number who are at high risk."[31]

Rigorous testing to evaluate efficacy and effectiveness of interventions is important to ensure that interventions are safe and feasible prior to their larger scale implementation. Testing usually includes small scale pilot studies or demonstration projects. Efficacy studies ask the question, "under ideal conditions, can an intervention work?" When proposed interventions are found to be safe and feasible, further testing with larger groups can lead to refinements or adaptation for group differences based on factors such as age, gender, or region. Effectiveness studies undertaken in actual clinical settings ask the question, "in the real world, does it prevent suicide?" The editors of the NSSP note that it is frequently difficult to conduct efficacy studies; and they add: "in actuality, definitive pilot studies are frequently missing for many types of social and mental health interventions, including those designed to prevent suicide. By default, program planners may incorporate 'promising' interventions into community suicide prevention plans before the evidence base is fully developed. This makes careful evaluation of local outcomes especially important."

Comprehensive suicide prevention programs—those employing a portfolio of intervention elements, and particularly those that incorporate a range of services and providers—are thought to have a greater likelihood of reducing suicide rates. Selecting which interventions to implement includes consideration of the needs and characteristics of the target population, ways to integrate interventions into existing programs, efforts to strengthen collaboration, and an analysis weighing the resource requirements versus the potential effectiveness of individual interventions.[32]

Evaluation is a tool used to ensure that programs, such as those designed to prevent suicide, accomplish what they intend. Evaluation may be concerned with the outcomes of interventions or the functioning of intervention programs. Evaluation can help determine for whom a particular strategy is best fitted and how it should be modified to improve efficacy. An outcome evaluation uses quantifiable data to determine whether or not a program has had the desired effects. While evaluation is often thought of in terms of overall or ultimate outcome, sometimes a more general question or proxy measure is examined. For example, it may look at the ability of an outreach program to actually reach people at risk. A process evaluation focuses on implementation. By documenting a program's development and operation, a process evaluation can provide understanding of the performance of a program, enhance a project's ability to stay on course, ensure

[D] Rose, G.: *The Strategy of Preventive Medicine*. Oxford, England, Oxford University Press, 1992.

accountability by comparing actual performance with expectations, and provide an opportunity to make mid-course modification and to identify problems or gaps that need attention.[33] Endorsement and implementation of the goals from NSSP is incorporated into the VHA Mental Health Strategic Plan.

C. Institute of Medicine's *Reducing Suicide: A National Imperative*

This 2002 Institute of Medicine report highlighted the construct that programs that address risk and protective factors at multiple levels are likely to be most effective. In addition, the report noted the importance of coping skills as a protective factor. Since research suggests that coping skills can be taught, they may therefore be an avenue toward prevention.[34,35] Endorsement and implementation of the report is incorporated into the VHA Mental Health Strategic Plan.

D. President's New Freedom Commission on Mental Health Report *Achieving the Promise: Transforming Mental Health Care in American*

In April 2002, the President's New Freedom Commission on Mental Health identified three obstacles preventing Americans with mental illness from getting the excellent care they deserve: (1) stigma that surrounds mental illness, (2) unfair treatment limitations and financial requirements placed on mental health benefits in private insurance, and (3) the fragmented mental health service delivery system. The President launched the Commission to conduct a comprehensive study of the delivery of mental health services and to address the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks. In his charge to the Commission, the President directed its members to study the problems and gaps and make concrete recommendations for immediate improvements that the Federal government, state governments, public health care providers, local agencies, and private health care providers could implement.

In its interim report to the President, the Commission concluded that the system is not oriented to the hopes of recovery; state-of-the-art treatments, based on research, are not being transferred from research to community settings; and in many communities, access to quality care is poor resulting in lost opportunities for recovery.[36]

In submission of the final report to the President, members of the commission wrote that:

> …for too many Americans with mental illness, the mental health services and supports they need remain fragmented, disconnected, and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the [American health care] system presents barriers that all too often add to the burden of mental illness for individuals, their families, and our communities. The time has

> long passed for yet another piecemeal approach to mental health reform. Instead the Commission recommends a fundamental transformation of the Nation's approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges. Too often, today's system simply manages symptoms and accepts long-term disability. Building on the principles of the New Freedom Initiative, the recommendations we propose can improve the lives of millions of our fellow citizens now living with mental illness…We look forward to the work ahead to make recovery from mental illness the expected outcome from a transformed system of care.[37]

The Commission identified six intertwined goals as the foundation for transforming mental health care in America. For each goal the Commission made recommendations. In addition, the Commission urged swift implementation of the NSSP. The ensuing table lists Commission goals and recommendations.[38]

Goal 1. Americans Understand that Mental Health is Essential to Overall Health

Recommendations

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Goal 2. Mental Health Care is Consumer and Family Driven

Recommendations

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

2.3 Align relevant Federal programs to improve access and accountability for mental health services.

2.4 Create a Comprehensive State Mental Health Plan

2.5 Protect and enhance the rights of people with mental illnesses.

Goal 3. Disparities in Mental Health Services are Eliminated.

Recommendations

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4. Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

Recommendations

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Goal 5. Excellent Mental Health Care is Delivered and Research is Accelerated.

Recommendations

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6. Technology is Used to Access Mental Health Care and Information

Recommendations

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

E. Under Secretary for Health's *A Comprehensive VHA Strategic Plan for Mental Health Services*

The Under Secretary for Health charged a work group to review the President's New Freedom Commission on Mental Health Report. The work group was tasked with determining the relevance of the Commission's goals and recommendations to veterans' mental health programs and to develop an action plan tailored to the special needs of the enrolled veteran population. This work group developed and published an Action

Agenda in *Achieving the Promise: Transforming Mental Health Care in VA*, in December 2003, which generated multiple talking points from the six tenets of the President's New Freedom Commission Report. The VA Action Agenda report, along with work derived from the Capital Asset Realignment for Enhanced Services (CARES) process and the need to address future geropsychiatric and other needs of the enrolled veteran population, prompted the Deputy Under Secretary for Health to task the Office of the Assistant Deputy Under Secretary for Health with facilitating the efforts of a workgroup to develop a comprehensive, overall strategic plan for mental health care services. The Action Agenda recommendations, the Acting Under Secretary's "12 in 12"[E] plan, and recommendations from a VA Mental Health Task Force report entitled "*Availability and Access to Mental Health and Substance Abuse Services for Veterans*," formed the foundation of the work of the Mental Health Strategic Plan Workgroup and the resulting MHSP. During this development process, the workgroup conducted meetings with over 125 experts in mental health. Ultimately the multiple talking points were incorporated into a 5-year strategic plan with more than 200 initiatives. The MHSP was initially approved by the Under Secretary in July 2004 and was finalized in November 2004.[39]

The purpose of the MHSP was to present a new approach to mental health care focused on recovery versus pathology and integration of mental health care into overall health care for veteran patients. The action plan includes timetables and responsible offices identified for each action item. In addition to the President's New Freedom Commission Report, other factors that influenced the MHSP Work Group included the influx of OEF/OIF veterans, the challenge to deliver quality mental health services to a growing number of women veterans, and the changing and future mental health service needs of aging Vietnam Era veterans.[40]

The following table lists initiatives from the MHSP that pertain to suicide prevention.[41]

- Develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care.
- Develop a plan to educate all staff who interact with veterans, including clerks and telephone operators, about responding to crisis situations involving at-risk veterans. This would include suicide protocols for intake, telephone operators, and other first contact personnel.
- Develop mandatory education programs for VA health care providers about suicide risks and ways to address these risks. Incorporate best practices for suicide prevention.
- Promote evidence based strategies for suicide assessment and

[E] Jonathan B Perlin, *Moving from Strategy to Action: 12 Priorities–12 Months,* VHA Senior Managers Conference, Washington, DC, August 17, 2004.

prevention including emphasis on special emphasis groups.

- Develop and test an electronic suicide prevention database.
- Develop a national systematic program for suicide prevention.
- Endorsement and implementation of the *National Strategy for Suicide Prevention* (2001) and the Institute of Medicine's report, *Reducing Suicide: A National Imperative* (2002).
- Develop a plan for 24-hour mental health care availability through VHA.
- Medical centers establish contacts through the Chaplain Service with faith-based organizations and community resources to assist with culturally competent suicide prevention and other mental health issues at local and national levels.
- Support for a new Mental Illness, Research, Education Clinical Center (MIRECC) with focus on suicide prevention, in collaboration with other MIRECC's working in this area.

In a section of the MHSP report entitled "*Issues in Mental Health Care for Specific Populations,*" under the heading of "Suicide Prevention," the report notes: "Another mental health focus is on suicide prevention. The VA's strategy for suicide prevention should include universal screening designed to activate the system as a whole for the prevention of suicide. Identification of periods of increased risk in veterans known to have mental health or substance use disorders is important and targeted interventions designed to address the needs of veterans acutely or chronically at increased risk for suicide are needed."[42]

Identification of periods of increased risk and targeted interventions is effectively subsumed in the suicide prevention related initiatives of the MHSP action plan and will be discussed under the targeted intervention and screening and referral headings in the findings of this report. The context for the phrase "universal screening" reportedly was to imply that, in line with the goals of the President's New Freedom Commission, just as psychiatrists should ask patients about any physical concerns and address these concerns through appropriate referral or intervention, non-psychiatrists should routinely ask all patients, regardless of health care venue (such as surgical or medical), if they are experiencing any mental health concerns and should refer or intervene appropriately. This "universal" strategy would potentially improve detection of mental illness, reduce stigma, enhance patient willingness to pursue treatment and thereby enhance suicide prevention efforts. Universal screening of all patients specifically for suicidal ideation or risk was not adopted by the MHSP workgroup as an initiative in the MHSP action plan.

The United States Preventive Services Task Force (USPSTF) has concluded that the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population. Screening instruments for suicidal ideation are more commonly used in specialty clinics and mental health settings but test characteristics of most commonly used screening instruments have not been validated to assess suicide risk in primary care settings. The USPSTF found: (1) no evidence that screening for suicide risk reduces suicide attempts or mortality; (2) limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk; (3) insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality [difficult to show statistically as the incidence of suicide in the general population (0.1percent) is relatively low]; and (4) studies that directly address the harms of screening and treatment for suicide risk. As a result, the USPSTF could not determine the balance of benefits and harms of screening for suicide risk in the primary care setting. However, the USPTSF does recommend screening adults for depression in clinical practices, including primary care settings, that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.[43]

The following sections of this inspection will describe the scope and methodology employed to derive information and data used in this evaluation and will assess and depict the extent to which VHA has implemented MHSP initiatives for suicide prevention.

Scope and Methodology

A. Survey of VHA Facilities

To ascertain implementation of MHSP suicide prevention initiatives at the point of service level we developed and conducted a 31-question web based survey. (Appendix A) The survey was initially piloted in early December and then distributed to Veterans Affairs Medical Centers (VAMCs) between mid-December 2006 and early February 2007. Surveys were sent to facility Chiefs of Staff to be completed in collaboration with clinicians from mental health, primary care, and quality management. The web based survey was intended to capture a descriptive on the ground snapshot of implementation at the facility level. The questions on the survey were intended to align with various MHSP suicide prevention initiatives.

Survey design included a series of yes/no questions. For several questions in which the respondent answered "yes," follow-up questions asked the respondent to mark applicable items or to describe the applicable programs or strategies implemented. This design was employed to discourage unsupported "yes" responses and to improve response validity. In addition, as we were aware that most or all of the initiatives were not implemented system-wide, we included qualitative descriptive items in the survey methodology in

order to capture an image of pilot sites and/or islands of local innovation. The survey was sent to all VISNs. Facilities from 17 VISNs responded. Facilities from four VISNs did not respond. Overall, 110 facilities responded to the survey instrument. Responses to follow-up questions asking for a brief description of programs/strategies implemented were reviewed. These responses were evaluated to gauge whether they aligned with the intent of the related index question.

B. Field Interviews

From December to February 2007, inspectors conducted interviews with present and former VHA mental health leadership, members of the MHSP workgroup, VHA clinical researchers at the VISN 3 MIRECC, VISN 4 MIRECC, VISN 19 MIRECC, and the newly-formed VISN 2 Canandaigua Center of Excellence. We conducted interviews with the Director of the VA's Readjustment Counseling Service, the Acting Director of Primary Care Services, a mental health liaison in the Office of Research and Development (ORD), and the Director for the Primary Care & Mental Health Integration Program. In addition, we interviewed clinical researchers from the VA Serious Mental Illness Treatment Research and Evaluation Center (SMITREC), and the VA National Center for Patient Safety. In addition, we reviewed materials from selected VA suicide education programs and conferences, and one of the inspectors was an observer at a February 7–9, 2007, regional conference "Evidence-Based Interventions for Suicidal Persons" co-presented by the VISN 19 MIRECC and the American Foundation for Suicide Prevention (AFSP). As we were aware that most of the MHSP initiatives for suicide prevention have not reached the level of system-wide implementation, one objective of the interview process was to ascertain a panoramic image of the nature and extent of implementation for the suicide prevention initiatives. The interview process began with an outline by VHA mental health leadership of work in progress. We then conducted specific detail oriented interviews with VHA experts in the "trenches" to enhance our perspective and understanding of the work being done, to assess the extent of progress toward implementation, and as a method for validation.

