REPORT OF THE
BLUE RIBBON WORK GROUP ON SUICIDE PREVENTION
IN THE VETERAN POPULATION

EXECUTIVE SUMMARY

The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population was chartered May 5, 2008, by Secretary of Veterans Affairs James B. Peake, MD, to provide advice and consultation to him on various matters relating to research, education, and program improvements relevant to the prevention of suicide in the veteran population. The Work Group's report presents its findings and recommendations to improve relevant VA programs, with the primary objective of reducing the risk of suicide among veterans.

The Work Group found that the VHA has developed a comprehensive strategy to address suicides and suicidal behavior that includes a number of initiatives and innovations that hold great promise for preventing suicide attempts and completions. Evaluation of the impact of these efforts will be of critical importance not only to promote continuous improvement in VHA's suicide prevention efforts, but also to inform suicide prevention efforts across the nation and reach veterans who do not utilize VHA services.

The Work Group had eight key findings and recommendations:

Finding 1. Conflicting and inconsistent reporting of veteran suicide rates were observed across various studies.

> **Recommendation 1: VHA should establish an analysis and research plan in collaboration with other federal agencies to resolve conflicting study results in order to ensure that there is a consistent approach to describing the rates of suicide and suicide attempts in veterans.**

Finding 2. Suicide screening processes being implemented in VHA primary care clinics go beyond the current evidence and may have unintended effects.

> **Recommendation 2: The VA should revise and reevaluate the current policies regarding mandatory suicide screening assessments.**

Finding 3. VA is attempting to systematically provide coordinated, intensive, enhanced care to veterans identified as being at high risk for suicide. However, the criteria for being flagged as high risk is not clearly delineated; nor are criteria for being removed from the high risk list.

> **Recommendation 3: Proceed with the planned implementation of the Category II flag, with consideration given to pilot testing the flag in one or more regions before full national implementation.**

Finding 4. The root cause analyses presented to the Work Group did not distinguish between suicide deaths, suicide attempts, and self-harming behavior without intent to die.

> **Recommendation 4: Ensure that suicides and suicide attempts that are reported from root cause analyses use definitions consistent with broader VHA surveillance efforts.**

Finding 5. The emphasis of VHA leadership on the use of clozapine and lithium does not appear to be sufficiently evidence-based.

> **Recommendation 5: VHA should ensure that specific pharmacotherapy recommendations related to suicide or suicide behaviors are evidence-based.**

Finding 6. Efforts to improve accurate media coverage and disseminate universal messages to shift normative behaviors to reduce population suicide risk behavior are not being fully pursued.

> **Recommendation 6: The VA should continue to pursue opportunities for outreach to enrolled and eligible veterans, and to disseminate messages to reduce risk behavior associated with suicidality.**

Finding 7. Concerns about confidentiality for OIF/OEF service members treated at VHA facilities may represent a barrier to mental health care.

> **Recommendation 7. The issue of confidentiality of health records of OIF/OEF service members who receive care through the VHA should be clarified both for patient consent-to-care and for general dissemination to Reserve and Guard service members contemplating utilizing VHA medical system services to which they are entitled.**

Finding 8. The introduction of Suicide Prevention Coordinators (SPCs) at each VA medical center is a major innovation that holds great promise for preventing suicide among veterans; however, there is insufficient information on optimal staffing levels of SPCs.

> **Recommendation 8. In order to maximize the effectiveness of the Suicide Prevention Coordinators program, it is recommended that there be ongoing evaluation of the roles and workloads of the SPC positions.**

In addition to the above findings and recommendations, the Work Group identified 14 other areas for possible action, including adopting a standard definition for suicide and suicide attempts, implementing a gun safety program targeting veterans with children in the home, working with community partners, consolidating suicide prevention activities into a comprehensive suicide prevention strategic plan, prioritizing research activities, and other areas for consideration.

BLUE RIBBON WORK GROUP ON SUICIDE PREVENTION IN THE VETERAN POPULATION

REPORT TO JAMES B. PEAKE, MD, SECRETARY OF VETERANS AFFAIRS

The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population was chartered May 5, 2008, by Secretary of Veterans Affairs James B. Peake, MD, to provide advice and consultation to him on various matters relating to research, education, and program improvements relevant to the prevention of suicide in the veteran population. This report presents the findings of the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population and its recommendations to improve relevant VA programs, with the primary objective of reducing the risk of suicide among veterans. As required in its charter, the report is submitted within 15 days of the Work Group's meeting.

I. Overview, Charter, Participants, and Process

The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population includes five Executive Branch employees who are experts in public health mental health programs (including suicide prevention and education programs), research (including mental health epidemiology and suicidology), and clinical treatment programs for patients at risk for suicide:

- **Colonel (US Army) Charles Hoge, MD** – Director, Division of Psychiatry and Neuroscience, Walter Reed Army lnstitute of Research
- **Colonel (US Air Force) Robert Ireland, MD** – Chairman, Program Director for Mental Health Policy, Clinical and Program Policy, Office of the Assistant Secretary of Defense (Health Affairs)
- **Debra Karch, PhD** – Lead Behavioral Scientist, National Center for Injury Prevention and Control, Division of Violence Prevention, Centers for Disease Control and Prevention
- **Richard McKeon, PhD, MPH** – Public Health Advisor for Suicide Prevention, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration
- **Jane Pearson, PhD** – Associate Director for Preventive Interventions, Division of Services and Intervention Research, National Institute of Mental Health

Meeting and Deliberations of the Blue Ribbon Work Group

The deliberations of the Work Group were informed by presentations and the counsel of a panel of nationally recognized experts (the "Expert Panel"), as well as by information provided by Veterans Affairs (VA) staff, at a meeting convened June 11-13, 2008, in Washington, DC (see Appendix A for a copy of the meeting agenda). The sessions were organized to allow for questions from the Work Group members and free-flowing discussion to assure that the Work Group members could gather the information they needed to make their recommendations.

