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VETERANS HEALTH ADMINISTRATION

Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died

HEALTHCARE INSPECTION | REPORT #19-08542-11 | NOVEMBER 17, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate an allegation regarding Veterans Crisis Line (VCL) staff's management of a veteran caller (Caller) who died the same day as contacting the VCL.

On May 19, 2019, the OIG received an allegation that VCL staff failed to initiate an emergency dispatch request for the Caller on July 4, 2018. During the inspection, the OIG identified concerns regarding VCL staff's management of intoxicated callers and coordination with the Veterans Health Administration (VHA) Suicide Prevention Program, specifically, the submission of consults (1) as routine rather than urgent, and (2) on holidays and weekends. In addition to interviews with VCL leaders and staff, the OIG team also interviewed five crisis line subject matter experts.[1]

The Caller, a veteran in their 30s with a history of depression and alcohol use disorder, received intensive outpatient mental health treatment at a VA facility that included a spring 2018 suicide prevention safety plan.[2]

On July 4, 2018, at approximately 4:30 a.m., the Caller telephoned the VCL and spoke with a responder (responder 1). The Caller described survivor guilt and frustration with fireworks. The Caller reported a 2016 suicide attempt, suicidal ideation during the prior two months, and "a gun pressed to [the Caller's] head right now." Responder 1 documented that the Caller reported not having bullets for the gun and having "consumed 7 shots of whiskey earlier tonight." Additionally, responder 1 documented that the Caller was intoxicated.

The call disconnected several times and after two unsuccessful attempts, responder 1 was able to reach the Caller. Responder 1 documented that the Caller reported dropping the call due to taking "2-4" diphenhydramine and that "this was not out of the ordinary for [the Caller] and that it just puts [the Caller] to sleep."[3] Responder 1 documented the Caller's suicide risk as "Moderate to Low Risk" and a safety plan that included the Caller's agreement not to touch or use a firearm for self-harm, not drink anymore, and call the VCL "if in crisis or in need of further support."

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[1] The five subject matter experts served on national crisis call center committees. Two of the five subject matter experts had primary academic affiliations. The three other subject matter experts served in leadership positions with crisis line organizations. Two of the three subject matter experts were from the same crisis line organization and participated in the OIG interview together.

[2] The OIG uses the singular form of they (their) in this circumstance for the purpose of patient privacy.

[3] Diphenhydramine is used to relieve symptoms of allergy and the common cold and to treat difficulty falling asleep or staying asleep. This medication may make a person drowsy and alcohol can add to the drowsiness. Diphenhydramine is found in nonprescription or over-the-counter medications. U.S. National Library of Medicine, Medline Plus, *Diphenhydramine.* https://medlineplus.gov/druginfo/meds/a682539.html. updated January 20, 2020. (The website was accessed on January 29, 2020.)

Responder 1 submitted a routine consult to the Caller's treating VA facility suicide prevention coordinator.

Approximately an hour after the initial call, the Caller telephoned VCL and reported to a different responder (responder 2) that the Caller did not want the police to come to the house. Responder 2 documented that the Caller reported telling responder 1, the Caller "had a gun in [the Caller's] mouth," and responder 2 explained that this would be a reason for responder 1 to initiate a rescue. The Caller denied current suicidal ideation or "means to carry out this plan to shoot." After approximately five minutes, the Caller disconnected the call and responder 2 unsuccessfully attempted to reach the Caller four times, with the last call occurring two hours after the initial call. Responder 2 consulted with a supervisor and documented discontinuing call attempts after noting that responder 1 had assessed the Caller, initiated a safety plan, and submitted a suicide prevention coordinator consult.

The Caller died sometime between the last VCL contact and when the police department called the medical examiner for emergency dispatch at 4:27 p.m. on July 4, 2018. The medical examiner determined that the Caller's cause of death was acute combined intoxication from alcohol, antidepressant medication, dextromethorphan, and diphenhydramine.[4] The medical examiner documented that the Caller's manner of death was "best classified as undetermined" because the intent of the overdose was uncertain.[5]

VHA policy requires that VCL responders are trained in suicide prevention, crisis intervention, risk mitigation, and safety planning. Additionally, responders are to make every effort to complete a thorough risk assessment on every caller.[6] The OIG substantiated that VCL staff did not initiate an emergency dispatch for the Caller who reported use of alcohol and over-the-counter medications that cause drowsiness. The OIG found that responder 1 inaccurately documented what the Caller reported, and a supervisor then decided not to initiate a rescue based on that documentation. Further, the OIG found that VCL policies did not address management of intoxicated callers or assessment of risk for accidental overdose. The OIG concluded that responders 1 and 2 failed to adequately clarify the Caller's access to lethal means

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[4] U.S. National Library of Medicine, Medline Plus, *Dextromethorphan*. https://medlineplus.gov/druginfo/meds/a682492.html. updated January 27, 2020. (The website was accessed on January 30, 2020.) Dextromethorphan is used to temporarily relieve a cough but does not treat the cause of the cough. Dextromethorphan may cause drowsiness. Dextromethorphan is found in nonprescription or over-the-counter medications.

[5] Office of the Chief Medical Examiner, *Frequently Asked Questions.* https://ocme.dc.gov/page/ocme-faqs. (The website was accessed on April 22, 2020.) The manner of death describes the circumstances surrounding an individual's death. A medical examiner classifies manner of death as either natural, accident, suicide, homicide, undetermined, or pending.

[6] VHA Directive 1503, *Operations of the Veterans Crisis Line Center,* May 31, 2017. This directive was in effect at the time of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1503, *Operations of the Veterans Crisis Line*, May 26, 2020. The two policies contain the same or similar language related to suicide prevention, crisis intervention, risk mitigation, and safety planning.

and subsequently did not engage adequately in the VCL protocol to reduce the Caller's access to a gun.[7] The OIG found insufficient supervisory documentation to determine the identity of the consulting supervisor(s) and to evaluate the sufficiency of the supervisory review of the Caller's contacts.

The OIG found that although responders 1 and 2 documented that the Caller was intoxicated, they did not adequately assess the Caller's use of alcohol or other drugs, failed to consider the Caller's potential overdose risk, and failed to initiate an emergency dispatch.

The combination of alcohol and over-the-counter medication can increase the risk of overdose.[8] In July 2018, the VCL did not have policies related to safety planning with intoxicated callers or risk assessment of accidental overdose of illicit or over-the-counter drugs. In May 2019, VCL leaders established a policy that provided call management guidance for callers who exhibit signs of medication misuse for prescribed medications; however, the policy does not address illicit or over-the-counter drug misuse.[9] VCL leaders told the OIG that responders are expected to use judgment with callers suspected of being impaired.

All subject matter experts supported responders screening for substance use as part of suicide risk assessment. When presented with a scenario similar to the Caller's, four of the subject matter experts recommended initiating a rescue.[10]

Based on the OIG team's review of the audio recordings from the Caller's contacts with the VCL, Medora documentation, and the subject matter expert input, the OIG would have expected both responders to assess further based on the Caller's inconsistent reports of amounts of substance use, apparent intoxication, and proximity to a firearm.[11] The OIG concluded that the responders' failure to complete a thorough assessment of the Caller's alcohol and medication use

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[7] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL, VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure included similar language regarding criteria for collaborative problem solving and safety planning (risk mitigation plan).

[8] National Institute on Alcohol Abuse and Alcoholism, *Harmful Interactions Mixing Alcohol with Medicines,* 2014. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines. (The website was accessed on March 25, 2020.)

[9] VCL-P-ACT-103-1905, *Policy for Discussions Surrounding Medications*, May 22, 2019.

[10] The five subject matter experts served on National Suicide Prevention Lifeline committees. Two of the five subject matter experts had primary academic affiliations. The three other subject matter experts served in leadership positions with crisis line organizations. Two of the three subject matter experts were from the same crisis line organization and participated in the OIG interview together. The OIG team presented a scenario that included a caller who reported having a gun to their head, a history of attempted suicide by police, recent ingestion of alcohol, and a mouthful of over-the-counter sleep medication. One of the five subject matter experts did not provide an opinion about dispatching an emergency rescue.

[11] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. Medora is the computer-based application used by responders to document VCL contacts.

and to consider accidental or intentional overdose potential contributed to an underestimation of risk.

VHA requires that VCL staff be trained on safety planning with callers.[12] VCL expects responders to complete a collaborative safety plan with callers at risk for self-harm and to document the safety plan in Medora. Additionally, when applicable, responders are to check the caller's electronic health record for "relevant assessment information and VA safety plan."[13]

Although responder 1 documented completion of a safety plan, the OIG concluded that neither responder 1 nor 2 adequately completed a safety plan with the Caller. Responder 1 documented completion of a safety plan but did not refer to information in the Caller's May 2018 VHA safety plan and failed to include key safety plan elements. Additionally, responder 1 did not review the safety plan with the Caller to ensure understanding prior to the calls being disconnected. Responder 1 did not initiate an emergency dispatch based on the perception of safety plan completion. Subsequently, responder 2 and a supervisor did not initiate an emergency dispatch process based upon responder 1's inaccurate documentation. Further, given that responder 2 documented the Caller was intoxicated with a high risk for suicide, the OIG opines that the realistic usefulness of a safety agreement was compromised. The OIG would have expected an emergency dispatch to be initiated based on the Caller's intoxication, high risk for suicide, and lethal means access.

VHA requires VCL leaders to implement silent monitoring to oversee the quality of responders' work in telephone calls, chats, and text communications.[14] The Deputy Director, Quality and Training, told the OIG team that silent monitoring of telephone calls started in April 2016 for quality assurance purposes and that the goal was 80 percent of staff receive at least one monitoring every two weeks. Until July 2019, silent monitoring was not used toward performance measures or standards.[15] If a responder did not meet criteria for the same critical rating area three or more times, the responder's supervisor was notified.[16] Additionally, the OIG

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[12] VHA Directive 1503, *Operations of the Veterans Crisis Line Center,* May 31, 2017. This directive was in effect at the time of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1503, *Operations of the Veterans Crisis Line*, May 26, 2020. The two policies contain the same or similar language related to safety planning.