This review does not address the financial resources attendant to MHSP suicide prevention initiatives. Because the Surgeon General's *National Strategy for Suicide Prevention* and the IOM report, *Reducing Suicide: A National Imperative*, are broad roadmaps for action to help guide an informed selection of activities for suicide prevention, and endorsement and implementation of the NSSP and IOM report are incorporated into the MHSP, the scope of this report will focus largely on implementation of suicide prevention initiatives unique to the MHSP action plan. The NSSP and IOM goals include efforts at improving outreach and reducing stigma. The extent of VHA implementation of initiatives related to outreach and reduction of stigma will also be reviewed in the findings.

C. Benchmark Considerations

An informed assessment of VHA implementation requires a brief discussion of benchmark comparisons and challenges to implementing a public health approach to suicide prevention.

1. Suicidologists have struggled with standardization issues for many years. While it has long been held that the pursuit of valid and reliable suicide statistics is important to public health policy and empirical research, establishing the validity and reliability of suicide rates had been a notable source of concern. In the U.S. it is widely assumed by mental health professionals that the actual suicide rate is significantly higher than officially reported rates. Establishing the validity and reliability of suicide rates is complicated by stigma. Other sources of variability include limitations of death certificates, variability in the training of those tasked with certifying cause of death, use of differing guidelines for suicide determination, and the presence of equivocal causes such as drug overdoses, single car deaths, jumps/falls, and sexually related asphyxia. There have been attempts in the literature to develop operational or empirical criteria for the determination of suicide but the challenges persist.[44] The fact that the majority of veterans receive health care at non-VHA venues complicates the ability to establish a reliable rate of veteran suicides in the general population. In terms of VHA utilizers, a facility may not become aware of or may experience a lag in awareness of an outpatient suicide by a veteran seen at infrequent intervals (for example, a relatively healthy veteran who commits suicide between annual primary care check-ups). Furthermore, reporting of suicide attempts and parasuicidal behavior tends to be subject to greater variability. A percentage of attempts never come to the attention of health care providers. In addition, there is often a lack of standardization in how health care providers define attempts/gestures/parasuicides or when defined, subjective interpretation and a lack of uniformity in categorization of attempts.[45]

2. Although it is the 11th leading cause of death, suicide is relatively infrequent and is difficult to track as discussed in the previous section. With 11 suicides for every 100,000 people, a very large sample is needed to reach valid conclusions using suicide as an outcome measure. Because of the very large sample size requirement demonstrating the ultimate impact of target interventions prior to implementation is a significant challenge. In addition, the use of number of suicides or rate of suicides as a quality outcome measure on the facility level is therefore of limited utility in the absence of an abrupt and dramatic trend or shift in the data. Suicide attempts are sometimes used as a proxy for completed suicides, because attempts are a risk factor for suicide death. As one in ten suicide attempters dies by suicide, the utility of attempts as a proxy measure is limited.[46] Despite the limitation of completed suicide or suicide attempts as outcome measures at the facility level, the use of process measures can help identify

meaningful gaps in service delivery and can provide opportunities for quality improvement.

3. Some suicidologists suggest that within the realm of self-injurious behavior, there are overlapping and clinically distinct groups that include ideators, threateners, first time attemptors, chronic, repetitive attempters, deliberate self mutilators, and suicide completers. How these groups overlap and what keeps patients from moving from one group to another are the work of ongoing research.[47]

4. Suicide is not a single illness with one true cause, it is a final common outcome with multiple potential antecedents, precipitants, and underlying causes.[48] Interventions most effective for a chronically suicidal patient with borderline personality disorder may differ from interventions that are most effective for an elderly male with depression and the early stages of Alzheimer's dementia.

5. Implementing interventions that target specific at-risk groups, such as the use of dialectical behavioral therapy (DBT) for patients with borderline personality disorder, requires recruitment and/or training of clinicians skilled in providing this mode of treatment. As dissemination of treatment skills takes time and resources, clinicians and policy makers are confronted with challenging decisions regarding which treatment interventions may be of greatest potential benefit to the greatest number of patients or alternatively the highest at-risk patients.

Clinician researchers generally consider the majority of suicides to be preventable. However, prevention of suicide remains a significant challenge. This being said, as stated in the 2002 World Health Organization report, *Violence—A Global Public Health Problem*, "…the impulse to invest only in proven approaches should not be an obstacle to supporting promising ones…. Violence is far too pressing a problem to delay public health action, while waiting to gain perfect knowledge."[49]

While the findings of this report could be presented using a binomial "fully implemented" versus "not fully implemented" method, this approach would provide little new information for relevant stakeholders, and would not fulfill, in a satisfactory manner, the task requested of us. Therefore, in order to best present our findings in an accurate, objective, and informative manner, we employed a method by which implementation was assessed along a spectrum of five stages which we have defined as follows:

1. No Action – An initiative for which we could not find evidence of plans for future development, piloting or implementation.

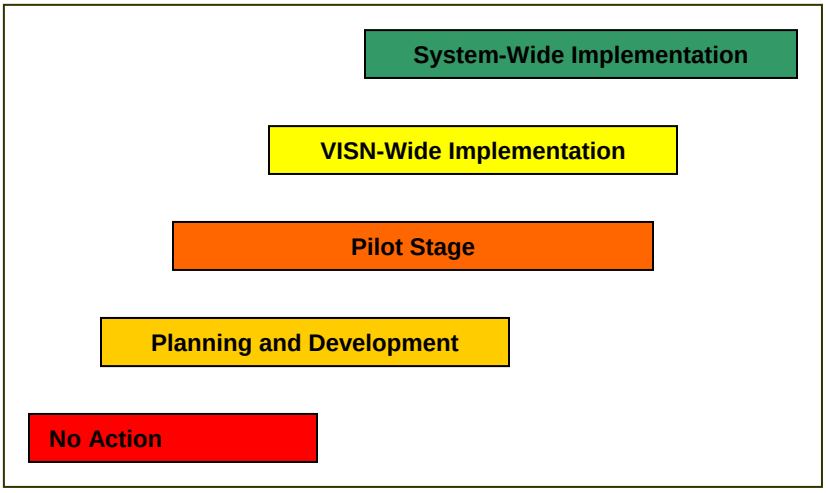
2. Planning and Development – An initiative for which we found evidence of resource and process planning but which we could not find evidence of piloting or local implementation.

3. Pilot or Demonstration – An initiative for which we found evidence of ongoing or completed pilot or demonstration projects.

4. VISN-Wide Implementation – An initiative for which we found evidence for implementation throughout an entire VISN or in multiple facilities in multiple VISNs.

5. System-Wide Implementation – An initiative for which we found evidence for implementation throughout VAMCs.

IMPLEMENTATION STAGES



Findings

Given the breadth of the topic of this report and the extent of information that will be provided in the findings, for the purpose of presentation, we have categorized individual MHSP initiatives into one of six domains:

A. Crisis Availability and Outreach
B. Screening and Referral
C. Tracking and Assessment of Veterans at Risk
D. Emerging Best Practice Interventions and Research
E. Development of an Electronic Suicide Prevention Database
F. Education

While we attempted to place each initiative in the most relevant category, some initiatives impact on multiple domains. These initiatives are therefore appropriately discussed or referenced in multiple sections.

Under each domain, we discuss several topics. Initially, there is a summary of the results from survey related to that topic. Following that, we generally have charts that illustrate the survey results we received. In many instances, this is followed by an arrowed bullet symbol (➲), which provides information we learned from interviews.

A. Crisis Availability and Outreach

Availability 24/7. More than 94 percent of facilities responding to the web based survey reported 24-hour availability of mental health care at their facilities. Slightly more than 5 percent reported lack of 24-hour availability. Ninety-eight facilities reported availability through the emergency room/urgent care; 24 facilities reported availability of a walk-in clinic; and 34 facilities reported availability of an in-house 24-hour crisis hotline. The question was formatted to allow for facilities that have more than one of these options to report all options.

Is mental health care available through your VAMC 24 hours a day?

	Counts	Percents	Percents 0 100
Yes	104	94.5%	
No	6	5.5%	
Totals	110	100.0%	

If yes, which of the following is available on a 24 hour basis? Mark all that apply:

	Counts	Percents	Percents 0 100
Walk in Clinic	24	23.1%	
24 hour crisis hotline	34	32.7%	
ER/Urgent Care	98	94.2%	
No Answer	1	1.0%	
Totals	104	n/a	

➲ In January 2007, JCAHO requirement 15A went into effect, which required that patients being treated for emotional or behavioral disorders be assessed to determine if they are at risk for suicide and that facilities should follow up accordingly. One expectation of the requirement is that organizations provide information such as a crisis hotline to individuals and their family members for crisis situations.[50] In response, VHA issued a policy and procedures guideline for JCAHO 15A.[F] At the time of initial interview in early December 2006, OMH leadership did not have data on how many facilities had an in-house 24/7 crisis

[F] Under Secretary for Health's Information Letter, IL 10-2006-013, *New JCAHO Performance Requirement for Mitigating the Risk of Suicide*, December 11, 2006.

line or arrangements with local community 24/7 crisis lines. Subsequently, the OMH internally surveyed VAMCs and reported that VHA is working with national and community agency run hotlines, so that if a facility does not have an in-house crisis line, patients calling the facility crisis number can be patched to a non-VA community or national hotline. The OMH reported working with the Substance Abuse and Mental Health Services Administration to ensure that existing non-VA suicide prevention hotlines are aware of veteran related issues and services. The Readjustment Counseling Service Office reported that patients who call Vet Centers at non-working hours are given a number for an area VAMC or a community crisis line. "A very early" planning proposal considers possibly establishing a manned vet center crisis line in areas where there is not an available 24-hour VAMC or community line.

Increased Access. Ninety-nine percent of responding facilities reported that they have undertaken efforts to increase access to mental health care and substance abuse services. In describing these efforts, several facilities reported increased staffing and recruitment of providers, expansion of mental health staff to Community Based Outpatient Clinics (CBOCs), implementation of Advanced Clinic Access principles, and integration of mental health clinicians into primary care settings. There were multiple innovations reported on a facility level. Strategies reported included creation of a Women's Behavioral Health Treatment Clinic in a separate area with a separate waiting room; initiation of a "OEF/OIF START" program to assesses newly returned combat veterans and assist them with appointments into the mental health clinic; an OEF/OIF Combat Stress Group that welcomes walk-ins; establishment of a Mental Health Access and Referral Clinic to help place patients in appropriate programs on the day that they request service using the "one stop shopping" approach; increased use of open scheduling and drop-in assessment clinics; expanded evening clinics; presence and availability of mental health professionals at outreach events; and a drop-in medical group for homeless veterans, and a Mental Health Intensive Rural Case Management program ("Pony Express" model) that is partially integrated with primary care.

Have efforts been undertaken to increase access to mental health care and substance abuse services?

	Counts	Percents	Percents 0 100
Yes	109	99.1%	
No	1	0.9%	
Totals	110	100.0%	

The web based survey asked facilities whether mental health clinicians were co-located in primary care clinics. Fifty-six facility respondents endorsed having the presence of mental health clinicians at primary care clinics.

As of the date of this survey, are mental health clinicians co-located and seing patients at your primary care clinic(s)?			
	Counts	Percents	Percents 0 100
Yes	56	51.9%	
No	52	48.1%	
Totals	108	100.0%	

- One of the more extensive system-wide efforts for improving access (and reducing stigma) is the Primary Care/Mental Health Integration Program whereby mental health clinicians will be present in primary care venues to treat patients, educate and support primary care providers, and educate patients and families. Some facilities have implemented locally initiated and developed co-located models for the past few years. The nationally directed program began implementation in the 1st quarter of fiscal year (FY) 2007. Request for proposals went out to facilities in May 2006, half were approved in the fall of 2006 and half were sent back to the facilities for re-adjustment and re-submission. Between the initial approvals and those re-submitted, the program will be implemented in 70–80 facilities. A program office and staff were funded and have been recruited.