Veterans Administration Staff Briefings

Employees of the Department of Veterans Affairs were called upon to provide background briefings to the Work Group on relevant VA programs, both to inform their deliberations and to provide a context for discussions of VA research, education, and program activities. Presentations were made by the following staff:

- **Alfonso Batres, PhD, MA, MSSW** – Chief Officer, Readjustment Counseling Service
- **Fred Blow, PhD** – Director, National VA Serious Mental Illness Treatment Research & Evaluation Center (SMITREC); Professor and Research Professor, Department of Psychiatry, University of Michigan, and Director, Mental Health Services Outcomes & Translation Section
- **Han Kang, DrPH** – Director, Environmental Epidemiology
- **Ira Katz, MD, PhD**, Deputy Chief Patient Care Services Officer for Mental Health
- **Janet Kemp, PhD, RN** – VA National Suicide Prevention Coordinator; Associate Director, Education and Training, Center of Excellence at Canandaigua
- **Kerry Knox, PhD, MS** – Director, Center of Excellence at Canandaigua; Associate Professor, University of Rochester Medical Center, Department of Psychiatry and Center for the Study and Prevention of Suicide
- **Peter Mills, PhD, MS** – Director, Field Office, VA National Center for Patient Safety; Adjunct Associate Professor of Psychiatry, Dartmouth Medical School
- **Cheryl Oros, PhD** – Deputy Director, Clinical Science Research & Development Service
- **Antonette Zeiss, PhD** – Deputy Chief, Mental Health Services

In addition to providing general background information about the organization and structure of the VA, program budgets, the numbers of veterans served, and the epidemiology of suicide and suicide risk among veterans, staff provided more in-depth presentations regarding the following programs and activities:

- Patient Safety Program (Mills)
- Findings on users of Veterans Health Administration services (Blow)
- Mental Health Services (Zeiss)
- Veterans Centers and Readjustment Counseling Service (Batres)
- VA Suicide Prevention Services (including Suicide Prevention Coordinators and the National Suicide Prevention Hotline) (Kemp)
- Suicide Prevention Research and Research Enabling Centers (Knox and Oros)

Veterans Health Administration (VHA) staff provided information about current programs, challenges to providing services (including institutional barriers), and suggestions for improving VA programs.

Expert Panel Presentations

The members of the Expert Panel included experts in public health suicide programs, suicide research, clinical treatment programs for patients, and other relevant areas. The following individuals were part of the nine-member Expert Panel:[1]

- **Dan Blazer, MD, PhD –** Professor of Psychiatry and Behavioral Sciences, Duke University Medical Center
- **Gregory Brown, PhD –** Research Associate Professor of Clinical Psychology in Psychiatry, University of Pennsylvania
- **Martha Bruce, PhD, MPH –** Professor of Sociology in Psychiatry, Weill Cornell Medical College, Cornell University
- **Eric Caine, MD –** Chair, Department of Psychiatry, University of Rochester
- **Jan Fawcett, MD –** Professor of Psychiatry, University of New Mexico School of Medicine
- **Robert Gibbons, PhD –** Director, Center for Health Statistics, University of Illinois at Chicago
- **David Jobes, PhD, ABPP –** Professor of Psychology, Catholic University of America
- **Mark Kaplan, DrPH –** Professor of Community Health, Portland State University
- **Thomas Ten Have, PhD, MPH –** Professor of Biostatistics in Biostatistics and Epidemiology, University of Pennsylvania School of Medicine

The Expert Panel provided the Work Group with their expert opinion, interpretation, and conclusions related to the information and data presented; expert information and data from other (non-VA) sources; and, recommendations on opportunities to improve VA programs. The Expert Panel presentations focused on a wide range of topics, including the following:

- Frameworks for preventing suicide among veterans (Caine)
- The epidemiology of suicide among veterans (Blazer)
- Suicide mortality among veterans in the general population (Kaplan)
- The statistics of suicide (ecological data and small area estimation, access and effectiveness of treatment in the VA, what suicide attempts data mean, the association between decreased suicide risk and antidepressants) (Gibbons)
- Dealing with the heterogeneity of the data (identifying geographic hot spots and high risk individuals, etiology versus prediction models) (Ten Have)

[1] Members of the Expert Panel have no significant direct relationship with the Department of Veterans Affairs.

- Assessment and psychosocial interventions (suicide classification nomenclature efforts, assessment methodologies, evidence-based psychosocial treatments including Dialectical Behavior Therapy and Cognitive Behavioral Therapy) (Brown and Jobes)
- Anxiety (PTSD) and mood disorders in suicide, including treatments (Fawcett)
- Integration of mental health into physical health care (including through home-based care programs) (Bruce)

Work Group Deliberations

Following the formal presentations, the Work Group members engaged in a process of discussion and consensus building regarding VA research, education, programs, and strategies for improvement, soliciting input and feedback from the Expert Panel and VA staff as necessary. The Work Group members continued their deliberations after the meeting through a series of conference calls. The Work Group prepared this report within 15 days of its meeting, including findings and recommendations for improving VA suicide programs, to include research, education, and prevention/clinical programs.

Scope of the Report

As the largest integrated health care system in the United States, the Veterans Health Administration serves 5.5 million veterans a year out of the 7.8 million veterans who have qualified for VA health benefits through income means testing and disability criteria (i.e., enrolled veterans). This represented approximately 23% of the total population of 23.8 million living veterans in 2007 (U.S. Department of Veterans Affairs, 2008). In 2007, 210,778 veterans receiving VHA services were veterans of the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) conflicts. The Work Group deliberated whether its recommendations should address suicide prevention only for veterans *served* by the VA, or for the *entire* population of veterans in the U.S., including those who do not receive care from the VHA or Vet Centers. Because the Department of Veterans Affairs is perceived by the public, and in particular veterans and active duty personnel, as the symbol of care for all veterans, the VHA carries a burden to provide accurate information on suicide rates that may go beyond its legislated mandate. Thus, this Work Group report highlights selected areas of suicide research and prevention that should potentially focus on all veterans, regardless of VHA eligibility or health service use. These include developing estimates of suicide rates for various segments of the veteran population, as well as opportunities for outreach to increase service use by eligible veterans.