[13] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure does not include mention of checking the caller's VA electronic health record for a safety plan.

[14] VHA Directive 1503, 2017; VHA Directive 1503, 2020. The 2017 and 2020 policies contain the same or similar language related to silent monitoring.

[15] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018; VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

[16] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018.

was informed that immediate supervisory review was required for calls in which the responder did not adequately mitigate risk or establish trust (unsuccessful calls).[17] In October 2019, the Deputy Director, Quality and Training, told the OIG that chat and text silent monitoring was in a pilot phase but not yet implemented, because the American Federation of Government Employees had not completed a review of the proposed program.[18]

Silent monitor social science program specialists (monitor specialists) are staff specifically trained to listen to active calls and assess responders.[19] Monitor specialists provide the responders with coaching for identified areas in need of improvement immediately following the call.[20] VCL leaders developed a silent monitoring protocol that outlines the evaluation criteria for responders' management of active and recorded calls to evaluate responders' interaction and call documentation accuracy and monitor specialists' coaching of responders for unmet criteria.[21] Monitor specialists evaluate responders' calls using VCL-established critical and noncritical criteria.[22] Critical criteria include the responder's completing a suicide risk assessment, offering a suicide prevention team consult, developing a plan to reduce current risk, and ending the call appropriately. Noncritical criteria include the responder's active call management such as focusing on the present and current concerns, defining the problem, accurately documenting the call, and assessing callers' homicidality.[23]

In July 2019, VCL leaders implemented an updated silent monitoring policy that included criteria for aggregated data reviews and supervisor follow-up.[24] Prior to the end of January 2020, VCL leaders did not provide supervisors with responders' silent monitoring data unless a responder demonstrated a pattern (three or more times) of unmet criteria in the same critical

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[17] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018.

[18] "The American Federation of Government Employees is the largest federal employee union proudly representing 700,000 federal and D.C. government workers nationwide and overseas." American Federation of Government Employees, *About Us.* https://www.afge.org/about-us/. (The website was accessed on May 20, 2020.)

[19] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring,* July 8, 2019.

[20] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. Responders are not aware that silent monitoring occurred until after the call.

[21] *Veterans Crisis Line Silent Monitoring Quality Improvement Protocols,* February 18, 2016, updated August 10, 2017. This policy was in effect during some of the time frame of the relevant silent monitoring data analysis used in this report. The policy was rescinded and replaced by VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring,* July 8, 2019. The updated and new policies included similar language regarding criteria for silent monitoring of call management.

[22] VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019. Veterans and Military Crisis Line, VCL Orientation and Employee Handbook, April 2018.

[23] VCL, *Silent Monitoring Quality Improvement Protocols*, February 18, 2016, updated August 10, 2017.

[24] VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

rating area, which was considered an unsuccessful call. Additionally, VCL leaders did not review the data for individual responders or overall staff trends. As of late January 2020, quality assurance staff were required to refer information to supervisors for follow-up when responders did not meet "three of six consecutive monitors" for the same critical item or "four of six consecutive monitors" for the same noncritical item.[25] Although not implemented for the time period reviewed, responders 1 and 2 would not have met current criteria for supervisory review.

The OIG concluded that although VCL leaders implemented criteria for aggregated data reviews and supervisor follow-up, the supervisory intervention was only applicable to consecutive calls rather than call trends reviewed over a period of time. The lack of monitoring and identification of responders' consistently missed criteria over a longer period may have contributed to inadequate performance improvement and quality assurance initiatives.

Upon learning of the Caller's death from the treating facility's Suicide Prevention Coordinator on July 19, 2018, the Deputy Director, Quality and Training, asked the VCL's Patient Safety, Risk Manager to conduct a root cause analysis. However, the internal review was not conducted at that time, and the Patient Safety, Risk Manager told the OIG that this was due to an oversight. On January 8, 2020, the Patient Safety, Risk Manager told the OIG about developing a tracking system to avoid missing email notification of caller deaths and preventing an internal review from being missed.

In an August 5, 2019, response to the OIG inquiry about the Caller's death, VCL leaders reported that they would complete a root cause analysis, and one was completed in October 2019. The OIG concluded that the VCL leaders' failure to complete a timely root cause analysis contributed to a delay in identification of process deficiencies and associated improvements.

The OIG determined that responder 1 submitted a "routine" suicide prevention coordinator consult to the Caller's treating facility. The VCL standard advises responders to submit routine consults for callers assigned a "Moderate to Low" suicide risk level.[26] However, consistent with the opinions of the subject matter experts, the OIG concluded that the Caller's lethality risk

[25] The Labor Relations Management and American Federation of Government Employees finalized the memorandum of understanding for the updated policy in April 2020. VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring,* July 8, 2019.

[26] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. VHA requires that a suicide prevention coordinator is appointed at each VA medical center and large community-based outpatient clinic. Suicide Prevention Coordinators are responsible for responding to National Suicide Prevention Hotline and other staff, tracking and reporting on patients who have attempted suicide and those at high risk for suicide, and coordinating with providers to ensure high risk patients receive education, support and treatment to reduce risk. VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult,* January 5, 2018. VCL, *Standard Operating Procedure for Routine Consult Calling*, September 20, 2019.

should have been considered high, and therefore, the responder would have initiated other actions including submission of an urgent or emergent suicide prevention coordinator consult.

Given the absence of VHA requirements for suicide prevention coordinator follow-up on weekends and holidays, it can be as many as four days after an initial call before a caller receives a suicide prevention team call.[27] In November 2019, the Acting Director of VHA Suicide Prevention told the OIG that VCL identified this potential gap in care and that a proposal was under review to employ peer specialists who would contact callers identified as at increased risk for suicide, including weekend and holiday callers. On May 4, 2020, the Director, Suicide Prevention Program informed the OIG team that the Peer Support Outreach Call Center was in development.

The OIG made seven recommendations to the VCL Director related to a review of the Caller's contacts and consultation with Human Resources and Office of General Counsel, evaluation of the current responder training on lethal means, written guidance on responders' documentation of supervisory oversight and consideration of independent supervisory documentation, policy and training of callers' substance use and overdose risk, use of a standardized safety plan template and completion of safety planning per VCL standards, criteria for supervisor follow-up including silent monitoring criteria, and a system to identify caller contacts that warrant root cause analysis or other internal reviews and to track the review process.

The OIG made one recommendation to the Office of Mental Health and Suicide Prevention Executive Director related to the development of suicide prevention strategies for weekend and holiday callers.

[27] If a caller contacts the VCL on a Thursday after suicide prevention coordinator duty hours, and Friday is a federal holiday, the caller may not be contacted until Monday. Similarly, if the caller contacts the VCL on a Friday after hours and Monday is a federal holiday, the caller may not be contacted until Tuesday.

Comments

The Executive in Charge, Office of the Under Secretary for Health, responded to the recommendations addressed to the VCL Director and Office of Mental Health and Suicide Prevention Executive Director.[28] The Executive in Charge concurred with recommendations 1–7, concurred in principle with recommendation 8, and provided an acceptable action plan (see appendix A). The OIG will follow up on the planned actions until they are completed.

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[28] The Executive in Charge, Office of the Under Secretary for Health, has the authority to perform the functions and duties of the Under Secretary for Health. Recommendations were addressed to the VCL Director and Office of Mental Health and Suicide Prevention Executive Director. The Executive in Charge provided all responses.

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Abbreviations

OIG	Office of Inspector General
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate an allegation regarding Veterans Crisis Line (VCL) staff's management of a veteran caller (Caller) who died the same day as contacting the VCL.

Background

In 2007, the Veterans Health Administration (VHA) established the National Veterans Suicide Prevention Hotline, now known as the VCL, in response to the Joshua Omvig Veterans Suicide Prevention Act (Act), Public Law 110-110.[1] The Act mandated that VHA provide mental health services 24 hours per day, seven days per week, and operate a toll-free hotline for veterans.[2] Since VCL was established, VCL responders have answered nearly 4.4 million calls, engaged in more than 511,000 chats, and responded to more than 150,000 texts.[3] VCL location sites include Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.[4] VCL is aligned under the Office of Mental Health and Suicide Prevention, makes referrals to local VHA mental health services, and is accredited by the Commission on Accreditation of Rehabilitation Facilities.[5]

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[1] VA OIG, *Healthcare Inspection–Evaluation of the Veterans Health Administration Veterans Crisis Line*, Report No. 16-03985-181, March 20, 2017.

[2] Joshua Omvig Veterans Suicide Prevention Act of 2007, Pub. L. No. 110-110, § 1720F, 121 Stat. 1031.

[3] A chat is a discussion held over the Internet by sending messages back and forth, usually in a chat room. Merriam-Webster Dictionary, "Chat." https://www.merriam-webster.com/dictionary/chat. 2020. (The website was accessed on February 21, 2020.) A text is a message sent electronically usually to or from a mobile cellular phone. https://www.merriam-webster.com/dictionary/text%20message. (The website was accessed on February 21, 2020.) A VCL responder is an employee who communicates and interacts with callers. Responders are also referred to by VCL as health science specialists. Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook,* April 2018. Veterans Crisis Line website. https://www.veteranscrisisline.net/about/what-is-vcl. (The website was accessed on April 2, 2020.)

[4] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook,* April 2018.

[5] VHA Directive 1503, *Operations of the Veterans Crisis Line Center,* May 31, 2017. This directive was in effect during the time frame of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1503, *Operations of the Veterans Crisis Line*, May 26, 2020. The two policies contain the same or similar language related to the purpose and background of the VCL. The Commission on Accreditation of Rehabilitation Facilities (CARF) is an independent, non-profit accrediting body of health and human services that include behavioral health. CARF International, *Who We Are.* http://www.carf.org/About/WhoWeAre/. 2020. (The website was accessed on May 19, 2020.)