- There are two models for integration. First is the *co-located collaborative care* between a mental health provider and primary care physician located in the same clinic area or close proximity at the same time. The second is a *case management model*, in which a primary care physician refers patients to a mental health care manager, usually a registered nurse, who conducts ongoing phone follow-up with patients regarding medication response and adherence, reinforces patient coping skills, and provides education to patients and ongoing decision support to the primary care physician. Under the co-located model, if a patient screens positive on a depression or PTSD screen and the positive screen is supported on primary care physician interview, then, if agreeable, the patient could be walked down the hallway for an assessment by a mental health clinician that day. When appropriate, patients will be referred to mental health clinic. Some patients will receive treatment or a short term course of structured therapy at primary care sites. The Primary Care Integration Program Office plans to inventory existing programs to ascertain what is being done, who is doing it, does it look like the co-located or case management model, and how is it working. The program office plans to develop performance measures, to host monthly national calls from the participating field sites to share best practices and experiences, and to tailor capacity to match actual demand at individual sites.

Increased Awareness. Facilities were asked what efforts have been undertaken to promote awareness that suicide is a preventable public problem. Ninety-seven facilities described efforts to promote awareness. Several facilities mentioned in house education

and in-service training for staff. Other local innovations included required reading for all nursing staff, outreach to local media to provide veteran and suicide related education and facility contact information, display of posters throughout the medical center, and creation of a pamphlet, "Recognizing the Warning Signs for Suicide and What YOU Can Do," which will be available to veterans and employees at that VAMC.

Reducing Stigma. Approximately 85 percent of responding facilities reported implementing strategies to reduce the stigma associated with pursuing mental health and/or substance abuse treatment. Local strategies described by facilities included the use of posters and newsletters; weekly educational classes for patients which teach the contribution of genetics and chemical imbalance in substance addiction; making mental health programs known to veterans groups in the area; the involvement of a Mental Health Consumer Council with a subcommittee focused on reducing stigma; establishment of a Peer Advisory Committee; presentations at National Guard and Reserve meetings and an agreement with National Guard leadership in one state to speak with returnees on a one-to-one basis to address stigma; and involvement in a Mental Health Awareness program with presentations by the state chapter of the National Alliance for the Mentally Ill (NAMI), veteran consumers of mental health care, and a member of Congress.

Have strategies been implemented to reduce the stigma associated with being a consumer of mental health and substance abuse services?

	Counts	Percents	Percents 0 100
Yes	94	85.5%	
No	16	14.5%	
Totals	110	100.0%	

- The OMH has emphasized transformation to a recovery model for patients with the seriously mentally ill (SMI) population in line with the philosophy of the President's New Freedom Commission Report. OMH has funded development of Psychosocial Rehabilitation (PSR) programming and positions for facility recovery coordinators to help coordinate efforts toward recovery and de-stigmatization. Psychiatric research indicates that patients with serious mental illness may be at greatest risk for suicide in the few years following initial diagnosis. PSR programming emphasizes moving from a focus solely on patient symptomatology to a focus on one's level of function in the world. PSR promotes the use of environmentally specific skills, strengths, and abilities to aid in re-integration and function within the community. By addressing stigma and focusing on function, the recovery model is aimed at fostering hope for the future rather than expectations of disability and chronicity.

Community Based Prevention. One fifth of facility respondents reported implementing community based suicide prevention programs. Descriptions of innovations implemented by local facilities included a relationship with the New York Police Department (NYPD) with presentations to NYPD officers who are OEF/OIF veterans in an attempt to de-stigmatize pursuing care for mental health symptoms and issues that may arise; QPR™[G] gatekeeper training for Community Residential Care (CRC) sponsors, VA licensed Family Care Home and Personal Care Home providers, and upcoming QPR™ gatekeeper training for parents and teachers at a local school; involvement in Crisis Intervention Team Training education for member of the Memphis Police Department; distribution of educational DVD's on young adult suicide to local schools and colleges; participation by mental health staff in local Spanish language radio and television shows; education to reservists on weekends; and participation in a Colorado Brain Injury Association exhibit and presentation regarding TBI patients.

- The Director of the VA Readjustment Counseling service reported that Vet Centers have made 134,760 cumulative outreach contacts to OEF/OIF veterans through June 2005. He reported that vet center personnel conduct information sessions at demobilizations all around the country. He emphasized an outreach at a New Hampshire National Guard base "to welcome them home; to give literature; to say we are like you." He reports that 2 weeks later, vet center personnel screened 800 guardsmen at the base by interview and let them know "if you need us we are here." He reports that 15 percent initially stated that they wanted help.

Involving Chaplains. Less than 20 percent of responding facilities reported utilizing VHA's Chaplain Service to establish contacts with faith-based organizations and community resources. Locally initiated strategies implemented at select VAMCs included inviting faith-based organizations in the Richmond area to a community meeting at the VAMC to explain hospital services available and for organizations to explain their services to VAMC participants; working with Vermont National Guard chaplains to assist with mental health issues; accompanying the OEF/OIF coordinator to all post-deployment events in the community; meeting with a group of local clergy to discuss ways in which VAMC chaplains may be of assistance; providing education programs at local denominational, local church, and city-wide pastoral meetings; and providing education on veteran mental health to clergy students from a local Clinical Pastoral Education training program.

[G] QPR™ stands for Question, Persuade, and Refer – an emergency intervention undertaken upon recognizing suicide warning signs in someone known to the QPR-trained person.

Have initiatives been undertaken by the Chaplain Service to establish contacts with faith-based organizations and community resources to assist with culturally competent suicide prevention ...?

	Counts	Percents	Percents 0 100
Yes	21	19.1%	
No	89	80.9%	
Totals	110	100.0%	

- Planning and developing an education program designed to optimize chaplain awareness of mental health issues and how to access appropriate mental health care is under consideration by the OMH. Potentially, the Chaplain Service could be trained for use as a resource to educate community chaplains, and in turn could educate mental health providers regarding spiritual issues that affect patient care. At present we could not find evidence of centrally guided implementation beyond pre-planning discussion and tentative planning.

Conclusions Regarding Crisis Availability and Outreach. In terms of MHSP initiatives related to the availability of crisis care and outreach, the extent of implementation by VHA can be summarized as follows:

1. Most facilities reported availability of 24-hour mental health care either through the emergency room, a walk-in clinic or a crisis hotline. However, available 24-hour mental health care has not achieved full system-wide implementation. In addition, although facilities in multiple VISNs have or refer to external 24-hour crisis hotlines, availability of a 24-hour crisis hotline is not yet universal throughout the system.

2. Most VAMCs have undertaken efforts locally to increase access to mental health and substance abuse services. It is anticipated that implementation of the primary care-mental health integration program at multiple sites in multiple VISNs will increase and/or expedite access to mental health and substance abuse services. At present co-location exists at several sites and a significant increase in sites is in process of implementation.

3. Overall, most VAMCs have implemented local strategies to reduce stigma. In addition, the Readjustment Counseling Service has undertaken significant outreach to returning veterans throughout the country. The Office of Mental Health Services has implemented transition to recovery and hope based programming for the Seriously Mentally Ill. PSR programming is in place in multiple VISNs and system-wide implementation is in process.

4. Many facilities have implemented innovative community based outreach/suicide prevention programs, although the majority of facilities did not report community

based linkages and outreach. As local community demographics, needs, and resources differ, local strategies may be more appropriate then universal, centrally driven strategies for this purpose.

5. Less than 20 percent of facilities reported utilizing the Chaplain Service for liaison and outreach to faith based organizations in the community.

B. Screening and Referral

Screening. In-depth, face to face, clinical interview remains the best way to screen and assess for suicide risk. At present, a widely accepted and effective suicide screening tool does not exist, partly because of the complexities associated with the phenomena of suicide. Though there are some underlying commonalities, suicide and suicide attempts result from the complex interaction of a constellation of biological, psychological and social factors that manifest themselves within specific cultural and situational contexts. It has therefore been difficult for researchers to develop a proven screening tool that captures this disparate phenomenon, reliably and efficiently, for use in a heterogeneous veteran population.

Depression, PTSD, and substance abuse are mental health conditions associated with increased suicide risk. Annual screenings for depression, PTSD and substance abuse at primary care clinics are performance indicators used by VHA. Not surprisingly, 98 percent of facilities reported at least annual screening for depression and problem drinking and/or substance abuse in primary care clinic. Slightly less, or 93 percent of facility respondents indicated at least annual screening for PTSD at primary care clinic. The reason for the slight difference (approximately six less facilities), was unclear. Facilities were asked who generally administers screenings. The question was set up to allow for multiple responses. Respondents reported that at most sites screenings are administered by a clinic nurse, physician, and/or nurse practitioner/physician assistant. A psychologist and/or mental health nurse administers screenings at slightly less than one-fourth of facilities, and a nursing aide/primary care tech at one-third of facilities. One facility spontaneously indicated that a social worker does PTSD screening for OEF/OIF patients.

Depression			
	Counts	Percents	Percents 0 100
Yes	108	98.2%	
No	2	1.8%	
Totals	110	100.0%	

PTSD			
	Counts	Percents	Percents 0 100
Yes	102	92.7%	
No	8	7.3%	
Totals	110	100.0%	

Problem Drinking or other Substance Abuse			
	Counts	Percents	Percents 0 100
Yes	107	98.2%	
No	2	1.8%	
Totals	109	100.0%	

- Screening tools are being developed and tested at the VISN level. As will be discussed in greater detail in the tracking and monitoring section of this report, VISN 3 facilities have been using a suicide assessment template that is incorporated into the electronic medical record. The template is administered to mental health and emergency room patients. A modified version of the VISN 3 template is being used as part of the mental health intake in VISN 19.

- Since patients who suffer TBI may experience increased impulsivity which can affect suicide risk, at the Denver VAMC TBI patients are reportedly asked about suicidal ideation at Physical Medicine and Rehabilitation clinic follow-up visits.

- Chronic unremitting pain is associated with an increased risk for suicide. At the Denver VAMC and some other sites in VISN 19, patients seen at chronic pain clinic are asked verbal suicide screening questions. Patients identified as at risk are referred for specialty mental health care.

Tools for Screening. Fifty-one responding facilities indicated that primary care providers utilize tools for recognition and screening of patients for suicidality. Nineteen facilities reported use of standardized clinician-administered instruments, 14 reported use of the EES suicide risk assessment pocket card, and 11 reported use of a patient self report questionnaire. Other responses included use of a suicide lethality check list, a positive depression screen clinical reminder, and use of a clinical reminder that includes risk factors.

Hierarchical Strategy. Survey respondents were asked whether primary care providers utilize a hierarchical strategy to follow up positive depression screens with additional inquiries about suicidality. Approximately 42 percent of facilities reported using a hierarchical strategy of some kind. Of these 46 facilities, 32 reported asking about hopelessness, 19 about helplessness, 19 about passive death wishes, 12 about hallucinations or delusions, 20 about preoccupation with death, 39 about suicidal ideation without plan, and 37 about suicidal ideation with plan. A few facilities reported that all of the above queries are included in a link to a depression screen template under development. Some facilities reported that primary care providers also follow up with questions about recent interpersonal loss, insomnia and access to a method of suicide. One facility reported use of a tool comprised of three sections. The first section lists 32 risk factors that can be checked off. The second section lists a hierarchical set of

questions used such as "Do you ever wish when you go to bed that you wouldn't wake up, etc." The third section is a patient self rating of risk for killing themselves on a scale of 1–10. Clinicians are reminded to pay attention to inconsistencies in patient responses. This tool then indicates appropriate intervention based on combination of responses to the three sections.

Do primary care providers utilize a hierarchical strategy (structured interview template or algorithm) to follow positive depression screens with additional inquiries about suicidality ...?

	Counts	Percents	Percents 0 100
Yes	46	41.8%	
No	64	58.2%	
Totals	110	100.0%	

Improving Referral. Facilities were asked whether they have implemented a system to facilitate referral of veterans with risk factors for suicide by primary care providers to specialty mental health care. Approximately 84 percent of facilities indicated a positive response. Facilities were asked to describe salient aspects of referral systems in place. Several facilities reported service agreements between primary care and mental health for same-day psychiatric evaluation. Several facilities responded that a patient who reports suicidal ideation is escorted to the acute psychiatry walk-in clinic for evaluation by a mental health professional. Some facilities cited local suicide related medical center memorandum or policies.

Has your facility implemented a system to facilitate referral of veterans with risk factors for suicide by primary care providers to specialty mental health care? (e.g., policy, guideline, algorithm)

	Counts	Percents	Percents 0 100
Yes	92	83.6%	
No	18	16.4%	
Totals	110	100.0%	

Innovative strategies reported by facilities include forwarding of all positive depression screens to the psychology service, and referral of all positive suicide screens for same day evaluation by a mental health crisis worker; a dedicated pager carried by mental health clinicians who will see patients for positive depression screens, PTSD screens and/or suicidal ideation; use of a screen for suicide risk factors resulting in a same day mental health consult for positive screens; use of a pop up screen with protocol that informs the provider to accompany actively suicidal patients to the emergency room for psychiatric evaluation. Essentially all but one facility reported same day mental health evaluation when a primary care provider detects a patient at risk for suicide. A few respondents

indicated the average length of time from referral would also depend on perceived level of risk and patient's clinical state.