Similarly, the Work Group also considered how extensive the recommendations should be, given the rapid evolution of suicide prevention initiatives. A May 2007 report by the VA Office of Inspector General (OIG) reviewed the implementation of the VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention (VA Office of Inspector General, 2007). The Mental Health Strategic Plan (MHSP), which was finalized in 2004, includes 10 areas specific to suicide prevention for which the OIG reviewed the extent of implementation as well as coordination across systems (e.g., outreach, screening, tracking, etc.). At the time of the May 2007 OIG report, many efforts were limited to a Veterans Integrated Service Network (VISN)-specific level of implementation. At its meeting, the Work Group heard that system-wide implementation of a

number of efforts has been initiated within the past year. Progress is ongoing in surveillance, research, program evaluation, patient safety, and quality improvement efforts by professionals working at a number of different VHA offices, including the Center for Excellence at Canandaigua; the War Related Illness and Injury Study Center; the VA National Center for Patient Safety; the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC); the Mental Illness Research, Education, and Clinical Centers (MIRECCs), particularly the Denver MIRECC, which has a specific focus on suicide; the National Center for PTSD; the Program Evaluation Resource Center; the Centers of Excellence and Quality Enhancement Research Initiatives (QUERI); and others. Key sources of data on suicides and suicidal behaviors include the VA medical centers, VISNs, and Suicide Prevention Coordinators; the National Death Index; the National Violent Death Reporting System (NVDRS); and the Centers for Disease Control and Prevention (CDC) Web-Based Injury Statistics Query and Reporting System (WISQARS).

This report considers the range of efforts relevant to a comprehensive suicide prevention strategy for veterans receiving services from the VA. This includes, for example, surveillance of veterans (outreach, screening, assessment, and tracking of both those eligible for care in the VA and those not eligible), multiple levels of prevention (i.e., universal indicated, and selected), and plans to implement quality improvement efforts. Section II highlights strengths of VA programs, and Section III offers areas for the Secretary to consider for improvement.

II. Summary of Strengths of the VHA Suicide Prevention Program

The Work Group congratulates the VHA for developing a comprehensive strategy to reduce suicides and suicidal behavior. This strategy includes a number of initiatives and innovations that hold great promise for preventing suicide attempts and completions. Evaluation of the impact of these efforts will be of critical importance not only to promote continuous improvement in VHA's suicide prevention efforts, but also to inform suicide prevention efforts across the nation. Because the majority of veterans do not utilize VHA services, significantly reducing the numbers of suicides among veterans will likely require dissemination of new knowledge throughout health care systems at large.

The Work Group found that, in its provider role, the VHA is optimizing care through best clinical practices and is exploring additional system-wide policies to further reduce suicide risk. The VA described its basic strategy as providing ready access to high quality mental health services, supplemented by programs specifically designed to address suicide. In order to provide ready access to mental health care, the VA has established standards that go beyond what is typically found in non-VA health care systems. These include requiring that all patients requesting or being referred for mental health services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. Other examples include the requirement that all VA emergency departments have mental health coverage, and that all patients discharged from inpatient psychiatric units following hospitalization are seen within seven days by a provider if a follow-up appointment is missed. In its intramural research role, there are many opportunities to further evaluate these best clinical practices, as well as to consider strategic questions about suicide rates, risk factors, and long-term outcomes. Indeed, the VHA is uniquely positioned to conduct large-scale prevention and

treatment initiatives and ongoing assessments of the effectiveness of these initiatives. Advantages of conducting such initiatives through the VHA include the availability of population-based data systems and the capacity for multisite initiatives and research, as well as the potential for moving toward "real time" surveillance of suicide deaths and attempts.

The current VA suicide prevention strategy is appropriately part of the comprehensive VHA MHSP. Although there is no single document that summarizes the entire suicide prevention effort, all elements of a comprehensive suicide prevention plan are included in the MHSP. The VA suicide prevention strategy also builds on the National Strategy for Suicide Prevention (USDHHS, 2001), which calls for improving awareness that suicide is preventable, and promotes universal, selective, and indicated approaches to prevention.

The VA suicide prevention strategy includes the following key components:

1. Comprehensive surveillance, research, and program evaluation. These activities include ongoing surveillance, research, program evaluation, patient safety, and quality improvement efforts implemented by professionals working at a number of different VHA offices, including the Office of Quality and Performance; the National Center for Patient Safety; the Office of Environmental Epidemiology; the Office of Mental Health Services (which includes the Center for Excellence at Canandaigua; the SMITREC; the MIRECCs; the National Center for PTSD; the Northeast Program Evaluation Resource Center; and other Centers of Excellence); and the Office of Research and Development (which includes the Quality Enhancement Research Initiatives and other programs).

2. Education, training, and clinical quality improvement. Activities in this category include operations and support for continuing education and training, including health promotion efforts and universal suicide awareness training for VHA staff members, as well as quality improvement through monitoring of selected practice outcomes, clinical diagnoses, number of sessions seen, no-show rates, and other measures that are a part of standard clinical practice quality monitoring.

3. Suicide Prevention Coordinators (SPCs). Instituting the role of Suicide Prevention Coordinators at all VA medical facilities is an important part of the comprehensive suicide prevention program. SPCs have responsibilities that include community outreach, training VHA personnel, flagging high risk patients, tracking and monitoring high risk patients, and participating in patient safety and environmental analyses. SPCs develop local suicide prevention strategies and also report to the VA National Suicide Prevention Coordinator.

4. Universal, selective, and indicated interventions. The VA engages in multiple levels of suicide prevention that include universal, selective, and indicated approaches.[2] With regard to universal prevention efforts, VA leadership directly addresses suicide risk across the VA through policies that facilitate these suicide prevention activities. Outreach at deployment and reintegration points for OEF and OIF soldiers is an example of universal prevention.

[2] Universal interventions refer to approaches designed for everyone in a defined population, regardless of their risk; selective approaches focus on subgroups that are at increased risk (e.g., patients diagnosed with depression, PTSD, substance abuse disorders, or chronic pain), and indicated approaches focus on individuals who have been identified as being at high risk (USDHHS, 2001).