VCL Responders

Responders engage callers through reflective listening, motivational interviewing, problem-solving, and safety planning.[6] Responders are trained to identify a caller's level of risk for harm and initiate an active rescue through the dispatch of emergency services when risk is imminent.[7]

A human resources' specialist and the Quality Assurance Clinical Officer, Deputy Director, Quality and Training, reported that responders possess a bachelor's degree in a mental health-related field at a minimum and are not required to hold a professional license. Further, the Deputy Director, Quality and Training, and Director of the Suicide Prevention Program (formerly the VCL Director) reported that responders are not licensed independent practitioners and are expected to follow training and written protocol when working with callers and to seek supervisory guidance when needed.[8]

Prior OIG Reports

In the 2016 report, *Veterans Crisis Line Caller Response and Quality Assurance Concerns,* the OIG identified concerns related to caller hold times, lack of adequate orientation and ongoing training for Social Service Assistants, inadequate quality assurance processes, and the lack of a VHA handbook or directive for operations of the VCL. The OIG made seven recommendations, all of which were closed as of July 27, 2017.[9]

The 2017 OIG report *Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line,* identified concerns related to governance structure and oversight;

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[6] Motivational interviewing is an approach to communicating with people with mental health and substance abuse disorders to help them to make healthy choices. Substance Abuse and Mental Health Services Administration, "Motivational Interviewing." https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing. (The website was accessed on December 20, 2019.) A safety plan is a collaborative plan which identifies ways to limit access to lethal means and to increase access to positive coping strategies, supportive people, and other resources with a goal of reducing suicide risk. National Institute of Mental Health, *Suicide Prevention,* July 2019. https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml. (The website was accessed on January 30, 2020.)

[7] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to active rescue procedures. An active rescue is initiated when responders determine that a caller has engaged in or is at imminent risk of engaging in potentially lethal self-harm and is not capable of securing their own safety. Once the need for an active rescue is determined, the responder consults with a supervisor, and a VCL Social Service Assistant determines the caller's location and contacts emergency services.

[8] The Acting Director of the Suicide Prevention Program served in this role since July 2019, was previously the Director of the VCL from July 2017 through July 2019 and was appointed the Director of the Suicide Prevention Program on March 24, 2020.

[9] VA Office of the Inspector General, *Veterans Crisis Line Caller Response and Quality Assurance Concerns*, *Canandaigua, New York*, Report No. 14-03540-123, February 11, 2016.

procedural and clinical issues; and quality management. The 16 recommendations were closed as of March 14, 2018.[10]

The 2019 OIG report, *Follow-Up Review of the Veterans Crisis Line,* reviewed select VCL administrative operations that were not relevant to this current inspection. The OIG made one recommendation regarding the analysis of rescue efforts when a caller's location cannot be found that remained open as of July 28, 2020.[11]

Although these three prior OIG reports focused on critical VCL operations and functions, the findings were not directly relevant to the current inspection.

Allegations and Related Concerns

On May 19, 2019, the OIG received an allegation that VCL staff failed to initiate an emergency dispatch request for the Caller on July 4, 2018. During the inspection, the OIG identified the following related concerns:

- VCL staff's management of intoxicated callers
- VCL staff's coordination with the VHA Suicide Prevention Program; specifically, the submission of consults (1) as routine rather than urgent, and (2) on holidays and weekends

The OIG also identified a concern about the accuracy of the Caller's VCL call record for quality management purposes. The OIG found that VCL processes accurately reflected the Caller's telephone contacts on July 4, 2018, and therefore will not be discussed further in this report.

Scope and Methodology

The OIG initiated the inspection on September 16, 2019, and conducted a site visit from October 21 through October 24, 2019, at the VCL in Canandaigua, New York.

The OIG team reviewed applicable VHA directives and VCL policies and procedures regarding operations of the VCL, suicide prevention, call management, suicide risk assessment, lethal means assessment, suicide risk mitigation/safety planning, facility transportation planning, and emergency dispatch. Other documents reviewed included relevant Commission on Accreditation

[10] VA OIG, *Healthcare Inspection–Evaluation of the Veterans Health Administration Veterans Crisis Line*, Report No. 16-03985-181, March 20, 2017.

[11] VA OIG, *Follow-Up Review of the Veterans Crisis Line, Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas*, Report No. 18-03390-178, July 31, 2019.

of Rehabilitation Facilities standards, a VCL March 2018 survey, and American Association of Suicidology guidelines.[12]

The OIG team reviewed VCL quality management data from October 5, 2016, to October 23, 2019, including silent monitoring data, an internal review report, and a root cause analysis. The OIG team reviewed relevant VCL staff's email and instant messages and the medical examiner's autopsy report. Additionally, the OIG team reviewed the Caller's July 4, 2018, VHA electronic health record, Medora documentation, and telephone records and audio recordings.[13]

The OIG team interviewed the complainant; VCL leaders including the Director of the Suicide Prevention Program, the Acting VCL Director, Deputy Director, Quality and Training, the Acting Assistant Deputy Director of Quality and Training, Social Sciences Program Specialist; the Assistant Deputy Director of Quality and Training, Social Sciences Program Specialist; and responders including the two responders who spoke with the Caller. The OIG team also interviewed five crisis line subject matter experts.[14]

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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[12] Commission on Accreditation of Rehabilitation Facilities, *Behavioral Health Standards Manual 2018*, July 1, 2018, through June 30, 2019. American Association of Suicidology, *Organization Accreditation Standards Manual, 13th Edition,* 2017.

[13] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. Medora is the computer-based application used by responders to document VCL contacts. The National Suicide Prevention Lifeline telephone greeting states "calls may be recorded for quality assurance, evaluation, or training purposes." The Deputy Director, Quality and Training, told the OIG team that VCL uses audio recordings for quality assurance and training purposes.

[14] The five subject matter experts served on national crisis call center committees. Two of the five subject matter experts had primary academic affiliations. The three other subject matter experts served in leadership positions with crisis line organizations. Two of the three subject matter experts were from the same crisis line organization and participated in the OIG interview together.

Caller Case Summary

The Caller, a veteran in their 30s with a history of depression and alcohol use disorder, received intensive outpatient mental health treatment at a VA facility.[15] In spring 2018, the Caller completed a suicide prevention safety plan with a social worker after reporting suicidal ideations related to a psychosocial stressor. The Caller participated in outpatient substance use disorder treatment through July 2, 2018.

On July 4, 2018, at approximately 4:30 a.m., the Caller telephoned VCL and spoke with a responder (responder 1). The Caller described survivor guilt and frustration with fireworks. The Caller reported a 2016 suicide attempt, suicidal ideation during the prior two months, and "a gun pressed to [the Caller's] head right now." Responder 1 documented that the Caller reported not having bullets for the gun and having "consumed 7 shots of whiskey earlier tonight." Additionally, responder 1 documented that the Caller was intoxicated.

The call disconnected several times and after two unsuccessful attempts, responder 1 reached the Caller at 5:36 a.m. Responder 1 documented that the Caller reported dropping the call due to taking "2-4" diphenhydramine and that "this was not out of the ordinary for [the Caller] and that it just puts [the Caller] to sleep."[16] The Caller ended the call abruptly, and at 5:38 a.m., responder 1 called back, and the Caller hung up within approximately five seconds.

Responder 1 documented the Caller's suicide risk as "Moderate to Low Risk" and a safety plan that included the Caller's agreement not to touch or use a firearm for self-harm, not drink anymore, and call the VCL "if in crisis or in need of further support." Responder 1 submitted a routine consult to the Caller's treating VA facility suicide prevention coordinator.

At 5:41 a.m., the Caller telephoned VCL and reported to a different responder (responder 2) that the Caller did not want the police to come to the house. Responder 2 documented that the Caller reported telling responder 1 the Caller "had a gun in [his] mouth," and responder 2 explained that this would be a reason for responder 1 to initiate a rescue. The Caller denied current suicidal ideation or "means to carry out this plan to shoot." When asked about homicidal ideation, Responder 2 documented that the Caller stated, "if the police show up at my house, there will be," and said there was a "shoot out" the last time police were called. After approximately five minutes, the Caller disconnected the call and responder 2 unsuccessfully attempted to reach the Caller four times with the last call at 6:16 a.m. Responder 2 consulted with a supervisor and

[15] The OIG uses the singular form of they (their) in this circumstance for the purpose of patient privacy.

[16] U.S. National Library of Medicine, Medline Plus, *Diphenhydramine*. https://medlineplus.gov/druginfo/meds/a682539.html. updated January 27, 2020. (The website was accessed on January 29, 2020.) Diphenhydramine is used to relieve symptoms of allergy and the common cold and to treat difficulty falling asleep or staying asleep. This medication may make a person drowsy and alcohol can add to the drowsiness. Diphenhydramine is found in nonprescription or over-the-counter medications.

documented discontinuing call attempts after noting that responder 1 had assessed the Caller, initiated a safety plan, and submitted a suicide prevention coordinator consult.

The Caller died sometime between the last VCL contact and when the police department called the medical examiner for emergency dispatch at 4:27 p.m. on July 4, 2018. The medical examiner determined that the Caller's cause of death was acute combined intoxication from alcohol, antidepressant medication, dextromethorphan, and diphenhydramine.[17] The medical examiner documented that the Caller's manner of death was "best classified as undetermined" because the intent of the overdose was uncertain.[18]

[17] U.S. National Library of Medicine, Medline Plus, *Dextromethorphan*. https://medlineplus.gov/druginfo/meds/a682492.html. updated January 27, 2020. (The website was accessed on January 30, 2020.) Dextromethorphan is used to temporarily relieve a cough but does not treat the cause of the cough. Dextromethorphan may cause drowsiness. Dextromethorphan is found in nonprescription or over-the-counter medications.

[18] Office of the Chief Medical Examiner, *Frequently Asked Questions.* https://ocme.dc.gov/page/ocme-faqs. (The website was accessed on April 22, 2020.) The manner of death describes the circumstances surrounding an individual's death. A medical examiner classifies manner of death as either natural, accident, suicide, homicide, undetermined, or pending.