Time to Evaluation. In order to ascertain a snapshot of time from referral to mental health evaluation for other mental health conditions, facilities were asked when a primary care provider refers a patient with symptoms of moderate severity and what is the average length of time before a patient is seen by a mental health provider for depression, PTSD, or substance abuse. It was assumed that responses for patients with severe symptoms would mirror those indicated for the previous section. In addition, we would expect lag time between referral and appointment for patients with mild symptoms to be variable and of unclear clinical relevance if the lag time was within some acceptable outer limit. Because patients with moderate symptoms may be progressing toward severe symptoms and/or the onset of suicidal thoughts, we felt that time to evaluation was most salient for this group.

Referral for Depression. For depression, 40 percent of facilities responding to the survey reported on average same day evaluation by a mental health professional when a primary care provider refers a patient with symptoms of moderate severity, 16 percent reported less than 1 week, 16 percent reported 1–2 weeks, and 25 percent reported 2–4 weeks. Five facilities reported a 4–8 week wait. (Note that the symbol < means "less than" and > means "greater than.")

Depression			
	Counts	Percents	Percents 0 100
Same Day	44	40.0%	
< 1 week	17	15.5%	
1 - 2 weeks	17	15.5%	
2 - 4 weeks	27	24.5%	
4 - 8 weeks	5	4.5%	
8 - 12 weeks	0	0.0%	
> 12 weeks	0	0.0%	
Totals	110	100.0%	

Referral for PTSD. For PTSD, 34 percent of facilities indicated patients are seen by a mental health professional within the same day, 17 percent within 1 week, 17 percent within 1–2 weeks, and 26 percent within 2–4 weeks. Six facilities reported a 4–8 week wait.

PTSD			
	Counts	Percents	Percents 0 100
Same Day	37	33.6%	
< 1 week	19	17.3%	
1 - 2 weeks	19	17.3%	
2 - 4 weeks	29	26.4%	
4 - 8 weeks	6	5.5%	

Referral for Substance Abuse. Forty-two percent of facilities reported that patients were seen by a mental health professional within the same day when a primary care provider refers patients for substance abuse. Twenty-four percent of facilities reported patients are seen in less than 1 week, 14 percent reported a 1–2 week period, and 18 percent a 2–4 week period. Three facilities reported a wait of 4–8 weeks. The reason(s) for the slightly lower times to be seen for substance abuse are unclear but may reflect a greater demand for PTSD and Depression evaluation, or the number of available substance abuse counselors relative to available psychiatrists, psychologists, and clinical social workers.

Substance Abuse			
	Counts	Percents	Percents 0 100
Same Day	46	41.8%	
< 1 week	26	23.6%	
1 - 2 weeks	15	13.6%	
2 - 4 weeks	20	18.2%	
4 - 8 weeks	3	2.7%	
8 - 12 weeks	0	0.0%	
> 12 weeks	0	0.0%	
Totals	110	100.0%	

Conclusions Regarding Screening and Referral. In terms of MHSP initiatives related to screening and referral, the extent of VHA implementation can be summarized as follows:

1. Although the USPTSF does not recommend screening of all primary care patients for suicidal ideation, screening for depression by primary care providers is recommended in practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up.[51] VHA has implemented system-wide screening by primary care providers for depression, PTSD, and substance abuse.

2. At least one VISN has implemented suicide screening of patients seen at TBI and chronic pain clinics, as these patients represent at-risk groups from an epidemiologic standpoint.

3. Several facilities reported local strategies to address positive depression screens with additional inquiries. Centrally, VHA has recently completed revision of a pocket card tool which it expects to disseminate system-wide.

4. Most facilities reported development of local strategies to facilitate referral of veterans with risk factors to mental health care. Co-location as previously referenced is also aimed at facilitating referrals.

5. While most facilities self-reported that three-fourths of those patients with a moderate level of depression who are referred by primary care providers are seen within 2 weeks of referral, a small percentage (approximately 5 percent) reported a significant 4–8 week wait. Similar numbers were reported for PTSD and substance abuse services.

C. Tracking and Assessment of Veterans at Risk

Tracking At-Risk Veterans. A comprehensive suicide prevention program must not only be able to identify those at risk for suicide but ideally should identify periods of increased risk and should have a method for tracking at-risk patients to ensure that they receive timely and appropriate care. About 30 percent of the facility responders reported electronically tracking veterans at risk for suicide. Approximately one-fourth reported tracking veterans through the electronic medical record while another 5 percent said that they were using other methods to track at-risk veterans.

Has your facility implemented a tracking system for veterans with risk factors for suicide?

	Counts	Percents	Percents 0 100
Yes	33	30.0%	
No	77	70.0%	
Totals	110	100.0%	

If yes, please mark all that apply:

	Counts	Percents	Percents 0 100
Through Electronic Medical Record	27	81.8%	
Through a Separate Electronic Registry or Database	11	33.3%	
Other	7	21.2%	
No Answer	0	0.0%	
Totals	33	n/a	

Tracking Periods of Increased Risk. One reason for tracking at-risk patients is to increase the likelihood of intervening in periods of increased risk. Fifty percent of responding facilities reported having implemented strategies to target periods of increased risk for suicide. The majority of these facilities reported increasing frequency of visits, utilization of intensive outpatient treatment groups, and increased phone

contacts during acute periods of increased risk. One facility reported ascertaining the anniversary of traumatic events in the initial psychosocial assessment, and then incorporating this information into the individual treatment plan. Integral to targeting periods of increased risk is the systematic identification of these periods in individual patients.

Have intervention strategies been implemented that target periods of increased risk for suicide (e.g. first year after initial diagnosis of schizophrenia, end of relationship, anniversary ...?

	Counts	Percents	Percents 0 100
Yes	55	50.0%	
No	55	50.0%	
Totals	110	100.0%	

- In January 2005, the VISN 3 MIRECC began installation and testing at a VAMC of evidence based suicide risk assessment that has been programmed as a note template with drop down supporting materials within the Computerized Patient Record System (CPRS). The template is linked to the alerts section and clinical reminders in CPRS. The template is based on a stress-diathesis model of suicidality. The stress-diathesis model proposes that suicidal behavior is attributed to the coincidence of stressors, (such as onset of a depressive episode or anxiety, the end of a relationship, unaddressed pain, or alcohol use) with a diathesis, or predisposition, for suicidal behavior. According to this model, only persons with a susceptibility to suicidal behavior are at risk of attempting to take their own lives after exposure to a stressor(s). Pessimism, aggression/impulsivity, and suicidal intent have been identified as three elements of the diathesis for suicidal behavior. These diathesis factors are due to genetic and/or environmental causes. Research studies of suicide completers and attempters have provided some evidence linking serotonin related dysfunction predominantly in a particular area of the brain (ventromedial prefrontal cortex) involved in executive function and decision making, with this susceptibility. In this model, suicide risk factors can be categorized as either diathesis (trait) related or (state) stress-related. If suicidal behavior occurs as the outcome of stress-diathesis, then management of suicidal patients necessitates both identifying and addressing stressor(s) and instituting treatment that attempts to reduce the diathesis.[52,53,54]

  This evidence based risk assessment template prompts the clinician regarding longstanding chronic trait-like risk factors, acute state-like risk factors, risk factors that have triggered previous suicidal behavior, access to means, and mitigating/protective factors. The electronic suicide template and tracking system classifies patients into high, medium and low suicide risk categories. Attention to high risk patients is linked to alerts and clinical reminders. The VAMC test site

began using the template for all new mental health and emergency room patients. By November 2006, the suicide template was being routinely administered to all new mental health patients and all emergency room patients in the VISN. MIRECC clinician-researchers are currently collecting data about the efficacy and effectiveness of the electronic suicide template and tracking system as a suicide prevention tool. After collection and analysis of sufficient data, mental health leadership and MIRECC researchers will determine the desirability and feasibility of expanding use of the suicide template to primary care and all new patients in VISN 3.

- In 2005, an electronic suicide registry for suicide attempters and suicide completers was implemented at a VAMC in VISN 19. In 2006, the registry was extended to all facilities in VISN 19. The registry contains 34 variables related to suicides and suicide attempters. The registry details the history and constellation of circumstances surrounding each suicide, or suicide attempt and allows for following trends. At present, the registry is linked to CPRS. When an attempt occurs, a provider completes the suicidal behavior template which consists of drop down items. A clinician-researcher at the MIRECC pulls the completed templates for the VISN and inputs the data into the registry. When a patient subsequently presents for an appointment at a VAMC and a provider opens the electronic medical record and clicks on the clinical progress note section, the completed suicidal behavior template will be listed and available for review. The presence of the suicidal behavior template and its content are intended to alert the provider to the potential need for heightened monitoring. The VISN chose to place the MIRECC in the clinical notes section in order to avoid "clinical reminder fatigue."

- Preliminary analysis of the data from the registry has provided some insights with implications regarding delivery of care. For instance, the data reportedly showed that 20 percent of the veterans in the registry had not accessed mental health services and did not have a psychiatric history, or diagnosis, at the time of their suicide, or suicide attempt. This underscores the importance of clinician awareness, mental health screening and outreach to veterans in non-mental health settings. In the past 2 months, the VISN 19 registry for suicides, and suicide attempters, was implemented for testing in a VA facility in VISN 2, and its use is currently being expanded to include all facilities in that VISN.

Case Managers. Facilities were asked if a case manager has been dedicated specifically for the care of patients identified by providers as high risk for suicide. This is not a specific initiative from the MHSP but is a potential targeted intervention, consideration of which had been recommended in the 2004 Suicide Prevention Work Group report. Ten responding facilities indicated having a dedicated suicide prevention case manager.

At your facility is there a case manager that has been dedicated specifically for the care of patients identified by facility providers as high risk for suicide?			
	Counts	Percents	Percents 0 100
Yes	10	9.1%	
No	100	90.9%	
Totals	110	100.0%	

- OMH leadership has reported plans to place suicide coordinators at each facility in 2007. Coordinators will maintain a case-load for case management of at-risk veterans. Final position descriptions are presently still under development and not yet determined. The additional comments section to the web survey does appear to indicate forward progress toward implementation of this suicide prevention strategy. We did not specifically ask facilities about funding or recruitment of suicide case managers, but in an additional comments section to the web survey, three facilities spontaneously indicated that a suicide prevention coordinator position had been funded, a position was being posted, and recruitment was underway.

- One VHA project involves the use of *health buddies*. These small electronic appliance devices have been given to those enrolled in a study of patients with co-morbid pain, depression, and substance use issues. The device routinely sends the patient reminders or messages. For example, the device may ask "what was your blood sugar today" or "are you feeling down today; if you are please call." The patient records a response to the question which is monitored by someone at the facility who, depending on the nature of the query and response, is responsible for calling the patient within 24 hours to follow up. At present the queries in the pilot study involve mood but not suicidality or suicide risk factors. Queries on suicidality may be used in future pilots. Mental health leadership reports that the process of being queried itself may have secondary effects. For example, a few anecdotal cases were cited in which patients later reported having had suicidal thoughts but having dismissed acting on those thoughts after receiving a health buddy prompt.

- Based on other inspections performed by the OIG's Office of Healthcare Inspections, we are aware of ongoing challenges to the bi-directional exchange of information between VA and Department of Defense (DoD) facilities for patients with mental illness.

Conclusions Regarding Tracking and Assessment. In terms of MHSP initiatives related to tracking of at-risk patients, the extent of VHA implementation can be summarized as follows:

1. A thorough evidence based risk assessment tool, electronically linked to CPRS has been piloted for emergency room and mental health patients in VISN 3. By its design, the tool targets identification of at-risk groups and periods of increased risk.

2. Prior suicide attempts are one of the better predictors of at-risk patients. An electronic registry of suicide attempts linked to CPRS progress notes has been piloted and tested in VISN 19 and recently began pilot testing in VISN 2.

3. The Office of Mental Health Services is in the process of implementing suicide case managers at all VAMCs.

D. Emerging Best Practice Interventions and Research

Programmatic, psychotherapeutic, and pharmacologic interventions are presented in this section to report on VHA progress in development and implementation of suicide prevention strategies and initiatives and to provide the reader with background information on specialized interventions in development, pilot or demonstration stages. This discussion should not be construed as an OIG endorsement of any particular individual strategy or intervention.

Suicide Prevention Strategies. VAMCs were asked whether specific suicide prevention strategies have been implemented to target special emphasis groups (such as OEF/OIF veterans, veterans with bipolar disorder with mixed states, and patients with borderline personality disorder). Slightly more than one-third of responding facilities indicated implementation of suicide programs targeting special emphasis groups.