Similar to people in the community at large, most VA enrollees are more likely to seek out primary care (and to see primary care providers routinely) than to seek out specialty care for mental health problems. As another universal approach, the VHA has incorporated mental health professionals into primary care clinics to improve mental health access, reduce stigma, and manage co-morbid mental health disorders using evidence-based collaborative care models.

Screening for suicide risk can be applied both universally (e.g., periodically screening all patients in primary care) as well as part of an indicated prevention strategy that focuses on those individuals who have been identified as being at high risk (e.g., suicide attempters). The VA has implemented screening in primary care setting through initial screening for depression using the Patient Health Questionnaire (PHQ)-2 or PHQ-9, and screening for PTSD with the PTSD Checklist (PCL); if these are positive, clinicians are required to further assess suicide risk; SPCs are then contacted about high risk patients. The presence of a SPC at each health care center also encourages increased awareness that suicidality is a health condition that can be assessed, treated, and tracked to maintain continuity and quality of care with a VISN. High risk individuals receive a Category II flag, and SPCs are currently implementing standard approaches for developing suicide risk safety plans for suicidal enrollees. These plans offer flexibility to adjust for monitoring and treatment needs that vary over time and across settings for at-risk enrollees. Safety plans are being embedded in efforts to implement evidence-based psychotherapy (e.g., cognitive-behavioral therapy, assertive community treatment) and pharmacologic treatments aimed at reducing mental and substance use disorders that increase suicide risk.

The VA National Center for Patient Safety services, using root cause analyses, provides another indicated preventive function through the assessment of possible systems factors in deaths by suicide, such as environmental vulnerabilities or issues in risk communication. Once identified, efforts to reduce these risk factors (e.g. removing door hinges that could be used for hanging) are implemented.

Vet Centers excel in providing selective and indicated preventive interventions through their outreach to identified combat veterans in distress, as well as to other high risk groups such as homeless or incarcerated veterans. Vet Centers typically include community networks to meet the needs of service women who have suffered sexual trauma, and bereavement support for family members of service members killed in action.

5. Suicide prevention hotline. Individuals in crisis, or others concerned about someone's suicide risk, can access a 24-hour suicide prevention hotline. In a partnership between the VA and the Substance Abuse and Mental Health Administration, all callers to the National Suicide Prevention Lifeline number (800-273-TALK) hear a prompt stating: "If you are a U.S. military veteran or are calling about a veteran, please press 'one' now." Callers who press "1" are then automatically connected to a crisis center operated by the VA Center of Excellence at Canandaigua in New York. VA crisis counselors, who are all mental health providers, are able to access the veteran's electronic medical record to best facilitate convenient (e.g., in the veteran's local community) and appropriate treatment. Efforts are underway to examine the effectiveness of referrals of the VA hotline.

6. New evidence-based clinical treatment modalities. The Work Group was very impressed with VA's efforts to incorporate new treatment modalities into clinical care based on emerging research showing the effectiveness of cognitive-behavioral therapy interventions that target suicidal ideation or behavior. Examples of this research include randomized controlled trials conducted by Brown and his colleagues on cognitive therapy for the prevention of suicide attempts (Brown, et al., 2005), by Slee and colleagues on cognitive-behavioral therapy and self-harm (Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008), and by Linehan and her colleagues on the effectiveness of dialectical behavioral therapy in patients with borderline personality disorder (Linehan, et al., 2006). Several other randomized controlled trials are underway currently by Brown's group, Jobes, and others. Additional research is encouraged in this area, as well as expansion to focus on more chronic patients with persistent suicidal ideation or behaviors.

III. Findings and Recommendations: Considerations for Improvement

There are several specific areas of concern that were identified during the two days of panel presentations and later deliberations by the Work Group that warrant further consideration. These are presented below as findings and recommendations.

FINDING 1: Conflicting and inconsistent reporting of veteran suicide rates were observed across various studies.

Similar to all large-scale suicide prevention efforts, both nationally and internationally, the VA is challenged by inconsistent definitions for the range of suicidal behaviors (deaths, attempts, ideation). But unlike other national efforts, the topic of suicide attempts and suicides in veterans has received high levels of public and media attention, and it is widely believed that veterans are at higher risk of suicide than non-veterans.

There are numerous problems with suicide rate reporting and a lack of consistency in the message that the pubic hears about the risk of suicides in veterans and the potential factors that may elevate (or reduce) this risk. As Dr. Blazer pointed out in his presentation to the Work Group titled "Runaway Numbers," news stories often report only numerator data (i.e., the *number* of suicides or attempts). When denominators or rates are presented, there is frequently a lack of clarity about what they mean. The public assumes that deployment and war-related experiences are the principle reason for higher rates of suicide in veterans, yet numerous studies by Dr. Kang's research group actually show that in prior conflicts, there was no increased risk associated with deployment to a war zone (e.g., Kang & Bullman, 2001; Michalek, Ketchum, & Akhtar, 1998; Watanabe, Kang, & Thomas, 1991). Differences in reporting and lack of clarity of numbers have resulted in public misunderstanding about the past and current scope of suicide risk for all veterans, as well as various subgroups of veterans.

Published peer-reviewed studies and other official sources of data are the principal sources of conflicting or inconsistent results on veteran suicides, including those reported by news organizations. There are a number of studies by Dr. Kang's group and others that have indicated that veterans who deployed to Vietnam, Gulf War 1, and OIF/OEF have *not* had significantly higher rates of suicide compared with era veterans who did not deploy, and in some cases also

compared with the general population. A notable exception is veterans with medical conditions, such as PTSD or a history of being wounded (see, e.g., Bullman & Kang, 1994; 1996). Studies have also consistently shown that rates of suicide among active duty military personnel are lower than demographically adjusted civilian populations (e.g., Eaton, Messer, Wilson, & Hoge, 2006). In aggregate, these studies indicate that veterans who deployed to combat zones are not at greater risk of suicide than era veterans who did not deploy, and that active duty service members represent a healthier segment of the population. Dr. Kang, in his briefing to the Work Group on June 11, 2008, stated that "The risk of suicide among war veterans, as a whole, is not significantly higher than non-deployed veterans or than the comparable U.S. general population."