Inspection Results

1. VCL Staff Failed to Initiate an Emergency Dispatch

The OIG substantiated that VCL staff did not initiate an emergency dispatch for the Caller who reported use of alcohol and over-the-counter medications that cause drowsiness. The OIG found that the responders' failure to thoroughly assess and integrate relevant risk information contributed to VCL staff's decision not to initiate an emergency rescue that could have prevented the Caller's death. The OIG concluded that responders 1 and 2 failed to adequately clarify the Caller's access to lethal means and subsequently did not engage adequately in the VCL protocol to reduce the Caller's access to a gun.[19] The OIG found that responder 1 inaccurately documented what the Caller reported, and in consultation with a supervisor, responder 2 then decided not to initiate a rescue based on that documentation. The OIG found insufficient documentation to determine the identity of consulting supervisors and to evaluate the sufficiency of the supervisory review of the Caller's contacts. Further, the OIG found that VCL policies did not address management of intoxicated callers or assessment of risk for accidental overdose. Although responder 1 documented completion of a safety plan, the OIG concluded that neither responder 1 nor 2 completed an adequate safety plan with the Caller.

Suicide Risk Assessment

Responders are required to demonstrate knowledge and skills in the identification of a caller's risk indicators and lethality assessment. Further, responders should decide the appropriate course of action to stabilize the crisis as soon as possible.[20] The American Association of Suicidology advises that responders should initiate active rescue if they are unable to de-escalate a caller at imminent suicide risk.[21]

VHA policy requires that VCL responders be trained in suicide prevention, crisis intervention, risk mitigation, and safety planning. Additionally, responders are to make every effort to complete a thorough risk assessment on every caller.[22] VCL directs responders to complete a

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[19] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure included similar language regarding criteria for collaborative problem solving and safety planning (risk mitigation plan).

[20] Commission on Accreditation of Rehabilitation Facilities, *Behavioral Health Standards Manual 2018*, July 1, 2018, through June 30, 2019.

[21] American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012. The American Association of Suicidology is a nonprofit accrediting organization that applies nationally recognized standards to crisis intervention programs.

[22] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to suicide prevention, crisis intervention, risk mitigation, and safety planning.

suicide risk assessment for callers who endorse thoughts of suicide and outlines nine domains for responders to address in a suicide risk assessment that includes

- Evaluation of "onset, duration, frequency, and severity of suicidal ideation,"
- Information gathering about the caller's access to lethal means,
- Asking about preparatory behavior,
- Exploring social, biological, and emotional risk factors, and
- Evaluating protective factors such as family support.[23]

VCL leaders told the OIG that responders are expected to determine risk level and appropriate actions based on the information a caller provided. The Medora note template includes a drop-down list for responders to choose from three suicide risk levels: (1) high, (2) moderate to high, or (3) moderate to low.

The OIG found deficiencies in both responders' documentation of the Caller's suicide risk assessment. Specifically, although the Caller reported survivor guilt, frustration with people setting off fireworks, current suicidal ideation and in the past two months, access to a firearm, and a past suicide attempt; responder 1 did not complete a thorough risk assessment. Responder 1 completed two of the nine elements that included exploration of any history of prior attempts and accessed the electronic health record to identify if the Caller had any patient record flags that alerted if the Caller was at imminent risk.[24] However, the OIG found that responder 1 did not complete two other elements of the suicide risk assessment and only partially completed five of the nine elements. Responder 1 documented the Caller's "desire to harm self and/or others" as moderate and responder 1's clinical impressions and formulation of the Caller's suicide risk as moderate to low risk. Further, the OIG found that training provided to responders for suicide risk level classification is different compared to the Medora note template options. Suicide risk levels in the responder training are: (1) low, (2) intermediate, or (3) high.[25] The

[23] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure included similar language regarding criteria for collaborative problem solving and safety planning (risk mitigation plan). VCL Position Description, *Health Science Specialist*, January 8, 2019.

[24] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. A "category II local patient record flag – patient at risk" is an alert in a patient's electronic health record that VHA facilities use for a range of approved purposes, including "flagging patients at high risk for suicidal behavior."

[25] Suicide Risk Classification levels are defined in VCL training. Low risk callers have "no history of suicidal behavior," no suicidal ideation and "some risk and protective factors." Intermediate risk callers have an elevated risk due to suicidal ideation and desire, chronic substance abuse, or relational or other stressors. High risk callers are defined as having a history of multiple suicide attempts, recent suicidal thoughts and plans, or anticipation of a triggering event.

language difference between responder training and the Medora template options may confuse responders and lead to inaccurate template documentation.

The OIG found conflicting information between responder 2's documentation and the VCL audio recording with the Caller. Responder 2 documented that the Caller denied current suicide ideation or in the past two months. However, the OIG found that during the call, when asked about suicidal thoughts currently and within the last two months, the Caller reported "I'm fine" and "yes, vaguely, but that's not the problem right now." The OIG found that responder 2 completed two of the nine elements of the risk assessment that included evaluation of the onset, duration, frequency, and severity of suicide ideation and exploration of history and prior self-harm attempts. Responder 2 documented the Caller's "desire to harm self and/or others" as high. Responder 2 documented that the Caller disconnected the call, responder 2 attempted to contact the Caller four times after the call was disconnected, but the Caller's voice mail was full, so a message was not left. Responder 2 consulted a supervisor, and no further contact was pursued.

Given the Caller's initial presentation reporting suicide ideation currently and within the last two months, access to a firearm, and a previous suicide attempt, the OIG would have expected responders 1 and 2 to inquire more thoroughly about additional factors of the suicide risk assessment domains to determine the Caller's risk level.

The OIG concluded that completion of a thorough risk assessment including the Caller's medical risk factors, such as alcohol and substance use and family or social support, may have revealed additional information regarding the Caller's risk and protective factors that might have changed the course of events. Additionally, responder 2 documented that the Caller did not have suicidal ideation at the time of the call or in the prior two months, which was in stark contrast to responder 1's documented information. The OIG found that the responders' failures to thoroughly assess and integrate relevant risk information contributed to VCL staff's decision not to initiate an emergency rescue that could have prevented the Caller's death.

Lethal Means Assessment

The American Association of Suicidology advises that lethality assessments should address an individual's "desire, capability, intent, and buffers" (protective factors) to suicide. Suicidal capability factors include a "history of suicide attempts, intoxication" as well as "fearlessness of taking action" and decreased sleep.[26] VCL responders are expected to complete a suicide risk assessment for callers who endorse thoughts of suicide that includes "onset, duration, frequency,

[26] American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012.

and severity of suicidal ideation" and access to lethal means.[27] Further, VCL trains responders on firearms means reduction including locking up and separating a gun from ammunition, exploring places to safely store a firearm, and engagement of responsible people to assist.

Responders 1 and 2 completed the required firearms means reduction training in 2018. Responder 1 documented that the Caller did not have any bullets for the gun. However, at the beginning of the initial call, the Caller agreed to unload bullets from the gun, and the audio tape included sounds indicating removal of bullets. Although responder 1 documented that the Caller secured the weapon, the audio recording did not include discussion of safe storage of the firearm.

Responder 2 documented that the "Caller denied current [suicidal ideation] or having any [suicidal ideation] in the previous two months." The OIG found that the Caller both acknowledged and denied suicidal intention. Early in the call, the Caller reported "I was about to kill myself and I don't want the cops to come to my house," and moments later said, "I'm not trying to kill myself." Additionally, responder 2 did not accurately document the Caller's answer to responder 2's inquiry about suicidal ideation within the last two months per the following call excerpt:

> Responder 2: Ok. Well, how have you been the last two months? Any thoughts of suicide the last two months?
>
> Caller: That's not really the question here.
>
> Responder 2: So, have you had any thoughts?
>
> Caller: Yes, vaguely, but that's not the problem right now.

Additionally, responder 2 documented that the Caller had "put gun in mouth" and that the Caller "did not respond" when asked about the means to carry out this plan. However, when responder 2 asked "do you still have the gun with you now?" the Caller reported "Well, of course I'm going to tell you I don't." Responder 2 told the OIG team that after the Caller disconnected the call, responder 2 reviewed responder 1's note and had concerns about the Caller's ideation expressed to responder 1. Responder 2 documented consulting with a supervisor and told the OIG team that the supervisor did not authorize initiating a rescue.

The OIG found that responders 1 and 2 failed to effectively evaluate the Caller's access to a gun, follow-up on the Caller's inconsistent reports regarding a gun, or discuss safe storage of the gun. The OIG concluded that responders 1 and 2 failed to adequately clarify the Caller's access to lethal means and subsequently did not engage adequately in the VCL protocol to reduce the

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[27] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure included similar language regarding risk assessment.

Caller's access to a gun.[28] The OIG would have expected the responders to more actively assess and mitigate the Caller's access to lethal means particularly since the Caller reported having a gun aimed for self-harm prior to calling VCL.

Supervisor Consultation

VA requires supervisors to be responsible for monitoring and evaluating performance and to "determine if deficiencies are performance-based or whether they result from other causes such as technological barriers, negligence, or misconduct."[29] VCL supervisory health science specialists (supervisory staff) provide oversight for all shifts and are responsible for reviewing responders' assessments for accuracy and completeness. VCL supervisory staff are expected to provide direct guidance and advice to responders regarding suicide, mental illness, and crisis. As discussed below, until July 2019, VCL leaders did not require responders or supervisors to document all supervisory consultations.[30]

The Deputy Director, Quality and Training, told the OIG that responders may contact supervisors through instant message or in-person contact. The VCL standard in effect in July 2018 directs responders to document supervisory consults when the responder has concerns about the collaborative safety plan or the current safety of the caller. The standard directs responders to document the consultation but does not include guidance on the critical elements that responders should document regarding the supervisory consultation.[31]

Both responders 1 and 2 told the OIG team that the decision not to initiate emergency dispatch occurred following consultation with supervisory staff. In an interview with the OIG team, responder 1 recalled thinking that a rescue should be dispatched and then consulting with a supervisor although responder 1 was unsure if the consult occurred through instant message or in

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[28] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure included similar language regarding lethal means access.

[29] VA Directive 5013 and VA Handbook 5013/13, *Performance Management Systems,* April 15, 2002, updated July 17, 2013.

[30] VCL-S-ACT-218-1906, *Standard Operating Procedure for HSS Documentation Guidelines*, July 24, 2019.