Have suicide prevention strategies been implemented to target special emphasis groups (e.g. victims of sexual trauma, returning OEF/OIF veterans, bipolar patients with mixed states)?

	Counts	Percents	Percents 0 100
Yes	42	38.2%	
No	68	61.8%	
Totals	110	100.0%	

Some interventions reported by individual VAMCs included screening returning OEF/OIF veterans and patients experiencing MST[H] at each mental health visit; increased contacts for OEF/OIF, elderly, and substance abuse patients; monitoring OEF/OIF patients for suicide risk factor criteria, monitoring these patients for "no shows" at appointments, and subsequently initiating follow-up phone contact; specific groups for patients with bipolar disorder who experience mixed states; trained case managers for bipolar patients who monitor for periods of increased risk such as mixed states; and a

[H] Military Sexual Trauma.

Women's Sexual Trauma Team that utilizes strategies like "Seeking Safety" with their patients.

- "Seeking Safety" is a present-focused therapy. Key principles of "Seeking Safety" are safety as the goal of the first stage of treatment; simultaneous, integrated treatment of PTSD and substance abuse; a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; cognitive, behavioral, interpersonal and case management content areas; and attention to therapist processes for example balancing praise and accountability. Eleven completed studies, 7 pilot studies and 4 controlled studies have been completed utilizing "Seeking Safety" in veteran and non-veteran groups. In VISN 1"Seeking Safety" has been piloted in a study of women veterans and a study of homeless women veterans.[55]

- Bipolar disorder is an affective disorder. Patients with bipolar disorder type I may experience prolonged periods of pervasive elevated mood, depressed mood or mixed states in which patients concomitantly experience the increased energy and restlessness of a manic phase with the dysphoria of the depressed phase of the illness. In general, patients with affective disorders (such as major depression and bipolar disorder) are at increased suicide risk. Mixed states are thought to represent a period of increased risk for suicide in patients with bipolar disorder. There is some evidence that case management helps sustain a more stable course in patients with bipolar disorder. It is hoped, therefore, that fostering symptom stability will bolster and impact suicide prevention. Office of Mental Health leadership reported funding a program to pilot case management for bipolar disorder patients at risk at eight sites.

Based on other inspections performed by the OIG's Office of Health Care Inspections during the last few years, we are aware of ongoing issues concerning admission criteria to specialized inpatient mental health programs for returning veterans with concurrent mental health and alcohol use issues. In the ideal situation, psychiatric symptoms and psychological issues are most effectively addressed during a period of sustained sobriety, when the patient can attend closely to the symptoms and issues. Admission criteria to specialized programs based on the expectation of sustained sobriety may be appropriate for the care of older veterans who have extended periods of chronic, mental health and co-morbid substance abuse issues. However, such expectations seem out of step with the pragmatic reality of many of the young, returning OEF/OIF veterans who present to VA facilties currently.

Cognitive-Behavioral Therapy. Facilities were asked about the availability of a specialized form of cognitive-behavioral therapy (CBT) focused on a suicide prevention. CBT is a structured, time limited, directive and change oriented form of psychotherapy that emphasizes the important role of thoughts and assumptions in guiding how we feel and what we do. Approximately 65 percent of facilities reported availability of CBT specifically focused on suicide prevention. The intent of the question was to gauge

implementation of a specialized modified version of CBT that has been tailored for use in suicidal patients. From our review of recent psychiatric literature we were aware that a specific type of CBT tailored for suicide prevention has been developed and piloted in non-VA studies by clinician-researchers at the University of Pennsylvania Center for the Treatment and Prevention of Suicide. We believe the response to this item reflects a methodological flaw in how the question was asked. Facilities appear to have based their responses on whether they offered any type of CBT since therapists may work with patients to address suicidal thoughts in the course of sessions regardless of the form of CBT utilized.

- Because suicide attempts are one of the more salient risk factors for suicide, prospective studies using cognitive therapy for suicide prevention have focused on suicide attempters. Underlying constructs for the development of a tailored cognitive therapy approach is the assertion that usual treatment for depression may not necessarily focus on suicide relevant cognitively mediated processes such as hopelessness, and reducing impulsivity, may not address other modifiable risk factors, and may not directly help patients develop skills to manage suicidal crises in the future. Researchers at the University of Pennsylvania recruited consenting, adult emergency department patients who had attempted suicide 48 hours prior to presentation at an emergency department, to participate in a randomized study, comparing a brief cognitive intervention with usual care. The purpose of the study was to determine if a brief course of this suicide targeted intervention would be effective in preventing repeat attempts, reducing the severity of established modifiable risk factors and increasing use of appropriate health services. In a study published in a 2005 issue of the Journal of the American Medical Association, these researchers reported no significant difference between groups based on suicidal ideation at any given assessment point, however, the CBT group had a significantly lower re-attempt rate, diminished severity of self-reported depression on the Beck Depression Inventory II, and less self reported hopelessness on the Beck Hopelessness. Consultants from the University of Pennsylvania are working with the VISN 19 MIRECC, where a pilot study for VA patients is starting in FY 2007. Training of select therapists from VISN 19, VISN 4, and VISN 3 to learn this form of CBT is planned for April 2007 and this intervention will be subsequently piloted in VISN 19.[56,57]

- The Collaborative Assessment and Management of Suicidality (CAMS) is a novel, comprehensive, multidisciplinary clinical assessment, planning, and clinical management approach aimed at reducing suicidal thoughts, feelings, and behaviors in outpatient settings developed by a clinician-researcher at The Catholic University of America in Washington, DC. CAMS is designed to provide an alternative to traditional risk factor and purely diagnostically-driven approach to suicide. Key aspects of CAMS are collaborative completion by patient and therapist of a structured "Suicide Status Form," emphasis on a form of

clinical care and management that is suicide specific, and a means to identify, assess, track and document suicidal risk throughout a course of treatment. In contrast to a traditional therapist directed symptom focused approach (such as insomnia, low mood, or low energy), in CAMS the therapist and patient collaboratively assess risk. Targeting suicide is the focus of treatment. Underlying issues such as pain, stress, agitation, hopelessness, self-hate, and reasons for living vs. reasons for dying are collaboratively assessed. In a 12-session treatment (CAMS-PST), collaborative assessment and treatment planning is followed by collaborative deconstruction of suicidogenic problems (relationship issues, vocational issues, self-related issues, pain and suffering), collaborative problem-solving interventions and development of reasons for living and protective factors. Research with CAMS includes empirical data from work done with the United States Air Force 10th Medical Group and work done by a Catholic University research team with Johns Hopkins University Counseling Center students. In April, the first large randomized controlled trial of CAMS-PST is scheduled to begin in VISN 19.[58,59]

Dialectical Behavioral Therapy. One half of responding facilities reported availability of dialectical behavioral therapy (DBT) for treatment of patients with borderline personality disorder.

- Personality disorders are estimated to be present in more than 30 percent of individuals who die by suicide. In clinical populations, the rate of suicide of patients with borderline personality disorder is estimated to be between 8–10 percent which is a much greater rate than in the general population. Sixty to 70 percent of patients with borderline personality disorder make suicide attempts, and unsuccessful attempts are therefore far more frequent than completed suicides in these patients. Co-morbidity of borderline personality disorder with depression and substance abuse has been well documented in the literature.[60] DBT is a cognitive-behavioral therapy designed for severe and chronic difficult to treat patients. DBT grew out of an iterative attempt to apply cognitive-behavioral therapy to the problem of treating suicidal behavior. DBT applies a dialectical (synthesis between two contradictory ideas) approach that attempts to balance change/problem solving with acceptance/validation. The extremes in thinking (often times an all-or-nothing paradigm), behavior, emotional states, and relationships experienced with borderline personality disorder makes DBT particularly relevant as a potentially promising treatment for these patients. DBT attempts to move patients from an either-or to a both-and framework. Researchers have studied the use of DBT in non-VA populations.[61] The VISN 4 MIRECC has held DBT workshops and a regional conference in 2006 with a breakout session for VISN 3 and 4 clinicians. DBT groups are offered at several VHA facilities.

Lithium Treatment. Survey respondents were asked to estimate the approximate percentage of newly diagnosed patients with bipolar disorder type I who have been prescribed the mood stabilization agent lithium in the past 24 months. Forty-five percent of facility respondents reported less than 10 percent utilization, approximately one-fourth of facility respondents reported 10–25 percent utilization, and slightly under one-fourth reported 26–50 percent utilization.

Approximate percentage of mental health patients who have been newly diagnosed with bipolar disorder type I in the past 24 months who have been prescribed lithium treatment by facility mental ...?

	Counts	Percents	Percents 0 100
< 10%	47	44.3%	
10 - 25 %	27	25.5%	
26 - 50 %	25	23.6%	
51 - 75 %	6	5.7%	
> 75 %	1	0.9%	
Totals	106	100.0%	

- In the psychiatric literature, lithium has been reported to have a specific anti-suicide effect for patients with mood disorders. In addition to its use as a mood stabilizing agent, there are randomized, controlled trials indicating that adding lithium to augment antidepressants may reduce symptoms in patients with unipolar depression who have incompletely responded to antidepressants alone. Despite these potential benefits, lithium use in VA and non-VA settings has been declining for several years. Reasons for this are unclear but may be due to concerns about safety, need for monitoring blood levels, tolerability, potential side effects, and stigma.[62,63]

Clozapine Treatment. To a similar question, in which VAMCs were asked to estimate the percentage of patients with schizophrenia who have been offered treatment with the antipsychotic medication clozapine over the past year, 90 percent of responding facilities reported less than10 percent utilization and 7 percent reported 10–25 percent utilization.

Approximate percentage of patients with schizophrenia who have been offered treatment with clozapine over the past year?			
	Counts	Percents	Percents 0 100
< 10%	98	90.7%	
10 - 25 %	8	7.4%	
26 - 50 %	1	0.9%	
51 - 75 %	1	0.9%	
> 75 %	0	0.0%	
Totals	108	100.0%	

- The completed lifetime suicide rate in schizophrenia is 4–13 percent. Suicide remains the leading cause of death among patients with schizophrenia under 35 years of age. In addition, the lifetime suicide attempt rate is 25–50 percent with 40 percent of attempters making their first attempt with the first year of psychosis. One-third of completed suicides among patients with schizophrenia occur after the age of 45. It is unclear whether suicide among these patients is a measure of untreated psychosis or a separate domain of psychopathology. There is psychiatric literature to suggest that clozapine is particularly effective in patients with schizophrenia who have had refractory responses to antipsychotic medication. In addition, studies such as the 2003 InterSePT study indicate a potential benefit of clozapine in respect to suicide attempts.[64,65] As with lithium, the low utilization for treatment of psychosis in the VA system also reflects the low utilization in non-VA community mental health settings and is not unique to the VA system. In response to the low utilization rate, the VISN 3 MIRECC has developed a clozapine education and consultation program to increase indicated usage throughout VISN 3 and ultimately VHA.[66]

Other Interventions. Other emerging best practice interventions include:

- PSR programming, which was discussed in a previous section of this report, beginning on page 25.

- The primary care-mental health integration program discussed in a previous section of this report. In addition, to potential mitigation of stigma, enhanced mental health access and care coordination, integrated sites could be particularly beneficial to targeting older veterans. A non-VA study using a care management model showed benefit in treating older adults with major depression and in particular, a sub-group of depressed, elderly diabetic patients. The SAMHSA[I]-VA

[I] SAMHSA is the Substance Abuse and Mental Health Services Administration, an organization of the Department of Health and Human Services.

PRIME[J] study[67] showed a greater engagement in care among patients with depression, anxiety, and at-risk drinking for elderly patients treated in the integrated setting versus referral to mental health. In the non-VA Prospect study,[68] those who got care in primary care practices with mental health availability had a lower all cause mortality.

- The NCPS has completed a review of RCA's for all inpatient suicide and parasuicide attempts from 1999–2006 in an effort to better understand the methods and environmental factors involved in inpatient suicide attempts in VA hospitals. This data will be used to make some recommendations for environmental interventions intended to reduce inpatient suicide and diminish parasuicide behaviors.[69]

- Through our interviews and observations during the course of this inspection, it was clear that the VISN 19 MIRECC—whose focus is on suicide prevention—is operational, a leader in suicide prevention clinical research within VA, and collaborates extensively with other MIRECC's working in this area. During the course of the inspection, it also became apparent that VHA mental health leadership actively promotes research on suicide and suicide prevention.

Conclusions Regarding Emerging Best Practice Inverventions and Research. In terms of MHSP initiatives related to emerging best practice interventions, the extent of VHA implementation can be summarized as follows:

1. Therapies and strategies that target patients at acute and chronic risk for suicide and have appeared promising in research from non-VA settings have been developed, piloted, and tested in select VISNs. Other potentially promising suicide specific strategies and therapeutic interventions are presently in or beginning pilot testing in VISN 19.