On the other hand, several studies and official sources of data have shown that rates of suicide in all veterans are higher than in non-veterans. Secretary Peake, in his testimony before the House Veterans Affairs Committee on May 6, 2008, reported that veterans had higher rates of suicide than the general U.S. population based on 2005 NVDRS data collected from 16 states,[3] with the greatest differences between veterans and general population observed in the younger age groups. For example, male veterans ages 18-29 had a suicide rate of 44.99 per 100,000 in 2005 compared with 20.36 for general population males in that age group; the rate was 31.52 versus 30.51 per 100,000 for men age 65 and above. Veterans who used VA services had higher rates than other veterans. National rates for 2005 reported through the CDC WISQARS that were noted in material presented to the Work Group showed different rates, but in a similar direction: Male veterans aged 18-29 had a rate of 26.94 per 100,000, compared with 19.35 for general population males of that age group; the rates were 34.27 versus 29.53 for age 65 and above. A study by Mark Kaplan and his colleagues that linked National Health Interview Survey data from 1986-1994 with National Death Index (NDI) data from 1986-1997 showed that veterans were twice as likely to die of suicide than non-veterans (Kaplan, Huguet, McFarland, & Newsom, 2007). During his presentation, Dr. Kaplan stated to the Work Group, "Regardless of the era of service, veterans are more than twice as likely to end their lives compared to persons who had not served in the Armed Forces." Numerous studies have shown the strong association of suicide with medical problems, particularly mental health problems, but also a history of being wounded and medical co-morbidity. Evidence also indicates that veterans are more likely to use firearms as a means of suicide than non-veterans.

These studies provide a very confusing picture of the risk of suicide among veterans, particularly from the perspective of the public, and there is clearly a need to resolve the differences. One of the fundamental questions is why veterans would have a higher risk of suicide in the first place, given that virtually every study of active duty populations demonstrates that rates are lower in service members than in civilian populations (e.g., because of the "healthy worker effect"). During the meeting, it was mentioned that veterans may become less healthy or develop a higher risk of suicide as they age compared with demographically matched non-veteran aging populations. However, this is unproven, and the assumptions underlying this should be analyzed. It cannot be assumed that two populations with different levels of health at one point in time would show an opposite relationship as they age. In addition, if deployment to a combat zone is not associated with increased risk of suicide (as Dr. Kang's studies indicate), what is the reason for higher rates among all veterans?

[3] NVDRS is funded in 17 states; however, data from California are excluded from the analysis because NVDRS has only been implemented in a limited number of cities and counties in that state.

Based on the above considerations, it seems very likely that there are explanations for the rate inconsistencies that have not been sufficiently evaluated to date. These include:

1. Biases related to the way in which veteran status is ascertained on death records. Studies that rely on death certificates and other death records, such as NVDRS, identify veteran status by a single question that asks whether or not the person had ever served in the U.S. Armed Forces. This is generally completed by funeral directors, who may obtain this information from next of kin.

In addition to concerns about accuracy, the general nature of this question means that anyone who has ever served in the Armed Forces, even for just a day (and thus are not eligible for benefits), can be identified as a "veteran." Every year, however, there are thousands of service members who fail to complete basic or advanced training or who leave the military due to problems such as misconduct, personality disorders, legal problems, adjustment reactions, alcohol and drug-related problems, and other administrative reasons for discharge. Attrition prior to completing the first term of enlistment has been as high as 30% in some years. Thus, it is likely that a significant percentage of persons identified on death records as a "veteran" fall into one of these categories. These individuals would be more likely to have risk factors for suicide, which would drive the rate of suicides up in NVDRS samples compared with other samples of veterans who are eligible for VA benefits. In addition, ascertainment of veteran status appears to differ somewhat between death records (numerator) and U.S. Census (denominator) data. For example, although individuals who trained in the Reserve Component but did not serve on active duty should not be counted as veterans in the U.S. Census figures, they may be counted on death records; this would also have the effect of increasing the apparent suicide rate in veterans.

2. Misclassification biases. The second likely reason for differences in rates across studies is misclassification biases. In the study presented by Dr. Kaplan, suicide accounted for a higher proportion of total deaths in veterans, but "other external causes" of death (accidents and homicides) accounted for a much higher proportion of deaths in non-veterans than in veterans (8% vs. 4.6% respectively). Dr. Kaplan also stated that undetermined deaths were higher in non-veterans than in veterans. This suggests that there may be classification biases that account for the apparently higher rates in veterans. There are several possible reasons for misclassification biases:

- Veteran suicides may be more likely to be correctly classified than suicides occurring in non-veterans because of the higher use of firearms by veterans. Self-inflicted firearm deaths are more likely to be classified as suicides than self-inflicted deaths due to other mechanisms, such as overdoses. Since overdoses account for a high proportion of undetermined deaths, it may be that non-veteran suicides are more likely to be misclassified as an undetermined cause, whereas suicides in veterans (who more often use firearms) are more likely to be correctly classified.

- Misclassification biases identified in active duty military samples illustrate the way in which these biases can affect conclusions about suicide rates. There is direct evidence of classification biases of suicides in active duty military service members (e.g., Car, Hoge,

Gardner, & Potter, 2004; Eaton, et al., 2006), and it is important to note that active duty military members will also likely be identified as "veterans" on death records. The study by Eaton, et al. (2006), based on an analysis of all suicides in active duty military personnel from 1999 to 2000, demonstrated that deaths in Navy service members were more likely to be classified as an "undetermined" cause compared with other services, and thus produce lower official rates of suicide. The most likely explanation for this had to do with the use of the undetermined category for Navy personnel who died by drowning from a ship ("overboards"), despite the fact that some portion of overboards are likely suicides. Once these undetermined deaths were added to the suicides, rates were found to be identical across services. This demonstrated how differences in the classification of deaths can account for apparent differences in rates of suicide across military services.