[31] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure requires documentation of the consulting supervisor's initials. VCL, *Standard Work for Positive Violent Behavior Risk Screening*, November 7, 2017. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-220-1908, *Standard Operating Procedure for Positive Violent Behavior Risk Screening,* August 8, 2019. The updated and new standard operating procedure included similar language regarding supervisory consultation documentation.

person and did not document the supervisory consultation. Responder 2 and supervisory staff ended call attempts because responder 1 "was able to assess Veteran and safety plan, and submit a consult for the Veteran." Neither responder 1 nor responder 2 could recall the name of the supervisor with whom the consultation occurred when speaking with the OIG team.

The OIG team's review of instant messages and emails did not identify the supervisor(s) who reportedly consulted with responder 1 and responder 2 regarding the Caller. In interviews with the OIG team, none of the 19 supervisors on duty at the time of the Caller's contacts recalled consulting with responders 1 or 2 about the Caller.[32]

The OIG found no evidence of responder 1's supervisory consultation although responder 1 reported that the decision not to initiate emergency dispatch occurred following consultation with a supervisor. Although responder 2 documented supervisory consultation as part of the decision-making process, the OIG was unable to identify the consulting supervisor.

Beginning in July 2019, VCL leaders advised responders to document supervisory consultations and the initials but not the full name of the consulting supervisors.[33] The Deputy Director, Quality and Training, informed the OIG that by September 30, 2020, the VCL will implement an updated template to include an area for the responder to document supervisory consultation.

Given the absence of supervisory documentation and identities, the OIG's evaluation of the sufficiency of the supervisory review could not be pursued. The lack of supervisory documentation contributed to the OIG team's inability to determine supervisors' involvement in ensuring accurate and complete assessments and providing appropriate guidance to responders regarding the Caller's risks, mental illness, and crisis needs. Further, without supervisory documentation to monitor input and redirection, supervisors may miss opportunities to identify responder deficiencies and determine the cause, as required by VHA.[34] The OIG would expect supervisors to ensure accurate and complete responder documentation as well as document decision-making processes independently.

2. Related Concern—Management of Intoxicated Callers

The OIG found that although responders 1 and 2 documented that the Caller was intoxicated, they did not adequately assess the Caller's use of alcohol or other drugs and failed to consider the Caller's potential overdose risk. The OIG team would have expected an emergency dispatch to be initiated based on the Caller's intoxication, high risk for suicide, and lethal means access.

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[32] Of the 20 supervisors on duty at the time of the calls with the Caller, one supervisor was no longer employed by the VA at the time of this inspection and was not interviewed.

[33] VCL-S-ACT-218-1906, *Standard Operating Procedure for HSS Documentation Guidelines*, July 24, 2019.

[34] VA Directive 5013 and VA Handbook 5013/13, *Performance Management Systems,* April 15, 2002, updated July 17, 2013.

The combination of alcohol and over-the-counter medication can increase the risk of overdose.[35] In July 2018, the VCL did not have policies related to safety planning with intoxicated callers or risk assessment of accidental overdose of illicit or over-the-counter drugs. In May 2019, VCL leaders established a policy that provided call management guidance for callers who exhibit signs of medication misuse for prescribed medications; however, the policy did not address illicit drugs or over-the-counter drug misuse.[36] VCL leaders told the OIG that responders are expected to use judgment with callers suspected of being impaired.

The OIG found that responder 1 did not perform a thorough assessment of substance use to ensure the Caller's safety. Responder 1 did not clarify the amount of alcohol and over-the-counter medication the Caller consumed and had available. Further, responder 1 appeared not to clearly identify the Caller's report of over-the-counter medication consumption after the Caller reported taking "all these sleeping pills," such as in the following exchange:

> Responder 1: Ok. How many did you take, [Caller]?
>
> Caller: I don't know, just a mouthful or two.
>
> Responder 1: Four or two?
>
> Caller: Yeah. Four or two.
>
> Responder 1: Ok, alright, alright.
>
> Caller: So, like six.

Additionally, the OIG found that at the end of the call the Caller reported taking "a bunch of" over-the counter medication and responder 1 did not clarify the amount the Caller consumed. Responder 1 documented that the Caller reported dropping "the call due to taking [diphenhydramine]" and taking "2-4 and this was not out of the ordinary for [the Caller] and that it just puts [the Caller] to sleep."

Although the Caller reported attending substance use treatment groups and responder 1 documented the Caller as "currently intoxicated" and "consumed 7 shots of whiskey earlier," the OIG team would have expected responder 1 to determine the Caller's level of intoxication and overdose risk by clarifying substance use behaviors, such as amounts and timing of alcohol and other substance ingestion.[37] Responder 1 told the OIG team that there was not a protocol for assessing an intoxicated caller. Further, responder 1 told the OIG team that the responder is

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[35] National Institute on Alcohol Abuse and Alcoholism, *Harmful Interactions Mixing Alcohol with Medicines,* 2014. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines. (The website was accessed on March 25, 2020.)

[36] VCL-P-ACT-103-1905, *Policy for Discussions Surrounding Medications*, May 22, 2019.

[37] National Institute on Alcohol Abuse and Alcoholism, *Understanding the Dangers of Alcohol Overdose,* November 2019. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-dangers-of-alcohol-overdose. (The website was accessed on March 23, 2020.)

required to assess for lethality, engage the caller in redirection, and it does not matter if the caller is "under the influence or not under the influence."

The OIG found that responder 2 did not inquire about substance use but documented that the Caller was intoxicated. In an interview with the OIG, responder 2 could not recall whether the information was based upon observations that the Caller's speech was slurred or if the information was obtained from responder 1's documentation. Although responders 1 and 2 documented that the Caller's overuse of prescription drugs was "Difficult to Determine," the OIG found no evidence that the Caller was asked about prescription medications.

All subject matter experts supported responders screening for substance use as part of suicide risk assessment. One of the subject matter experts provided information regarding how responders in another crisis line assess overdose potential by asking the caller about medication type, dosage, when medication was taken, alcohol and street drug use, and willingness to consult with poison control or an emergency room on a three-way call. When presented with a scenario similar to the Caller's, four of the subject matter experts recommended initiating a rescue.[38]

Based on the OIG team's review of the audiotape and documentation and the subject matter expert input, the OIG would have expected both responders to assess further based on the Caller's inconsistent reports of amounts of substance use, apparent intoxication, and proximity to a firearm. The Caller's cause of death was acute combined intoxication from alcohol, antidepressant medication, dextromethorphan, and diphenhydramine. The OIG concluded that the responders' failure to complete a thorough assessment of the Caller's alcohol and medication use and to consider accidental or intentional overdose potential contributed to an underestimation of risk.

Safety Planning

VHA requires that VCL staff be trained on safety planning with callers.[39] VCL expects responders to complete a collaborative safety plan with callers at risk for self-harm and to document the safety plan in Medora (see table 1).[40] Further, a responder is to initiate the emergency dispatch process when unable to "formulate safety plan" with a caller at risk for

[38] The OIG team presented a scenario that included a caller who reported having a gun to their head, a history of attempted suicide by police, recent ingestion of alcohol, and a mouthful of over-the-counter sleep medication. One of the five subject matter experts did not provide an opinion about dispatching an emergency rescue.

[39] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to safety planning.

[40] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure included similar language regarding criteria for collaborative problem solving and safety planning (risk mitigation plan).

self-harm.[41] Additionally, when applicable, responders are to check the caller's electronic health record for "relevant assessment information and VA safety plan."[42]

In response to a 2017 OIG report, VHA requires that suicide prevention safety plans are documented in a templated electronic health record as of September 2018.[43] VHA allows select staff other than independent practitioners, such as registered nurses, to complete safety plans.[44] On May 15, 2020, the VCL Director, Field Operations, told the OIG team that VCL leaders were considering use of the VHA standardized template and the impact on call length and call metrics.

Table 1. Safety Plan Elements

	VCL Collaborative Safety Plan Elements
1	Reduce access to means of self-harm (such as medications, substances, weapons, or driving)
2	Identify coping skills or activities (such as reading, walking, meditation, hobbies, or social supports)
3	Identify positive social supports to contact
4	"Document rationale for why safety plan is sufficient given risk assessment"

Source: VCL, Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult, January 5, 2018

The subject matter experts identified the following components to be included in a safety plan: (1) identifying and securing means of intended self-harm, (2) identifying triggers for suicidal thoughts, and (3) trying to mitigate those triggers through coping strategies and social supports.[45]

[41] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure advises the responder to consult a supervisor if unable to develop a risk mitigation plan.

[42] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure does not include mention of checking the caller's VA electronic health record for a safety plan.

[43] VA OIG, *Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities*, Report No. 16-03808-215, May 18, 2017. Deputy Under Secretary for Health for Operations and Management (10N), *Suicide Prevention Safety Plan National Computerized Patient Record System Note Templates Implementation*, June 1, 2018.

[44] Department of Veterans Affairs (VA), *Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates, Staff Specific Guide*, April 17, 2019. An independent practitioner is any individual permitted by law and the facility to provide patient care services without supervision, within the scope of the individual's license, and in accordance with clinical privileges. VHA Handbook 1100.09, *Credentialing and Privileging* October 15, 2012.

[45] Three subject matter experts from two crisis line organizations provided this information.

Subject matter experts also reported that their crisis lines used a templated note for documentation of safety plans.

The OIG was informed that both responders 1 and 2 received safety planning training prior to the calls with the Caller on July 4, 2018.[46] Responder 1 documented in a safety plan that the Caller would not touch the gun or use it for self-harm, not drink any more, and call the VCL if in crisis or in need of further support. Additionally, as discussed above, in contrast to responder 1's documentation, the audio of the call indicated that responder 1 did not adequately engage the Caller in an effort to reduce gun access. Responder 1 inquired about positive coping activities and social supports briefly but did not prompt the Caller to identify a positive social support or willingness to access social support. Although responder 1 accessed the Caller's electronic health record, the OIG found no evidence that responder 1 referred to the VHA May 2018 safety plan that included names of one family member "who may offer help" and a friend and a family member "who may distract from the crisis." The safety plan documented by responder 1 did not include coping skills or activities, social support contacts, or warning signs for suicidal thoughts as expected by VCL standards.[47]

The OIG found that responder 1 discussed elements of the safety plan throughout the call, but the safety plan was not reviewed with the Caller before the Caller disconnected abruptly from the initial call. Responder 1 attempted to contact the Caller over the course of approximately one minute, successfully reached the Caller on the third attempt, and asked to review the safety plan with the Caller. The Caller reported being tired, sleepy, and taking sleeping pills.[48] Responder 1 did not review the safety plan with the Caller prior to the Caller disconnecting from the call. The OIG observed the Caller's speech on the call audiotapes to be notably slurred during the call that lasted less than one minute before the Caller disconnected. Responder 1 almost immediately attempted to reconnect with the Caller and the Caller disconnected within approximately five seconds after answering the call. Responder 1 documented that the Caller dropped the call several times and that the responder was able to contact the Caller, complete safety planning, and stayed on the line until the call ended normally, contrary to the OIG team's review of the audiotaped calls.