2. Some promising therapies targeted at higher risk patients, (for example, DBT for patients with borderline personality disorder) are locally offered at several facilities.

3. System-wide implementation of PSR programming targeting patients with serious mental illness is in process.

4. Co-location of primary care and mental health providers has been in place at several facilities over the past few years. Centrally coordinated implementation of integrated primary care with mental health co-location/collaborative case

[J] PRIME (Primary Care in Internal Medicine) is the VA-funded medical residency program designed to produce physicians who are committed to both the study and practice of primary care, using evidence-based medicine as the framework for decision making and problem analysis.

management is in process and implementation is anticipated over the next year at more than 60 sites.

5. In parallel to utilization in non-VA public and private settings, utilization rates of lithium for treatment of bipolar disorder (or anti-depressant augmentation) and clozapine for treatment of schizophrenia are low.

6. An integrated strategy targeting patients with PTSD and substance abuse has been piloted at select facilities in VISN 1.

7. Post-acute detoxification, psychiatric symptoms, and psychological issues in the ideal are traditionally addressed in VA and non-VA settings in the context of sustained sobriety. VHA offers outpatient mental health treatment for patients with on-going substance abuse co-morbidity. Disentanglement of mental illness symptoms from substance induced symptoms allows clinicians to interrupt perpetuation of physiologic and psychological drives that have been entrained and have taken on a life of their own independent of patient history and circumstances, to more accurately diagnose and to more appropriately treat underlying illnesses and issues. While this approach appears appropriate for and is relatively standard for patients with a chronic, longstanding history of substance abuse and/or dual diagnosis in non-VA settings, pragmatically, the expectation of sustained sobriety prior to admission to specialized inpatient mental health programs may be out of step with the needs, reality and expectations of young, returning veterans.

E. Development of an Electronic Suicide Prevention Database

National Surveillance System. Ascertaining an accurate rate of suicide among veterans is an essential element of a nationwide VHA suicide prevention program. Currently a VA national surveillance system and registry is under development and testing but has not been fully implemented.

- The Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) at Ann Arbor, Michigan, has been working on two surveillance projects to attempt to accurately determine suicide rates for veterans. Data on those who sought health care within VHA in the year 2000 was matched with the same data for subsequent years through 2003. A database of patients who did not access VHA care in subsequent years was identified. This data was then matched to data from CDC's National Death Index (NDI) to determine which patients no longer accessing VHA care had died. The resultant data was then matched to the enhanced version of the NDI, which includes cause of death from death certificates, to ascertain how many of the deceased veterans had died by suicide. Cause of death was classified into three levels of likelihood for suicide. The data from these matches is being used to determine a rate inclusive of upper and lower bounds.

- The National Violent Death Reporting System (NVDRS) is CDC's effort to develop a nationwide, state-based monitoring system for violent deaths. State and local agencies use this system to input detailed information from medical examiners, coroners, death certificates, and other sources. The NVDRS then pools the data with the hope that it can ultimately be used to answer fundamental questions about violence related deaths. At present, 17 states participate in the system.[70] Veteran status is one of several uniform data elements recorded for input in the system. Researchers at SMITREC reported cleaning and analyzing NVDRS data from Virginia and Oregon in recent months to try to determine an overall suicide rate for all veterans in these states. These rates could then be compared to the rates determined for VHA utilizers who live in these states.

- Once rates are worked out through these two mechanisms, plans are for data to be added for subsequent years and rates adjusted. SMITREC researchers hope that once rates are determined, predictive models can be used to examine specific factors. For example, one factor might be the characteristics of those who suicide within 24 hours of receiving care. Researchers hope to evaluate potential temporal or regional clusters, or micro-level temporal clusters, such as timing of suicides relative to changes in interventions. From the data SMITREC researchers will try to ask whether there are previously un-identified at-risk sub-populations or correlations with types and intensity of treatment interventions. In addition, SMITREC researchers hope to better understand characteristics and determinants of the veteran VHA utilizer and non-VHA utilizer sub-populations.

Conclusion Regarding National Surveillance System. In terms of MHSP initiatives related to surveillance, the extent of VHA implementation can be summarized as follows:

> VHA researchers have developed and are in the process of piloting and testing an electronic suicide prevention database and surveillance mechanisms.

F. Education

First Contact Personnel. Results from the web based survey found that 63 or 57 percent of the facility respondents reported that they provide education programs to first contact non-clinical personnel. Slightly more than two-thirds of the facilities providing programs reported that these programs were mandatory. A little more than half of the facilities providing programs reported that these programs included suicide response protocols and approximately 70 percent of these facilities reported that programs including response protocols were mandatory.

Are programs provided to educate first contact non-clinical personnel such as clerks and telephone operators, about how to respond to crisis situations involving veterans at risk for suicide?

	Counts	Percents	Percents 0 100
Yes	63	57.3%	
No	47	42.7%	
Totals	110	100.0%	

If yes, are any of these programs mandatory for first contact non-clinical personnel?

	Counts	Percents	Percents 0 100
Yes	45	68.2%	
No	20	30.3%	
No Answer	1	1.5%	
Totals	66	100.0%	

Overall, approximately 40 percent of all respondent facilities reported providing education programs for first contact personnel that were mandatory, approximately one-third of all responding facilities reported inclusion of suicide response protocols, and a little less than one-fifth reported that programs inclusive of response protocols were mandatory.

Do any of the provided education programs include suicide response protocols for first contact non-clinical personnel?

	Counts	Percents	Percents 0 100
Yes	36	54.5%	
No	29	43.9%	
No Answer	1	1.5%	
Totals	66	100.0%	

If yes to 7b, are the education program(s) that include suicide response protocols mandatory for first contact, non-clinical personel?

	Counts	Percents	Percents 0 100
Yes	27	71.1%	
No	11	28.9%	
No Answer	0	0.0%	
Totals	38	100.0%	

- In our interviews, we found the VISN 3 MIRECC has established the VISN 3 Suicide Risk Assessment and Prevention Initiative (SAP) in an effort to "educate clinicians, improve recognition of veterans at risk for suicide, improve documentation of risk, and enhance communication with mental health and non-mental health clinicians." As part of the SAP initiative, VISN-wide computerized training modules for new staff, mental health staff, and all staff have been developed and implemented. A live training module that includes a suicide prevention protocol has been piloted for non-clinical staff. In addition, clinician-researchers have been in the process of developing a script for clerical staff and telephone operators specific to VISN 3.

- On a central level, VHA implementation of an educational program for first contact personnel and non-clinical personnel is in development-pilot stage. One consideration discussed has been whether to develop and expand a program within VHA (such as the one being developed in VISN 3) or whether to purchase an existing proprietary program aimed at the general public. A second consideration has been the scope of staff to be included. For example, as is the case with blood borne pathogens, would education be required for all personnel; for non-clinical

personnel in clinical and non-clinical domains such as the cafeteria or canteen; or only for non-clinical personnel and first contact personnel who interact with veterans within clinical areas of the facility?

- The Director of VA Readjustment Counseling Services reported that 100 percent of vet center clerical and clinical staff receive suicide prevention education/training. In collaboration with researchers at the University of Rochester, vet center personnel have participated in suicide prevention regional training based on a QPR™ community gatekeeper training model. QPR™ stands for "Question, Persuade, and Refer," an emergency intervention undertaken upon the recognition of suicide warning signs in someone known to the QPR™ trained person. Gatekeepers are people who regularly come into contact with individuals and families in distress. In a community setting, gatekeepers could be pharmacists, meter readers, hairdressers, or other groups. QPR™ is designed to instill the same response from all who are trained, just like CPR. Because suicidal individuals may not tend to self-refer, the model is to train an entire community to be aware of symptoms and behaviors and to thereby facilitate earlier intervention and referrals for mental health treatment.

  The four principles underlying the theory of a community risk reduction program are that:

  (1) Those who most need help in a suicidal crisis are the least likely to ask for it; thus, community and family members must recognize and respond positively to at-risk loved ones and fellow citizens, and go to them with help without requiring that they ask for it first.

  (2) The person most likely to prevent an at-risk individual from dying by suicide is someone he or she already knows; thus we must know what to do if someone we know becomes suicidal. This can only be accomplished when everyone is trained in suicide warning signs and intervention strategies.

  (3) Prior to making a suicide attempt, those in a crisis are likely to send warning signs of their distress; thus, learning these warning signs and how to take quick, bold action during these windows of opportunity will save lives.

  (4) When we solve the problems people kill themselves to solve, the reasons for suicide disappear; thus crisis intervention, problem resolution, enhancement of protective factors, and competent and accessible mental health treatment will save lives.[71]

A gatekeeper training model has been implemented and researched in the U.S. Air Force community. In this closed setting, researchers found a 33 percent reduction in suicide rate over a 4-year period.[72] It was reported to us that researchers at the newly starting

VA Canandaigua Center of Excellence, whose focus will be suicide prevention from a public health approach and dissemination of educational processes, have begun demonstration projects in VISN 2 to study the feasibility of adapting and modifying the Air Force Suicide Prevention Program for use in VA.

Health Care Providers. Results from the web based survey indicate that more than 90 percent of responding facilities indicated that suicide related education programs were available at their facility for health care providers. Virtually all of these programs were available for physicians, psychologists, nurses, physician assistants, nurse practitioners and social workers. At least three-fourths of these programs were available for physical therapists, occupational therapists, speech therapists and nursing aides. Six facilities reported availability to all employees, nine facilities reported availability to all clinical staff, and additional facilities sporadically reported availability to recreation therapists, substance abuse counselors, mental health associates and medical assistants.

Are suicide related education programs available at your facility for health care providers (could include web based programs, videoconferences, seminars/colloquia, and/or EES programs)?.

	Counts	Percents	Percents 0 100
Yes	100	91.7%	
No	9	8.3%	
Totals	109	100.0%	

Seventeen percent of responding facilities indicated these education programs both included information on suicide risks and were also mandatory for all health care providers. Twenty-one percent indicated that these programs included information on suicide risks and were mandatory for some but not all health care providers and 62 percent indicated that programs inclusive of information on suicide risks were available but not mandatory. One facility indicated that programs including information on suicide risks were not available.

Suicide Risks

	Counts	Percents	Percents 0 100
Mandatory for **all** Health Care Providers	17	16.8%	
Mandatory for **some** Health Care Providers	21	20.8%	
Available but not Mandatory	62	61.4%	
Not Available	1	1.0%	
Totals	101	100.0%	

Overall, 99 percent of facilities indicated that ways to address risks were available in suicide related education programs. Approximately 15 percent of facilities included ways to address suicide risks in suicide related programs and these programs were mandatory for all health care providers. At 22 percent of facilities, ways to address suicide risks were included and mandatory for some but not all health care providers. At 63 percent of facilities, the topic was included in available programs but was not mandatory for health care providers.

Ways to Address these Risks			
	Counts	Percents	Percents 0 100
Mandatory for **all** Health Care Providers	15	14.9%	
Mandatory for **some** Health Care Providers	22	21.8%	
Available but not Mandatory	63	62.4%	
Not Available	1	1.0%	
Totals	101	100.0%	

Overall, approximately 91 percent of facilities indicated the topic of "best practices" for suicide prevention was available in suicide related programs for health care providers. Ten percent of these facilities indicated that these programs were mandatory for all health care providers. At 16 percent of facilities, these programs were mandatory for some but not all health care providers, and at approximately 66 percent of facilities, programs inclusive of this topic were available but not mandatory.

Best practices for Suicide Prevention			
	Counts	Percents	Percents 0 100
Mandatory for **all** Health Care Providers	10	9.9%	
Mandatory for **some** Health Care Providers	16	15.8%	
Available but not Mandatory	66	65.3%	
Not Available	9	8.9%	
Totals	101	100.0%	

As an extension to MHSP education initiatives, we asked if programs were available to educate health care providers on mental health issues in returning OEF/OIF veterans. Of the approximately 90 percent, or 109 facilities, that responded in the affirmative, 81 reported that the content of these programs included information on suicide risk and 11 facilities reported that these programs were mandatory for all health care providers. The National Center for PTSD's *The Iraqi War Clinician Guide* (2nd edition available for download or in CD form) should be available at facilities. Again, for the 10 percent who

did not endorse available programs, it is unclear if this reflects lack of availability or lack of resource awareness.

At your facility are programs available to educate health care providers on mental health issues in returning OEF/OIF veterans (including web based programs)?

	Counts	Percents	Percents 0 100
Yes	98	89.9%	
No	11	10.1%	
Totals	109	100.0%	

If yes, do any of the above mentioned programs include information on suicide risk?