- Veteran suicides may be more likely to be correctly classified as suicides than suicides occurring in non-veterans because of the availability of more accurate information to complete the death certificate. Veterans may as a whole actually have greater access to high quality health care and better family support than demographically matched non-veteran samples. Thus, there may be more information available to coroners and funeral directors when completing death certificates, making it less likely that deaths will be classified as an undetermined cause (and hence more likely that suicides will be correctly classified) in veterans than in non-veterans.

- There may also be implicit societal beliefs (e.g., that veterans are at higher risk of suicide) that bias the determination of death, which for suicide involves the subjective assessment of whether or not there was intent.

3. There may be unadjusted demographic differences or differences across years. There are large differences in rates of suicide by race/ethnicity, but much of the data comparing veterans and general populations only adjust for gender and age. A higher proportion of veterans (81.9% vs. 67.6%) are white-non-Hispanic individuals than in the general population (US Census Bureau, n.d.), and this may increase the apparent differences between veterans and non-veterans since suicide rates are higher in whites. There are also somewhat confusing data regarding age, with NVDRS showing that the highest risk in veterans is in the youngest age group, and Dr. Kaplan's data indicating that the highest risk is in the older age group. Again, the lack of consistency suggests that there are biases that have not been sufficiently evaluated.

<u>RECOMMENDATION 1</u>: VHA should establish an analysis and research plan in collaboration with other federal agencies to resolve conflicting study results in order to ensure that there is a consistent approach to describing the rates of suicide and suicide attempts in veterans.

This is necessary to inform both the public and the VA itself about progress in suicide prevention. It is recommended that the VA commission an outside group of experts (such as the Institute of Medicine or other highly respected independent scientific organization) to assist in reconciling the data already gathered, as well as to help plan future surveillance efforts by a variety of entities (e.g., federal agencies, states, deployment bases) that would implement the use of uniform definitions (such as those being developed by the CDC). This would also facilitate

surveillance efforts that cut across other systems of interest (e.g., emergency departments, criminal justice settings, state Medicaid services). The CDC is currently working to achieve more uniform state and local suicide death and suicide attempt reporting, and VA's involvement in this activity would be of great benefit.

The Work Group considered a number of specific areas where surveillance and epidemiological research could be improved. Studies that compare rates of suicide between veteran and non-veteran populations should ensure that undetermined deaths are examined (along with, if possible, accidental causes of death). Any higher rate of undetermined deaths (or accidental deaths) in non-veterans that counterbalances higher rates of suicide in veterans requires explanation. Studies that compare veteran and non-veteran populations should also include analysis of self-injurious behavior without regard to intent in order to determine if trends based on officially classified suicides are consistent with data for all self-injurious deaths or behaviors.

Demographically adjusted comparisons between veteran and non-veteran populations should include race/ethnicity in addition to age and gender. Additionally, a detailed analysis is needed of how veteran status is ascertained on available sources of data used in rate calculations, as well as an assessment of any biases that may result from differences in ascertainment. Studies should clearly delineate the total veteran population and the veteran population eligible for VA benefits. Studies should assess the proportion of the veteran population that was only in service for a short time period and were discharged due to problems such as misconduct, personality disorders, substance use disorders, and other administrative reasons that may put them at uniquely high risk for suicide compared with those who remained in service.

Studies may need to link multiple data sets (e.g., VA, Department of Defense [DoD], NVDRS, and NDI data) to accurately compile VHA treatment history, service characteristics, and death circumstances. The NDVRS, which currently functions across 16 states and in four counties in California, has demonstrated the value of a more consistent approach to defining suicide deaths, as well as compiling information on veteran decedents who may have received care across multiple systems. Linking NVDRS data with VA and DoD data has the potential to address the ascertainment and misclassification biases mentioned previously. The NVDRS would be able to better serve the VA and the nation by expanding to all states, and evaluation of the potential advantages of this (e.g. geographic mapping) should be included in the review and recommendations for uniform approaches to defining veteran status.

FINDING 2: Suicide screening processes being implemented in VHA primary care clinics go beyond the current evidence and may have unintended effects.

The initiative in the VA Mental Health Strategic Plan Initiatives for Suicide Prevention that will touch the greatest number of veterans is depression and PTSD screening of all veterans in primary care on a periodic basis, coupled with mandatory assessment for suicide risk for those veterans who screen positive (i.e., at higher risk). Currently, suicide assessments must be completed for any veteran who screens positive on the PHQ-2, PHQ-9, or PCL, even if the clinician's evaluation does not support a diagnosis of depression or PTSD or the suicide ideation question on the PHQ-9 is not endorsed. Cutoff criteria for the PHQ-2, PHQ-9, and PCL are all set at a low cut-point (high sensitivity), which results in low specificity, low positive predictive

value (even in a primary care setting), and a high rate of false positive results (see Terhakopian, Sinaii, Engel, Schnurr, & Hoge, 2008, for further discussion on population screening). This approach to screening for depression and PTSD is reasonable in primary care settings, as the initial positive screen is followed by an interview with the primary care with additional questions about depression and PTSD to determine if treatment (or referral) is necessary for these conditions. However, the new mandatory requirement to also assess all veterans who screen positive on the initial screen for suicide risk has not been validated in an evidence-based manner. Because of the lack of sufficient evidence, all of the experts who presented to the Work Group clearly stated that they did not at this time endorse routine mandatory screening for suicide in non-mental health settings.

Although it is logical that veterans diagnosed with PTSD or depression should be assessed for suicide risk in some manner, it is not reasonable that all veterans who screen positive for these conditions on the preliminary screen (which will include a large number of false positives) should undergo a complete suicide risk assessment. Even those diagnosed with depression or PTSD do not necessarily require a formal suicide assessment with a standardized assessment instrument. The current approach will likely result in a large percentage of veterans being required to undergo suicide risk assessments who in fact do not have depression or PTSD or a need for such an assessment.