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[46] VCL, *Health Science Specialist (HSS) Standard Works,* was in effect at time of the New Employee Orientation in March 2018. The Assistant Deputy Quality and Training reported to the OIG that the content of the New Employee Orientation training modules remained the same as of May 2020.

[47] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. This standard was in effect during the time frame of the event. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The updated and new standard operating procedure contains similar language regarding elements expected in a risk mitigation plan.

[48] For the first call attempt, the Caller's voicemail was full, and responder 1 was unable to leave a message; the second attempt did not appear to connect.

The OIG found that responder 2 did not complete a safety plan with the Caller; however, the Caller disconnected abruptly. Although responder 2 asked the Caller about history and current suicidal thoughts, past attempts, a plan, and lethal means; the Caller did not provide straightforward answers. When asked if the Caller had a gun, the Caller responded "well, of course I'm going to tell you I don't" and responder 2 did not ask further about access to lethal means. After four unsuccessful attempts to contact the Caller, responder 2 documented that, after consulting with a supervisor and a review of responder 1's documentation, no further attempts to call were taken because responder 1 was able to assess the Caller and complete a safety plan. Responder 2 documented that the Caller was intoxicated and desire to harm self or others was high.

Although responder 1 documented completion of a safety plan, the OIG concluded that neither responder 1 nor responder 2 adequately completed a safety plan with the Caller. Responder 1 documented completion of a safety plan but did not refer to information in the Caller's May 2018 VHA safety plan and failed to include key safety plan elements. Additionally, responder 1 did not review the safety plan with the Caller to ensure understanding prior to the calls being disconnected. Responder 1 did not initiate an emergency dispatch based on the perception of safety plan completion. Subsequently, responder 2 and a supervisor did not initiate an emergency dispatch process based upon responder 1's inaccurate documentation. Further, given that responder 2 documented the Caller was intoxicated with a high risk for suicide, the OIG opines that the realistic usefulness of a safety agreement was compromised. The OIG would have expected an emergency dispatch to be initiated based on the Caller's intoxication, high risk for suicide, and lethal means access.

Quality Management

In August 2013, VHA defined leadership roles for the oversight of patient care quality and safety and required an integration of the functions of quality, safety, and high reliability at each organizational level.[49] On October 24, 2019, VHA rescinded the directive "so that it doesn't conflict with modernization efforts as they are being rolled out as part of the new VHA governance process."[50] VHA supporting program offices, such as the National Center for Patient Safety and Risk Management, continued to provide guidance for quality and safety oversight.[51]

[49] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

[50] VHA Notice 2019-21, Recession of VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, October 24, 2019.

[51] VHA Notice 2019-21.

The VCL's activities are categorized into three areas of specialization: business operations, clinical operations, and quality management.[52] Quality management is focused on the assessment and management of the quality of service delivered to callers through quality assurance activities such as silent monitoring.[53] The OIG will discuss silent monitoring policies that were in effect at the time of the events under discussion and revisions made in 2019.

Silent Monitoring

VHA requires VCL leaders to implement silent monitoring to oversee the quality of responders' work in telephone calls, chat, and text communications.[54] The Deputy Director, Quality and Training, told the OIG team that silent monitoring of telephone calls started in April 2016 for quality assurance purposes and that the goal was 80 percent of staff receive at least one monitoring every two weeks. Until July 2019, silent monitoring was not used toward performance measures or standards.[55] If a responder did not meet criteria for the same critical rating area three or more times, the responder's supervisor was notified.[56] Additionally, the Deputy Director, Quality and Training, reported to the OIG team that immediate supervisory review was required for calls in which the responder did not adequately mitigate risk or establish trust (unsuccessful calls).[57] In October 2019, the Deputy Director, Quality and Training, told the OIG that chat and text silent monitoring was in a pilot phase but not yet implemented, because the American Federation of Government Employees had not completed a review of the proposed program.[58]

Silent monitor social science program specialists (monitor specialists) are staff specifically trained to listen to active calls and assess responders.[59] Monitor specialists provide the responders with coaching for identified areas in need of improvement immediately following the

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[52] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. Business operations oversee management of VCL services to callers and evaluate the effectiveness of services including staffing patterns and timekeeping. Clinical operations oversee the delivery of services to callers.

[53] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018.

[54] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to silent monitoring.

[55] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

[56] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018.

[57] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018.

[58] VCL leaders told the OIG team that the pilot was a quality assurance pilot. "The American Federation of Government Employees is the largest federal employee union proudly representing 700,000 federal and D.C. government workers nationwide and overseas." American Federation of Government Employees, *About Us.* https://www.afge.org/about-us/. (The website was accessed on May 20, 2020.)

[59] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring,* July 8, 2019.

call.[60] VCL leaders developed a silent monitoring protocol that outlines the evaluation criteria for responders' management of active and recorded calls to evaluate responders' interaction and call documentation accuracy and monitor specialists' coaching of responders for unmet criteria.[61] Monitor specialists evaluate responders' calls using VCL-established critical and non-critical criteria.[62] Critical criteria include the responder's completion of a suicide risk assessment, offering a suicide prevention team consult, developing a plan to reduce current risk, and ending a call appropriately. Non-critical criteria include the responder's active call management such as focusing on the present and current concerns, defining the problem, accurately documenting the call, and assessing a caller's homicidality.[63]

According to the Deputy Director, Quality and Training, responders 1 and 2 met silent monitoring quality standards, because there were no calls that warranted immediate supervisory review from October 5, 2016, through October 23, 2019.[64]

In July 2019, VCL leaders implemented an updated silent monitoring policy that included criteria for aggregated data reviews and supervisor follow-up.[65] In December 2019, Labor Management Relations staff initiated a review of the updated policy. Prior to the end of January 2020, VCL leaders did not provide supervisors with responders' silent monitoring data unless a responder demonstrated a pattern (three or more times) of unmet criteria in the same critical rating area, which indicated a call was unsuccessful. Additionally, VCL leaders did not review the data for individual responders or overall staff trends. In late January 2020, VCL quality assurance staff shared information electronically with supervisors that included explanation of new standards and applicable data as well as a list of identified responders who

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[60] Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018. Responders are not aware that silent monitoring occurred until after the call.

[61] *Veterans Crisis Line Silent Monitoring Quality Improvement Protocols,* February 18, 2016, updated August 10, 2017. This policy was in effect during some of the time frame of the relevant silent monitoring data analysis used in this report. The policy was rescinded and replaced by VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring,* July 8, 2019. The updated and new policies included similar language regarding criteria for silent monitoring of call management.

[62] VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019. Veterans and Military Crisis Line, *VCL Orientation and Employee Handbook*, April 2018.

[63] *Veterans Crisis Line Silent Monitoring Quality Improvement Protocols*, February 18, 2016, updated August 10, 2017. This policy was in effect during some of the time frame of the relevant silent monitoring data analysis used in this report. The policy was rescinded and replaced by VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring,* July 8, 2019. The updated and new policies included similar language regarding criteria for silent monitoring non-critical criteria.

[64] The OIG team reviewed available silent monitoring data for responders 1 and 2. Silent monitors completed 60 reviews of responder 1's calls from October 5, 2016, through October 22, 2019, and 41 reviews of responder 2's calls from June 3, 2018, through October 23, 2019. The OIG team reviewed available silent monitoring data for responders 1 and 2 for the time periods noted.

[65] VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

met the criteria for a performance monitor.[66] Quality assurance staff refer information to supervisors for follow-up when responders do not meet "three of six consecutive monitors" for the same critical item or "four of six consecutive monitors" for the same non-critical item.[67] Although not implemented for the time period reviewed, responders 1 and 2 would not have met the current criteria for supervisory review.

The OIG concluded that although VCL leaders implemented criteria for aggregated data reviews and supervisor follow-up, the supervisory intervention was only applicable to consecutive calls rather than call trends reviewed over a period of time. The lack of monitoring and identification of consistently missed criteria over a longer period may have contributed to inadequate performance improvement and quality assurance initiatives.

VCL Leaders Response

While VCL leaders completed a root cause analysis, it was not initiated at the time of notification of the Caller's death in July 2018; it was started approximately one year later after the OIG's June 2019 inquiry about the Caller.

The Deputy Director, Quality and Training, told the OIG team that some elements of VHA's patient safety program including root cause analyses applied to the VCL, and VCL managers were consulting with National Center for Patient Safety staff for guidance.[68] The Deputy Director, Quality and Training, and current Patient Safety, Risk Manager told the OIG team that VCL did not have a patient safety or risk manager assigned until June 2018.

Upon learning of the Caller's death from the treating facility Suicide Prevention Coordinator in summer 2018, the Deputy Director, Quality and Training, asked the Patient Safety, Risk Manager to conduct a root cause analysis. However, the internal review was not conducted then, and the Patient Safety, Risk Manager told the OIG that this was due to an oversight. On January 8, 2020, the Patient Safety, Risk Manager told the OIG about developing a tracking system to avoid missing email notification of caller deaths and prevent missing an internal review.

The Deputy Director, Quality and Training, told the OIG that beginning on October 1, 2020, supervisors will increase call reviews from one every three months to one per month.

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[66] The Labor Relations Management and American Federation of Government Employees finalized the memorandum of understanding for the updated policy in April 2020.