	Counts	Percents	Percents 0 100
Yes	81	82.7%	
No	16	16.3%	
No Answer	1	1.0%	
Totals	98	100.0%	

- As part of the VISN 3 MIRECC's Suicide Risk Assessment and Prevention Initiative, a VISN-wide education program has been implemented throughout VISN 3. These programs have included facility-by-facility training sessions, comprised of an interview with a control patient, a suicide assessment discussion, and hands-on training with a suicide assessment instrument; development and implementation of updates for mental health staff on new information on suicide risk as it becomes available; and VISN-wide suicide conference with a morning VTEL (video-telephone) didactic presentation, followed by afternoon breakout sessions at each facility with risk assessment workshops and focus groups on suicide risk assessment. Participants reportedly receive training on how to respond to patient phone calls.

We identified the following additional OMH plans or programs aimed at implementing training for recognition of at-risk behavior:

- In 2000, VHA held its first satellite broadcast on prevention of suicide. The focus was on assessment and identification of suicide risk in primary care, mental health, and geriatrics. The program was developed with input from the National Institute of Mental Health (NIMH) and the University of Rochester, and program videos were widely distributed throughout the system. At the time, VHA also developed a pocket suicide risk assessment card for distribution to clinicians. In 2001 or 2002, VHA held a second satellite program on the management of suicide; in 2004, they had a third satellite program with focus on family and community involvement. In 2005, a satellite presentation focused on health promotion and re-integration for war-injured veterans, with an emphasis on clinicians alerting patients to signs and potential risks.

- In August 2006, material from the War Injury/Suicide Prevention Program (WISP) was beta tested. Originally the material was presented in satellite form, but plans are for the material to ultimately become web based. In June 2006, the VISN 3 and VISN 4 MIRECCs ran a regional workshop on evidence based interventions for suicide prevention. After editing, there are plans for VHA's Employee

Education System (EES) to distribute a DVD to VAMCs that it will produce from the June 2006 conference and also to post on the their web site.

- In recent months, OMH has been working on development of revisions of the EES suicide risk assessment pocket cards. An OMH official reported that there will be a revised version for assessment/management in inpatient settings and a second version for front line personnel (clinic, emergency department, and so forth) that will be available in a PDF word version that staff at VAMCs will be able to download and laminate. The revised version for front line personnel inclusive of references was reportedly completed in February 2007 and sent to EES.

- VISN 4 and VISN 19 MIRECC personnel have conducted in-service training and seminars for facilities in these and other VISNs. The VISN 4 MIRECC has been hosting yearly suicide prevention conferences.

Conclusion Regarding Education. In terms of MHSP initiatives related to education, the extent of VHA implementation can be summarized as follows:

1. Fifty-seven percent of facilities provide programs to train first contact non-clinical personnel. Only one-fifth of these programs includes suicide response protocols and are mandatory. VISN 3 has implemented a training module for all staff and a script for clerical staff is under development. VISN 2 sites are piloting QPR™ gatekeeper training. Vet center staff receive annual QPR™ gatekeeper training.

2. Almost all facilities provide education to health care providers on suicide risks, ways to address these risks and best practices for suicide prevention. At only a small percentage of facilities were these programs mandatory. More than 90 percent of facilities reported availability of education on mental health issues in OEF/OIF veterans. Ten percent of facilities may be unaware of the availability of the National Center for PTSD's *Iraq War Clinician Guide*.

3. The VISN 3, 4, and 19 MIRECC staff provide onsite facility training sessions at VHA facilities throughout their VISNs. VISN 19 staff provide training sessions at facilities throughout VHA.

Conclusions

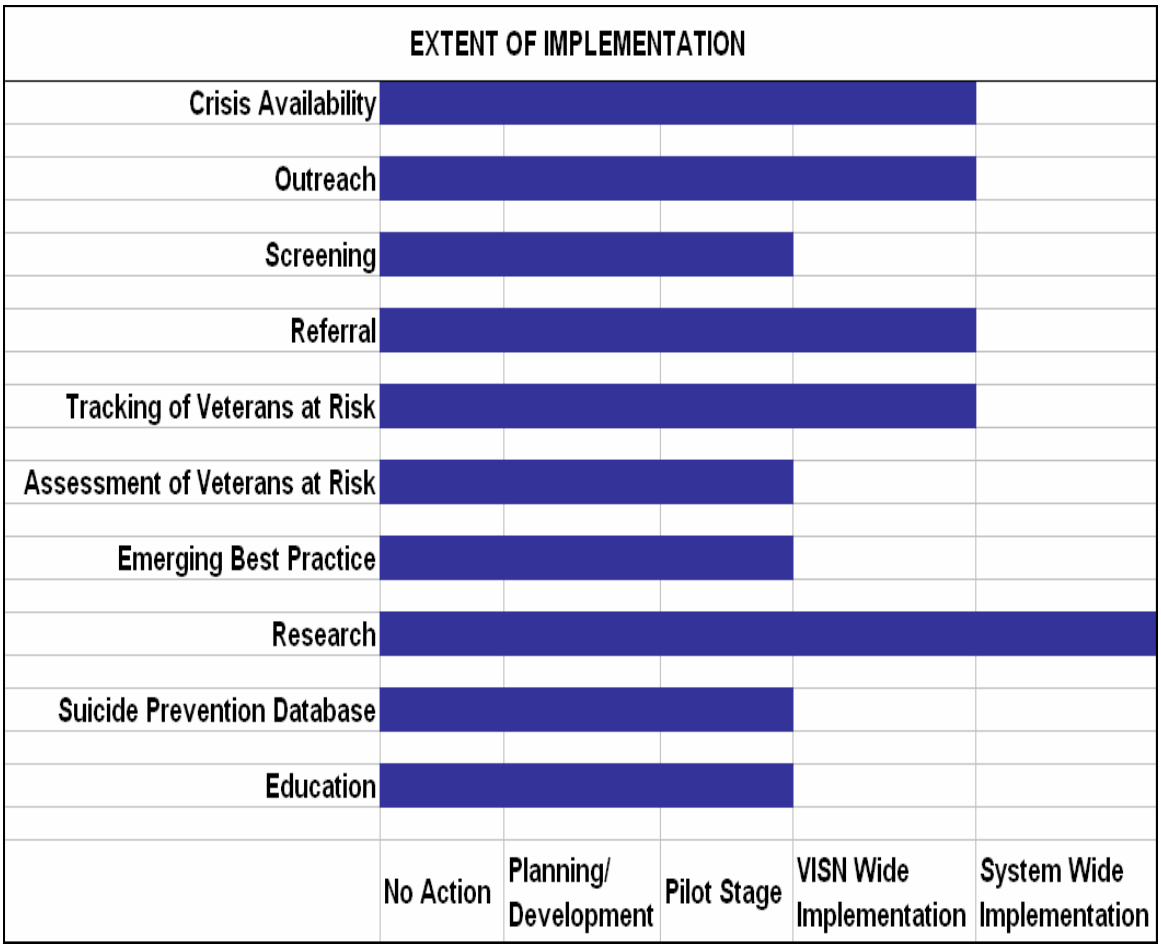
Suicide is an unequivocally tragic and often incomprehensible event. Preventing suicide is a complex, multifaceted challenge, to which there is not one "best" practice but several promising but not proven approaches and methods. Suicide prevention requires a comprehensive plan, integrated strategies, coordinated effort, and steadfast commitment to forward progress, since "even the most well-considered plan accomplishes nothing if it is not implemented."[73] In the course of this inspection we interviewed clinician-leaders, and clinician-researchers dedicated to the prevention of suicide among veterans. Through

the web based survey we obtained an on-the-ground status report from clinicians who serve our Nation's veterans. Since 2004, significant progress has been made toward implementation of the MHSP initiatives for suicide prevention. The progress is ongoing, with greater integration and at an accelerated pace.

However, more work remains to ensure a coordinated effort in achieving system-wide implementation. Central to this effort is the ongoing need for greater integration of local, network, and national level projects and innovations; a readiness to make difficult choices among best available options; and the impetus to translate this readiness into widespread and sustained implementation. In the near term, system-wide implementation of a set of promising and/or emerging best practices, coupled with their ongoing evaluation and modification, would facilitate provision of a single standard of preventative care for all veterans seen at VHA facilities.

A national system-wide suicide prevention plan is intended to provide proactive strategies for identifying, screening, assessing, referring, tracking, and treating veterans at risk. Although ultimate outcomes cannot be guaranteed, it is anticipated that a coordinated, system-wide prevention program could reduce the likelihood of attempted and completed suicides. At present, MHSP initiatives for suicide prevention are partially implemented. It is therefore incumbent upon VHA to continue moving forward toward full deployment of suicide prevention strategies for our Nation's veterans.

The following chart depicts the extent of VHA's MHSP implementation for all 10 categories, ranging from "No Action" to "System-Wide Implementation."



The next table depicts the extent of implementation for each suicide prevention initiative unique to the MHSP (it does not include those solely contained in the Surgeon General's *National Strategy for Suicide Prevention* or the IOM report, *Reducing Suicide: A National Imperative*).

	No Action	Planning/ Development Stage	Pilot Stage	VISN–Wide Implementation	System–Wide Implementation
Develop a plan for 24 hour mental health care availability through VHA.				X	
Medical centers establish contacts through the Chaplain Service with faith-based organizations and community resources to assist with culturally competent suicide prevention and mental health issues at local and national levels.		X			
Promote evidence based strategies for suicide assessment and prevention including emphasis on special emphasis groups.			X		
Develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care.				X	
Develop and test an electronic suicide prevention database.			X		
Develop a plan to educate all staff that interact with veterans, including clerks and telephone operators, about responding to crisis situations involving at-risk veterans. This would include suicide protocols for intake, telephone operators, and other first contact personnel.			X		
Develop mandatory education programs for VA health care providers about suicide risks and ways to address these risks. Incorporate best practices for suicide prevention.			X		
Support for a new MIRECC with focus on suicide prevention, in collaboration with other MIRECC's working in this area.					X

Recommendations

Recommendation 1. The Acting Under Secretary for Health should ensure that VISN directors ensure that facilities in their VISNs have made arrangements for 24-hour crisis and mental health care availability either in person, via a facility-run crisis line, or by facility referral to an established, functioning non-VA crisis/suicide hotline staffed by trained personnel. In addition, an on-call mental health specialist should be available to crisis staff either in person or by phone.

Recommendation 2. The Acting Under Secretary for Health should ensure that VISN directors ensure that facility directors ensure that all non-clinical staff who interact with veterans receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.

Recommendation 3. The Acting Under Secretary for Health should ensure that VISN directors ensure that facility directors ensure that all health care providers receive mandatory education about suicide risks and ways to address these risks.

Recommendation 4. The Acting Under Secretary for Health should ensure that a requirement of sustained sobriety should not be a barrier to treatment in specialized mental health programs for returning combat veterans.

Recommendation 5. The Acting Under Secretary for Health should facilitate bi-directional information exchange between VA and DoD for patients with mental illness coming into VHA health care and/or leaving VHA health care for re-deployment to active duty status.

Recommendation 6. The Acting Under Secretary for Health should establish a centralized mechanism to review ongoing suicide prevention strategies, to select among available emerging best practices for screening, assessment and treatment, and to facilitate system-wide implementation, in order to ensure a single VHA standard of suicide prevention excellence.

Appendix A

Survey Questions

VA Office of Inspector General
Office of Healthcare Inspections
Suicide Prevention Questions – Not Including Follow-Up Questions

Access and Outreach

(1) At your facility, have efforts been undertaken to promote awareness that suicide is a public problem that may be preventable?
(2) Have strategies been implemented to reduce the stigma associated with being a consumer of mental health and/or substance abuse services?
(3) Has your facility implemented community based suicide prevention programs?
(4) Have efforts been undertaken to increase access to mental health care and substance abuse services?
(5) In the past 12 months has your facility conducted any suicide or depression awareness and/or screening outreach events?
(6) Have initiatives been undertaken by the Chaplain Service to establish contacts with faith-based organizations and community resources to assist with culturally competent suicide prevention and other mental health issues?

Education

Non-Clinical Personnel

(7) Are programs provided at your facility to educate first contact **non-clinical** personnel such as clerks and telephone operators, about crisis situations involving veterans at risk for suicide?

Clinical Personnel

(8) Is your facility affiliated with a medical school?
(9) Are suicide related education programs available at your facility for health care providers (could include web based programs, videoconferences, seminars/colloquia, and/or EES programs)?
(10) Are programs available to educate health care providers on suicide risk factors in patients over 65 years old?
(11) Are programs available at your facility to educate Health Care providers on mental health issues in returning OEF/OIF veterans (including web based programs)?

Primary Care Screening and Referral

Depression, PTSD, and Substance Abuse - Mental Health Conditions

(12) Are clinical reminders used by primary care providers for screening of OEF/OIF veterans for any of the following mental health conditions?
(13) Does your facility require at least annual screening of veteran's mental health conditions at primary care clinic for the following?
(14) As of the date of this survey, are mental health clinicians co-located and seeing patients at your primary care clinic(s)?