The Work Group was informed that there are currently no specific instructions from the VA Office of Mental Health Services regarding how facilities are supposed to conduct these suicide risk assessments. Consequently, it is likely that this mandatory requirement will be implemented in a variety of ways across the system, with markedly variable results. Some primary care clinicians (or nurses in primary care) may be perfectly comfortable doing a quick assessment using the pocket card included in training packages. However, the term “suicide risk assessment” implies a formal structured process, and thus it is likely that many facilities will mandate the use of standardized suicide risk assessments that take a considerable amount of time to administer (e.g., the Columbia Suicide Severity Rating Scale). Some facilities may refer all patients who screen positive for depression or PTSD to mental health due to this new requirement if they consider mental health professionals to be the only professionals qualified to formally conduct such an assessment. It is not known if the number of new mental health professionals being incorporated into primary care clinics will be sufficient to conduct these suicide risk assessments, or how many referrals to specialty mental health services will result. Furthermore, it is not known if the SPCs will have to be notified of persons found to have some level of suicidal ideation (even if very low risk) through these processes.

This screening process, as designed, affects a large number of veterans, is time consuming, potentially stigmatizing, likely to be variable in implementation, and not evidence-based, and may result in unnecessary referrals to specialty mental health services. This is not in concert with evidence-based collaborative primary care models, such as those described by Dr. Martha Bruce in her presentation to the Work Group.

It should be noted that the Work Group only had time to review the materials provided by the Office of Mental Health Services leadership and did not conduct any interviews directly with professionals working in primary care or mental health clinics to determine how acceptable the

new policies are to clinicians and patients. However, Dr. Jobes, in his presentation to the Work Group on disseminating assessments and psychosocial interventions, noted that he had received feedback from VHA mental health clinicians regarding concerns about treating veterans with suicidal ideation and behaviors. The VA should systematically explore these concerns, obtaining feedback from both primary care and mental health clinicians. Assuring the "buy in" of the clinicians who will need to implement VA suicide prevention initiatives will increase the likelihood that these efforts will be successful. The implementation of the screening processes as outlined above will need to be evaluated thoroughly to ensure that primary care clinicians as well as patients respond positively and effectively to these initiatives.

RECOMMENDATION 2: The VA should revise and reevaluate the current policies regarding mandatory suicide screening assessments.

Screening for depression and PTSD should continue in primary care, and the PHQ-2, PHQ-9, and PCL are reasonable instruments with which to do this. However, a formal suicide assessment for all patients who screen positive at this initial step should *not* be mandatory. Rather, after the initial screening with PHQ-2, PHQ-9, or PCL, it is important for a clinician to first confirm that the initial screen is a true positive for depression or PTSD by evaluating the patient. Patients who screen positive for depression or PTSD should be asked about suicidal ideation. Clinicians should verify that any positive response to question 9 of the PHQ (including those not otherwise positive for depression or PTSD) does indeed reflect the presence of suicidal ideation, since this question is also very general. If suicidal ideation or recent suicidal behavior is present, then the clinician should be required to proceed with further clinical evaluation and documentation.

Guidance that is broad enough to encompass the current standard of clinical practice, both in primary care and specialty mental health care, should be provided to facilities to clarify the various ways to appropriately evaluate and document suicide risk. The term "assessment" should generally be reserved for structured risk assessments. It should be clarified that the evaluation by the clinician does not have to involve the use of a structured instrument. Structured suicide assessment instruments should be available as a resource to clinicians, but any mandatory requirement to use them should be specifically guided by evidence-based studies or program evaluations. Program evaluation should be conducted to assess the impact on primary care, mental health professionals, and patients, and to encourage candid and open feedback from professionals working in these clinics about these new policies. Collaborative care approaches for the management of depression and PTSD within primary care should continue to be encouraged.

FINDING 3. VA is attempting to systematically provide coordinated, intensive, enhanced care to veterans identified as being at high risk for suicide. However, the criteria for being flagged as high risk is not clearly delineated; nor are criteria for being removed from the high risk list.

Because transitions across care settings are known to be high risk periods for suicidal behavior, many health providers and care systems struggle to find ways to improve continuity of care and to maintain quality of care during these periods. The VHA, through its own root cause analyses, has identified communication deficiencies, such as the communication and documentation of

risk, as the single largest potential root cause category associated with suicidal behavior; similar results have been found by The Joint Commission in looking at deaths by suicide in inpatient facilities (see http://www.jointcommission.org/SentinelEvents/). The VHA's plans to "flag" individuals assessed for risk for suicidal behavior "within VISN" electronic medical records is a bold step to improve communication about a patient's risk status. As planned, this Category II flag would travel across care settings with a patient's consent, but would not be "universal" in the electronic medical record to which providers might have national access. Planned safeguards for this Category II flag include requiring the patient's consent to include the flag in the medical record, and removing the flag as the patient's condition improves.

As described in an April 24th memorandum to VISN directors from the VA Principal Deputy Under Secretary for Health and the Deputy Under Secretary for Health for Operations and Management, placement on the high risk list is associated with a set of requirements that represents current best practices in suicide prevention. These include requiring careful follow-up by a provider during the high-risk period after inpatient discharge, following up after missed appointments, involving family or friends in treatment, developing a written safety plan, and utilizing a mail program to keep in contact with veterans at risk. Implementation of such requirements may help prevent suicides, but evaluation will be critical to determine this. As this ambitious effort is a work in progress, continuous quality improvement efforts are essential.

The Category II flag and the "high risk list" are two closely related, but not identical initiatives. Coordination between these two efforts should be a priority to minimize potential confusion among providers.

A potential unintended consequence pertaining to the flag is that being labeled as "high risk" for suicide within a medical facility may be stigmatizing to patients. This could be compounded if a suicide flag becomes visible to facilities on a national level, as there are plans to add a suicide designator to the Category I risk flag now reserved only for violent patients. Alternate labels for such flags could be developed, such as "high interest," although these labels could also be stigmatizing

RECOMMENDATION 3: Proceed with the planned implementation of the Category II flag, with consideration given to pilot testing the flag in one or more regions before full national implementation.