[67] VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

[68] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. This handbook describes the required patient safety program activities at VA medical facilities. A root cause analysis is an internal review process that utilizes an interdisciplinary approach to identify the system or process factors that underlie adverse events or close calls for the purpose of identifying improvements to decrease the likelihood of such events in the future.

Supervisors will also be provided access to employee dashboards to review utilization of time and productivity.

On July 15, 2019, prior to the completion of the root cause analysis, VCL leaders updated a standard operating procedure that more thoroughly addressed risk mitigation and safety planning than the one in effect in July 2018.[69] Additionally, the Deputy Director, Quality and Training, reported that a supervisory consultation section will be included in the Medora documentation template by September 30, 2020.

In an August 5, 2019, response to the OIG inquiry about the Caller's death, VCL leaders reported that they would complete a root cause analysis, and one was completed in October 2019.

The OIG concluded that VCL leaders' failure to timely complete a root cause analysis contributed to a delay in identification of process deficiencies and associated improvements.

3. Related Concern—Suicide Prevention Coordinator Consult Process

The OIG determined that responder 1 submitted a "routine" suicide prevention coordinator consult to the Caller's treating facility. The VCL standard advised responders to submit routine consults for callers assigned a "Moderate to Low" suicide risk level.[70] However, consistent with the opinions of the subject matter experts, the OIG concluded that the Caller's lethality risk should have been considered high, and therefore, the responder would have initiated other actions including submission of an urgent or emergent suicide prevention coordinator consult.

Consult Priority Designation

VCL responders are required to submit a suicide prevention coordinator consult to the VA facility based on the caller's request or VCL staff assessment of the caller's need to engage in mental health treatment.[71] Additionally, responders should notify the receiving suicide

[69] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning*, July 10, 2019.

[70] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. VHA requires that a suicide prevention coordinator is appointed at each VA medical center and large community-based outpatient clinic. Suicide Prevention Coordinators are responsible for responding to National Suicide Prevention Hotline and other staff, tracking and reporting on patients who have attempted suicide and those at high risk for suicide, and coordinating with providers to ensure high risk patients receive education, support and treatment to reduce risk. VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018; VCL-S-ACT-217-1907, *Standard Operating Procedure for Routine Consult Calling*, September 20, 2019.

[71] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to suicide prevention coordinator consults except the new directive requires the suicide prevention coordinator to "complete documentation and consult closing within 3 business days."

prevention team of the consult through the Medora application.[72] The Suicide Prevention Coordinator is required to make a minimum of three attempts to reach the individual that may consist of two phone calls and a letter or three phone calls.[73]

VCL identifies three priority levels for suicide prevention coordinator consults based on the intervention initiated by a responder (see table 2). If an emergent or urgent suicide prevention coordinator consult is entered, the responder must speak directly to the suicide prevention coordinator or leave a voice mail message providing detailed contact information for the caller.[74] Since May 9, 2012, one responder per shift is assigned to perform "routine consult calling" to review routine consults and call the suicide prevention teams.[75] Until May 26, 2020, the suicide prevention team was expected to follow up and close consults within one business day, except for holidays and weekends.[76]

Table 2. VHA Suicide Prevention Coordinator Consult Priority Levels

Consult Priority Level	Submitted When VCL Staff
Emergent	Initiates an emergency dispatch rescue
Urgent	Arranges transportation to the closest or caller-preferred facility
Routine	Determines caller does not need emergent psychiatric care and is willing to have contact with facility suicide prevention team within one business day.

Source: VCL, Health Science Specialist Standard Work, May 26, 2017[77]

On July 4, 2018, responder 1 documented that the Caller accepted a routine consult "to get connected with Social work" and talk with the Suicide Prevention Coordinator "about mental health resources." Because responder 1 assigned the Caller a "moderate to low" risk level for

[72] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. VCL-S-ACT-217-1907, *Standard Operating Procedure for Routine Consult Calling*, September 20, 2019. VCL-S-ACT-218-1906, *Standard Operating Procedure for Health Science Specialist Documentation Guidelines*, July 24, 2019.

[73] *VHA Suicide Prevention Coordinator Guide*, June 19, 2015.

[74] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018. VCL-S-ACT-218-1906, *Standard Operating Procedure for Health Science Specialist Documentation Guidelines*, July 24, 2019. The new policy included similar language regarding criteria for suicide prevention consults. VCL, *Health Science Specialist Standard Work*, May 26, 2017.

[75] VCL-S-ACT-240-1909, *Standard Operating Procedure for Routine Consult Calling*, September 20, 2019.

[76] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to suicide prevention coordinator consults except the new directive requires the suicide prevention coordinator to "complete documentation and consult closing within 3 business days." VHA *Suicide Prevention Coordinator Guide*, June 19, 2015.

[77] VCL, *Health Science Specialist Standard Work*, May 26, 2017.

suicide and the Caller agreed to a suicide prevention coordinator consult, a routine suicide prevention coordinator consult was consistent with VCL standard operating procedures. On July 4, 2018, at 7:12 a.m., a VCL staff member notified the treating VA facility suicide prevention team of the routine consult by email, as required.

On July 5, 2018, the facility's Suicide Prevention Coordinator attempted to telephone the Caller three times, and once the following day. However, the Caller's voicemail was not accepting messages, and on July 6, 2018, the facility Suicide Prevention Coordinator mailed a letter to the Caller.

Four of the five subject matter experts recommended engagement with first responders when asked what a responder should do if a caller reports having a gun to the caller's head as well as recent use of alcohol and a mouthful of over-the-counter medication.

Weekend and Holiday Consult

Until May 26, 2020, the suicide prevention team was expected to follow-up and close consults within one business day, except for holidays and weekends.[78] VHA does not require that a suicide prevention coordinator follow up on weekends and holidays, although mental health coverage must be available at all times in emergency departments.[79] For emergent and urgent consults, the caller should be assessed by a clinician at a higher level of care and; therefore, a suicide prevention coordinator follow-up would not be the caller's only post-VCL call assessment and intervention. However, for routine consults, during holidays and weekends, responders confirmed that they can offer callers local resources accessed on the VCL SharePoint site.[80]

Given the absence of VHA requirements for suicide prevention coordinator follow-up on weekends and holidays, it can be as many as four days after the initial call before a caller receives a suicide prevention team call.[81] In November 2019, the Acting Director of VHA Suicide Prevention told the OIG that VCL identified this potential gap in care and that a proposal

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[78] VHA Directive 1503. The 2017 and 2020 policies contain the same or similar language related to suicide prevention coordinator consults, except the new directive requires the suicide prevention coordinator to "complete documentation and consult closing within 3 business days." VHA *Suicide Prevention Coordinator Guide*, June 19, 2015.

[79] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[80] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, May 26, 2017. The standard was rescinded and replaced by VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation,* July 15, 2019. The standard and new standard operating procedure included similar language regarding criteria for resources.

[81] If a caller contacts the VCL on a Thursday after suicide prevention coordinator duty hours, and Friday is a federal holiday, the caller may not be contacted until Monday. Similarly, if the caller contacts the VCL on a Friday after hours and Monday is a federal holiday, the caller may not be contacted until Tuesday.

was under review to employ peer specialists who would telephone callers identified as at increased risk for suicide, including weekend and holiday callers. On May 4, 2020, the Director, Suicide Prevention Program informed the OIG team that the Peer Support Outreach Call Center was in development.

Conclusion

The OIG substantiated that VCL staff did not initiate an emergency dispatch for the Caller who reported use of alcohol and over-the-counter medications that may cause drowsiness. The OIG found that responder 1 inaccurately documented what the Caller reported, and in consultation with a supervisor, responder 2 decided not to initiate a rescue based on that documentation. Further, the OIG found that VCL policies did not address management of intoxicated callers or assessment of risk for accidental overdose. The OIG concluded that responders 1 and 2 failed to adequately clarify the Caller's access to lethal means and subsequently did not engage adequately in the VCL protocol to reduce the Caller's access to a gun.

The OIG found insufficient supervisory documentation to determine the identity of consulting supervisor(s) and to evaluate of the sufficiency of the supervisory review of the Caller's contacts.[82] Although responder 1 documented completion of a safety plan, the OIG concluded that neither responder 1 nor responder 2 adequately completed a safety plan with the Caller. Further, given that responder 2 documented the Caller was intoxicated with a high risk for suicide, the OIG opines that the realistic usefulness of a safety agreement was compromised. The OIG would have expected an emergency dispatch to be initiated based on the Caller's intoxication, high risk for suicide, and lethal means access.

Prior to the end of January 2020, VCL leaders did not (1) provide supervisors with responders' silent monitoring data unless a call was considered unsuccessful or (2) review the data for individual responder or overall staff trends.[83] The OIG concluded that although VCL leaders implemented criteria for aggregated data reviews and supervisor follow-up, the supervisory intervention was only applicable to consecutive calls rather than call trends over a period of time. The lack of monitoring and identification of consistently missed criteria over a longer period may have contributed to inadequate performance improvement and quality assurance initiatives.

In response to the OIG's June 2019 inquiry about VCL staff's management of the Caller's contacts, VCL completed an internal review of responder 1's management of the calls. VCL

[82] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018.

[83] VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

leaders' failure to provide feedback about the internal review findings was a missed opportunity for supervisory evaluation of the cause of responder 1's deficiencies and follow up.[84]

VCL leaders did not initiate a root cause analysis upon notification of the Caller's death in July 2018 but completed the root cause analysis in October 2019 because of an oversight by the Patient Safety, Risk Manager. The OIG concluded that VCL leaders' failure to complete a root cause analysis contributed to a delay in identification of process deficiencies and associated improvements.

The OIG determined that responder 1 submitted a routine suicide prevention coordinator consult to the Caller's treating facility. The VCL standard advised responders to submit routine consults for callers assigned a "Moderate to Low" suicide risk level.[85] However, consistent with the opinions of the subject matter experts, the OIG concluded that the Caller's lethality risk should have been considered high, and therefore, the responder would have initiated other actions including submission of an urgent or emergent suicide prevention coordinator consult.