(15) When a primary care provider refers a patient with symptoms of moderate severity, what is the average length of time before a patient is seen by a mental health professional for each of the following conditions:
(16) Do primary care providers utilize a hierarchical strategy (structured interview template or algorithm) to follow positive depression screens with additional inquiries about suicidality such as that indicated on the EES Suicide Risk Assessment pocket card?

Suicidality

(17) Do primary care providers utilize tools for recognition of patients with suicidality?
(18) Do primary care providers utilize tools for screening patients for suicidality?
(19) Has your facility implemented a system to facilitate referral of veterans with risk factors for suicide by primary care providers to specialty mental health care? (e.g., policy, guideline, algorithm etc.)
(20) When a primary care provider detects a patient at risk for suicide, what is the average length of time before a patient is seen by a mental health professional? (If other, please specify in number of weeks.)

Mental Health Monitoring and Intervention

(21) Is mental health care available through your VAMC 24 hours a day?
(22) Has your facility implemented a strategy for ongoing monitoring of suicidality in mental health patients?
(23) Have intervention strategies been implemented that target periods of increased risk for suicide (e.g. first year after initial diagnosis of schizophrenia, end of relationship, anniversary of traumatic events such as combat or deaths, etc.) in veterans known to have mental health and/or substance abuse disorders?
(24) Have suicide prevention strategies been implemented to target special emphasis groups (e.g. victims of sexual trauma, returning OEF/OIF veterans, bipolar patients with mixed states)?
(25) Is cognitive therapy that is specifically focused on prevention of suicide attempts available to patients at your facility?
(26) Approximate percentage of mental health patients who have been newly diagnosed with bipolar disorder type I in the past 24 months who have been prescribed lithium treatment by facility mental health providers?
(27) Approximate percentage of mental health patients with schizophrenia who have been prescribed treatment with clozapine over the past 24 months?
(28) Are specialized substance abuse treatment programs available at your facility?
(29) Is dialectical behavioral therapy available for patients with borderline personality disorder at your facility?

Tracking Systems

(30) Has your facility implemented a tracking system for veterans with risk factors for suicide?
(31) At your facility is there a case manager that has been dedicated specifically for the care of patients identified by facility providers as high risk for suicide?

Appendix B

Acting Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: April 24, 2007

From: Acting Under Secretary for Health (10)

Subject: **OIG Draft Report, *Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*, Project No. 2006-03706-HI-0007, (WebCIMS 377064)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I concur with the recommendations therein which will help to ensure a more coordinated effort of implementing proactive suicide prevention strategies throughout the Veterans Health Administration (VHA). VHA's goal is to ensure continual awareness and prevention of suicide among veterans.

2. One example of VHA's ongoing and increasing commitment to suicide prevention is the recent designation of Suicide Prevention Coordinators in each medical center. These Coordinators will serve to facilitate implementation of suicide prevention strategies at the local level. Activities will include support for the identification of veterans at high risk; coordinating enhanced care when needed; education of providers, veterans, families, and members of the community on risk factors and warning signs for suicide; and treatment options.

3. As you know, suicide prevention is among the primary goals of VHA's Mental Health Strategic Plan (MHSP), and since its establishment in 2004, significant progress has been made to implement the suicide prevention initiatives within the Plan. VHA's progress in providing educational programs on suicide risks and prevention to our health providers and non-clinical staff has been ongoing. Prior to the release of your report, to further help our system maintain its focus on suicide prevention among veterans, I designated March 1, 2007, as Veteran Suicide Prevention Awareness Day. This annual event will enhance suicide prevention education for clinicians and non-clinical staff throughout the VA health care system. Each Vet Center, Veterans

Integrated Service Network (VISN), and medical center will hold Veterans Suicide Prevention Day annually to conduct suicide prevention programs and activities, to include educational presentations that are extended during the year through a number of VHA Employee Education System (EES) programs.

4. In addition, VHA is in the process of developing additional awareness and training protocols at the local level that involve training of front-line patient contact personnel on the concepts of suicide recognition, early interventions, and the steps necessary in responding to crisis and obtaining assistance for veterans at risk of suicide. Awareness training on suicide prevention for clinical personnel is also under development. Although these efforts are already outlined with target dates in our MHSP, in the interim, we have expedited these initiatives to limit any remaining gaps in service delivery involving suicide prevention.

5. Thank you for the opportunity to review the report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 565-7638.

(original signed by:)

Michael J. Kussman, MD, MS, MACP

Acting Under Secretary for Health Comments to Office of Inspector General's Report

The following Acting Under Secretary for Health comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

We recommend the following:

Recommendation 1. The Acting Under Secretary for Health should ensure that VISN directors ensure that facilities in their VISNs have made arrangements for 24-hour crisis and mental health care availability either in person, via a facility-run crisis line, or by facility referral to an established, functioning non-VA crisis/suicide hotline staffed by trained personnel. In addition, an on-call mental health specialist should be available to crisis staff either in person or by phone.

Concur

VHA, through the Office of Mental Health Services (OMHS) within the Office of Patient Care Services, will work with the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM), to ensure 24 hour on-site or on-call coverage by mental health professionals in all medical facilities with emergency departments or 24/7 urgent care centers by June 1, 2007. An implementation plan for all remaining faclities will be completed by July 31, 2007, and will include standards for determining which faclities should have round the clock and onsite coverage, or to include mental health care availability either in person, via a facility-maintained crisis line, or facility referral to an established, functioning non-VA crisis/suicide hotline.

OMHS is also currently developing a VA national 24/7 suicide prevention hotline that will function as part of a comprehensive program for suicide prevention. It is anticipated that this program will be ready for roll-out on November 30, 2007, with full national implementation and a follow-up assessment of compliance estimated for January 30, 2008.

In process January 30, 2008

Recommendation 2. The Acting Under Secretary for Health should ensure that VISN directors ensure that facility directors ensure that all non-clinical staff who interact with veterans receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.

Concur

Based on the April 10, 2007, discussion and interpretation of this recommendation with Deputy Assistant Inspector General for Healthcare Inspections, VHA will work to ensure that each facility has developed their own ongoing training, awareness and communication plan that includes appropriate procedures/suicide protocols, and community resources for all first contact personnel in both clinical and non-clinical areas. Each facility will establish a list of those individuals within their own areas who would be most likely to interact with veterans at-risk for suicide or who may be experiencing some type of crisis, such as, but not limited to, telephone operators, registration personnel, volunteers, or patient escorts. VHA will establish a work-group comprised of PCS, OMHS, the Office of the DUSHOM and EES, not later than April 30, 2007, to develop a plan to implement the recommended action, anticipating that full-roll out will occur no later than October 31, 2007.

In the interim, an educational offering was presented and made available for all VA staff that interacts with patients on March 1, 2007 as part of Suicide Prevention Awareness Day. National, system-wide activities will be an ongoing process with programs for training for all staff with patient contact as part of Suicide Prevention Awareness Day as an annual event. Additionally, a number of related EES programs are planned for this year, with additional programs projected in subsequent years. The content will vary from practical training for non-clinical staff to more conceptually-oriented training materials for mental health professionals.

National efforts will be supplemented with local and regional efforts implemented as part of the activities of the Suicide Prevention Coordinators. These newly created positions were funded on April 1, 2007 (a position description is attached). A workgroup under the leadership of OMHS has been established to develop the educational training requirements and needs for this position, and plans to complete this work by October 2007.

In process October 31, 2007

Recommendation 3. The Acting Under Secretary for Health should ensure that VISN directors ensure that facility directors ensure that all non-clinical staff who interact with veterans receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.

Concur

Based on the April 10, 2007, discussion and interpretation of this recommendation with Deputy Assistant Inspector General for Healthcare Inspections, PCS and OMHS will work with the Office of the DUSHOM and EES to develop a mandatory training program, which will include different levels of training, based on the professional needs of the individual clinician and their clinical responsibilities, to include suicide prevention, risk-assessment, protocols and interventions. Development of this educational offering was planned as part of the MHSP for the end of Fiscal Year 2008, but efforts will be accelerated to be implemented no later than October 30, 2007, with full compliance for all facilities by January 30, 2008.

National efforts will be supplemented with local and regional efforts implemented as part of the activities of the Suicide Prevention Coordinators.

In process January 30, 2008

Recommendation 4. The Acting Under Secretary for Health should ensure that a requirement of sustained sobriety should not be a barrier to treatment in specialized mental health programs for returning combat veterans.

Concur

The Acting Under Secretary for Health delegated the review of the expectation of sustained sobriety prior to admission to specialized inpatient PTSD programs to OMHS, within the Office of PCS.

The review emphasized the principles that PTSD is often complicated by substance use disorders, and that having dual diagnoses should not be a barrier to the implementation of treatment. However, it also recognized that it may be of value for specialized inpatient PTSD programs to focus their efforts on providing specific forms of evidence-based psychological treatments, and that substance use or withdrawal may compromise an individual's ability to participate in these interventions.

To address these principles and emphasize VHA's commitment to providing needed care, OMHS will work with the Office of the DUSHOM, to prepare and distribute an information letter from the Acting Under Secretary for Health to all VHA facilities through the Veterans Integrated Service Networks (VISNs). The letter will confirm VHA's commitment to ensure that inpatient mental health care is available to all veterans at the time of need, to those who require it for treatment of mental illness, substance use disorders, or dual diagnoses, regardless of complicating factors that may have an impact on the overall diagnosis or course of treatment.

In process October 31, 2007

Recommendation 5. The Acting Under Secretary for Health should facilitate bi-directional information exchange between VA and DoD for patients with mental illness coming into VHA health care and/or leaving VHA health care for re-deployment to active duty status.

Concur

There are on-going efforts designed to facilitate the transfer of information between DoD and VA to support the clinical care of service men and women transitioning between systems, as well as to support the health care operations and programs of both Departments. For those with serious injuries who have required medical evacuation for acute treatment, and subsequent transfer to VA, information sharing about mental health conditions as well as other problems is included in the Seamless Transition program. For all veterans, DoD is currently sharing information derived from Post-Deployment Health Assessments (PDHAs) and Post-Deployment Health Reassessments (PDHRAs). VA currently shares information on health care provided within its system for veterans who have been redeployed with DoD providers on a priority basis. The legal authorities for sharing protected health information between DoD

and VA for treatment, payment, health care operations and other purposes, such as to meet a military mission, are outlined in the DoD/VA Memorandum of Understanding for Data Sharing.

Mechanisms for sharing information about suicide attempts, and possibly, other risk factors for suicide could be an important part of VA's and DoD's efforts at suicide prevention. There is legal authority under applicable Federal privacy laws for this information sharing under certain conditions; however, the processes on when and how to share information in these situations will need to be determined. To ensure that policies recognize the importance of this issue, the Acting Under Secretary for Health will request that this recommendation and possible future actions be addressed by the joint VA/DoD Work Group on Mental Health.

In process On-going

Recommendation 6. The Acting Under Secretary for Health should establish a centralized mechanism to review ongoing suicide prevention strategies, to select among available emerging best practices for screening, assessment and treatment, and to facilitate system-wide implementation, in order to ensure a single VHA standard of suicide prevention excellence.

Concur

The Acting Under Secretary for Health will direct PCS/OMHS to convene a Suicide Prevention Steering Committee that will consist of: additional representation from the Office of Readjustment Counseling Service (RCS); National Center for Patient Safety; Office of Public Health and Environmental Hazards; Office of Research and Development/Health Services Research; Office of Nursing Services; the Office of the DUSHOM; the following offices or entities within PCS including Primary Care, Geriatrics and Extended Care, Pharmacy Benefits Management, Social Work, and field representatives from VISN 19 Mental Illness Research Education and Clinical Center (MIRECC); the Center for Excellence in Mental Health and PTSD at Canandaigua, NY; and the Seriously Mental Illness Treatment, Research and Education Center (SMITREC).

The Committee will ensure that on-going suicide prevention strategies become integrated broadly into daily VHA operations. Specifically, the Committee will guide VHA's suicide prevention program through on-

going review of suicide prevention implementation plans, emerging opportunities from advances in research and clinical practice, and both epidemiological findings and clinical observations on suicidal behavior among veterans. As recommended, its activities will include the selection of emerging best practices for screening, assessment, referral, and treatment and facilitation of system-wide implementation in order to ensure a single VHA standard of suicide prevention excellence.

This Committee will be convened by June 1, 2007.

In process June 1, 2007 and on-going

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Michael Shepherd, M.D. Washington, DC (202) 565-4846
Acknowledgments	Sunil Sen-Gupta Marnette Dhooghe Rayda Nadal Roxanna Osegueda Katherine Owens

Appendix D

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Appendix E

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