Given the absence of VHA requirements for suicide prevention coordinator follow-up on weekends and holidays, it can be as many as four days after a call that a caller receives a suicide prevention team call.[86] In November 2019, the Acting Director of VHA Suicide Prevention told the OIG that VCL identified this potential gap in care and that a proposal was being reviewed to employ peer specialists who would contact callers identified as at an increased risk for suicide, including weekend and holiday callers. On May 4, 2020, the Director, VA Suicide Prevention Program informed the OIG that the Peer Support Outreach Call Center was in development.

[84] VA Directive 5013 and VA Handbook 5013/13, *Performance Management Systems,* April 15, 2002, updated July 17, 2013.

[85] VCL, *Standard Work for Suicide Risk Assessment, Collaborative Planning, and Routine Consult*, January 5, 2018.

[86] If a caller contacts the VCL on a Thursday after suicide prevention coordinator duty hours, and Friday is a Federal holiday, the caller may not be contacted until Monday. Similarly, if the caller contacts the VCL on a Friday after hours and Monday is a Federal holiday, the caller might not be contacted until Tuesday.

Recommendations 1–8

1. The Veterans Crisis Line Director conducts a comprehensive review of the Caller's contacts and staff documentation on the day of the Caller's death, consults with Human Resources and General Counsel Offices, and takes action as warranted.

2. The Veterans Crisis Line Director evaluates the effectiveness of current training for responders on lethal means assessment, takes action as warranted, and ensures supervisory oversight of lethal means assessments and related documentation.

3. The Veterans Crisis Line Director provides written guidance on responders' documentation of supervisory consultation and considers implementing independent supervisory documentation.

4. The Veterans Crisis Line Director establishes policy and training for responders' assessment of callers' substance use and overdose risk, and monitors compliance.

5. The Veterans Crisis Line Director expedites the decision whether to implement a standardized safety plan template and ensures completion of safety planning per Veterans Crisis Line standards.

6. The Veterans Crisis Line Director evaluates the criteria for supervisory follow-up including silent monitoring criteria and internal program review outcomes and takes action, as warranted.

7. The Veterans Crisis Line Director implements a system to identify caller contacts that warrant root cause analysis or other internal reviews and tracks the review process to completion and includes interviews of all relevant staff.

8. The Office of Mental Health and Suicide Prevention Program Executive Director expedites efforts to develop suicide prevention strategies for weekend and holiday callers who are identified at increased risk for suicide.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 30, 2020

From: Executive in Charge, VHA Office of the Under Secretary for Health (10)[87]

Subj: OIG Draft Report, Healthcare Inspection: Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died (Project Number # 2019-08542-HI-0981) (VIEWS 03493240)

To: Assistant Inspector General for Healthcare Inspections (54)
Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the subject draft report.
2. I concur with the draft report as written and provide action plans in response to recommendations 1-7. I concur in principle with recommendation 8.
3. The staff and leaders of the Veterans Crisis Line (VCL) are saddened by the loss of any Veteran to suicide. VCL will continue working to enhance processes and procedures for lethal means assessment, safety planning and identification, and handling of substance use and overdose risks. Through continuous development of best practices and protocols we will continue to meet the evolving needs of the Veterans we serve.
4. If you have any questions, please contact Karen Rasmussen, M.D., Director, GAO-OIG Accountability Liaison (GOAL) Office at VHA10EGGOALAction@va.gov.

(*Original signed by:*)
Richard A. Stone, M.D.

[87] The Executive in Charge, Office of the Under Secretary for Health, has the authority to perform the functions and duties of the Under Secretary for Health.

Executive in Charge Response[88]

Recommendation 1

The Veterans Crisis Line Director conducts a comprehensive review of the Caller's contacts and staff documentation on the day of the Caller's death, consults with Human Resources and General Counsel Offices, and takes action as warranted.

Concur.

Target date for completion: April 2021

Comments

A Root Cause Analysis was performed subsequent to this event, as noted in the draft report. Per new Veterans Crisis Line (VCL) policy since time of this event, VCL leadership will conduct an independent review of the Caller's contacts and staff documentation on the day of the Caller's death to assess for any areas of non-compliance with VCL policy. These calls will be reviewed utilizing VCL's standard criteria for call monitoring. Any areas requiring administrative action will be outlined and VCL leadership will consult with Human Resources and General Counsel, for any warranted actions.

Recommendation 2

The Veterans Crisis Line Director evaluates the effectiveness of current training for responders on lethal means assessment, takes action, as warranted; and ensures supervisory oversight of lethal means assessments and related documentation.

Concur.

Target date for completion: March 2021

Comments

In addition to VCL's current pre- and post-training evaluations, VCL will develop additional program evaluation metrics focused upon lethal means assessment implementation. VCL will review specific metrics related to lethal means assessment as part of both supervisory and quality assurance silent monitoring for consideration for expansion or revision. VCL will increase usage of supervisory silent monitoring to an occurrence of 1 call per responder per month (versus 1 call per responder per quarter). VCL will provide documentation to denote completed monitoring for a full quarter as evidence of completion of this increased monitoring.

[88] Recommendations were addressed to the VCL Director and OMHSP Executive Director, and the Executive in Charge provided the responses.

Recommendation 3

The Veterans Crisis Line Director provides written guidance on responders' documentation of supervisory consultation and considers implementing independent supervisory documentation.

Concur.

Target date for completion: April 2021

Comments

VCL guidance currently requires responders to identify when a supervisory consultation occurs. VCL will add requirements to include identification of the specific supervisor consulted in chart documentation. VCL leadership will also review the ability to implement independent supervisory documentation within current electronic record capabilities.

Recommendation 4

The Veterans Crisis Line Director establishes policy and training for responders' assessment of callers' substance use and overdose risk and monitors compliance.

Concur.

Target date for completion: April 2021

Comments

VCL consulted with the National Mental Health Program Director for Substance Use Disorder and Philadelphia VA Center of Excellence in Substance Abuse Treatment and Education regarding the development of internal guidance for responders working with callers with substance use disorders and those at risk for overdose. VCL will develop enhanced guidance and procedures related to substance use and overdose risk for review with these consultants. VCL will update compliance criteria for monitoring of the new standards. VCL will provide a copy of updated guidance as evidence of completion of this recommendation.

Recommendation 5

The Veterans Crisis Line Director expedites the decision whether to implement a standardized safety plan template and ensures completion of safety planning per Veterans Crisis Line standards.

Concur.

Target date for completion: April 2021

Comments

VCL currently uses a 3-part safety plan with callers to whom such a plan applies. VCL will continue to assess for safety plan completion through supervisory and quality assurance silent monitoring. Both forms of silent monitoring allow for immediate feedback to employees when safety planning does not adequately address imminent risk. VCL will design and launch changes in safety plan documentation to standardize documentation, and prompt consistent responder work. Because responders are not VA licensed independent providers, and because individuals in crisis often are not able to engage in all elements of standardized safety planning during the crisis, VCL will develop a pilot program to determine whether a lengthier templated safety plan used in clinical settings could be applied in a crisis call center setting. VCL will provide evidence of further standardization of the 3-part safety plan and provide a copy of an implementation plan for the pilot program to close out this recommendation.

Recommendation 6

The Veterans Crisis Line Director evaluates the criteria for supervisory follow-up including silent monitoring criteria and internal program review outcomes and takes action as warranted.

Concur.

Target date for completion: April 2021

Comments

VCL will create an internal workgroup to perform an examination of the criteria leading to the supervisory follow-up process both for Quality Assurance and Performance Silent Monitoring and program reviews. Recommendations for improvement made by this workgroup will be utilized to update guidance for implementation. VCL will provide to OIG a copy of any updated draft guidance, based on the workgroup's recommendations, as appropriate.

Recommendation 7

The Veterans Crisis Line Director implements a system to identify caller contacts that warrant root cause analysis or other internal reviews and tracks the review process to completion and includes interviews of all relevant staff.

Concur.

Target date for completion: April 2021

Comments

VCL will consult with VA national subject matter experts in patient safety to review VCL's Root Cause Analysis (RCA) program and methods for identifying critical incidents which would

benefit from RCA. Consultation findings may result in potential updates to VCL's RCA policies, development of additional training materials for RCA team members, improvements in standardization of methods for identification of critical incidents and aggregate reviews needed, strengthening of reporting and tracking of incidents for RCAs, and strengthened documentation templates. RCA guidance will be refined to ensure the completion of interviews with all relevant personnel. OIG will be provided with any drafted RCA guidance updated related to the consultation.

Recommendation 8

The Office of Mental Health and Suicide Prevention Program Executive Director expedites efforts to develop suicide prevention strategies for weekend and holiday callers who are identified at increased risk for suicide.

Concur in principle.

Comments

VHA suicide prevention efforts and strategies are the same regardless of the day of week, weekend, holiday, or time of day. At the VCL and VA Medical Centers (VAMC), all mental health crises, regardless of time or date, receive the same intervention strategy.

- Local welfare checks or other appropriate immediate response (e.g., assistance by present family member) are requested for all crisis calls deemed to be at imminent risk.
- As appropriate, callers and concerned family members are encouraged to utilize their local emergency department for safety.
- All non-emergent (i.e., routine) mental health follow-up requests are managed in a timely manner established by policy.
- All VAMC Emergency Department facilities are required to have mental health staff available (on site or on call) for emergency (crisis) situations, regardless of the day or time.

As outlined in policy, routine consult requests (non-emergent) are addressed in a timely manner by the Suicide Prevention Coordinator/Team at the receiving VAMC. Establishing separate processes for weekend/holiday callers is inefficient and increases risk for failure. A single process in which all calls are managed and triaged through similar expectations for routine follow-up promotes consistency of interventions. Routine VCL consult follow-up does not present as a gap in care. To ensure consistency of suicide prevention efforts and routine consult follow-up, VHA:

1) Requests local facility review of all crisis management standardized operating procedures to confirm inclusion of weekend, holiday, and evening hours.

2) Confirms all individuals engaged in VHA care and call the VCL are engaged in VCL Caring Contacts.
3) Explores capabilities of conducting a review of consult completion by suicide prevention coordinators comparing completion rates for holiday, weekend, and evening hours with those sent during business hours to assess for any potential process improvements.

OIG Contact and Staff Acknowledgments

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