In implementing the Category II flag, the VA should ensure that clear guidelines are disseminated for notifying the SPCs regarding use of both the high risk list and the Category II flag. The Category I flag should not be used for suicide risk until an evaluation of the current use of the high risk list and the Category II flag has taken place and supports the need for a Category I flag.

Program evaluation of the SPC notification and high risk flag process and outcomes should be conducted, and the program modified accordingly based on feedback from primary care, mental health professionals, and SPCs in combination with documented outcomes. Additionally, patient reactions to being placed on the high risk (or "high interest") list should be assessed, along with potential stigma.

FINDING 4. The root cause analyses presented to the Work Group did not distinguish between suicide deaths, suicide attempts, and self-harming behavior without intent to die.

The root cause analyses now being conducted in the VA represent one of the most comprehensive efforts ever undertaken to examine potential systems issues that may play a role in suicide attempts or deaths by suicide. For this reason, information emerging from this initiative is of great potential value. However, to improve the value and comparability of these data it is necessary to evaluate data from completed suicides and suicide attempts separately.

RECOMMENDATION 4: Ensure that suicides and suicide attempts that are reported from root cause analyses use definitions consistent with broader VHA surveillance efforts.

The suicide deaths and attempts reviewed in root cause analyses should be defined in a manner consistent with broader VA suicide surveillance efforts, which optimally will be consistent with CDC definitions (see Recommendation 1).

VHA, as the country's largest health care system, offers a tremendous opportunity to work with The Joint Commission to increase knowledge about suicide prevention through root cause analyses. Periodic reports that summarize findings from these analyses should be prepared and shared with clinicians for quality improvement. It is common in mental health systems of all types for clinicians to view root cause analyses of deaths by suicide with great concern. It is essential that the processes used both to conduct the root cause analyses and to utilize the information to improve systems be kept separate from any type of disciplinary proceedings. The root cause analyses reports should thus make clear that the purpose of these reviews is to improve systems, not blame individuals.

FINDING 5. The emphasis of VHA leadership on the use of clozapine and lithium does not appear to be sufficiently evidence-based.

VHA leadership has specifically emphasized the value of clozapine and lithium as modalities with evidence in preventing suicide (e.g. internal VA memo to VISN directors, April 24, 2008). This command-level emphasis does not appear to have a sufficient body of evidence, and there are serious side effects associated with clozapine and lithium that newer atypical antipsychotics approved for schizophrenia and bipolar disorder do not have.

RECOMMENDATION 5: VHA should ensure that specific pharmacotherapy recommendations related to suicide or suicide behaviors are evidence-based.

The VHA has the opportunity to test the potential effectiveness of clozapine, lithium, and other pharmacotherapies for alleviating symptoms of conditions associated with increased suicide risk and for which such medications are indicated. Selective serotonin reuptake inhibitors (SSRIs) are likely to reduce depression and anxiety symptoms, and there is mounting evidence that there is no increased risk of iatrogenic suicidality in adults taking them. Thus, there is no indication for the VHA to in any way restrict use of SSRIs on the basis of concerns about inducing suicidality when prescribed as indicated for the treatment of mental health disorders. With its large

population of veterans served, the VA is encouraged to continue its research examining the safety and efficacy of SSRI pharmacotherapy for depression and anxiety disorders where systematic assessment of suicidality could further inform treatment course and outcomes.

FINDING 6: Efforts to improve accurate media coverage and disseminate universal messages to shift normative behaviors to reduce population suicide risk behavior are not being fully pursued.

As noted under the problems in VA suicide surveillance, current media coverage focused on numerators and undefined cohorts has resulted in unintended messages that could potentially discourage eligible veterans from seeking needed services. With regard to efforts to reduce the risk of suicide for the broader population of veterans that would likely involve media outreach, the workgroup was concerned about the apparent restrictions on the VA against "advertising" its services.

RECOMMENDATION 6: The VA should continue to pursue opportunities for outreach to enrolled and eligible veterans, and to disseminate messages to reduce risk behavior associated with suicidality.

Positive social norming and marketing are potentially potent interventions to enhance the quality of care by providers as well as to improve veterans' health behaviors. Thus, VA restrictions on advertising or social marketing its available services should be clarified and barriers to such advertising removed. Although family members of veterans are often encouraged to promote veteran health behaviors in Vet Center settings, it is less clear to what degree Congressional authorizations allow VA Medical Centers and other VHA facilities to provide outreach to family members in order to facilitate access to care by veterans. Such outreach to families would be beneficial.

FINDING 7. Concerns about confidentiality for OIF/OEF service members treated at VHA facilities may represent a barrier to mental health care.

There was a concern raised during the meeting that policies pertaining to confidentiality for OIF/OEF military service members (i.e., Reserve and Guard) while receiving care at VHA facilities may represent a barrier to needed mental health care. When asked about current policies, VHA representatives who were present at the meeting were unable to provide an answer at that time or in a subsequent email query, suggesting that other clinicians working throughout VHA might also not have a ready answer to this question if asked by one of their patients. It is unclear whether any policy for providers within the VHA clearly articulates the parameters of confidentiality for Reserve and Guard service members. This lack of clarity can be a significant potential barrier to the mental health care of Reserve and Guard service members.

Clinicians in DoD facilities, who constantly balance patient confidentiality with a Commander's need to know specific medical information pertaining to fitness for duty, may be more comfortable with their dual clinical and occupational medicine roles than VA clinicians, who may not be familiar with service members' obligation to inform their unit when unable to fully perform their duties due to a medical or mental health condition.

Within DoD, military Commanders receive limited information pertaining to fitness for duty. Information is conveyed by the medical professional to the Commander using a mechanism such as a one-page profile that lists duty restrictions and the duration of such restrictions. In some cases, a command-directed evaluation may be requested by a Commander when a member is performing poorly or appears to be at risk to him/herself or to others. A formal response to the Commander is provided by the mental health provider(s) conducting the evaluation that lists the member's diagnoses (if applicable), the recommended treatment in general terms, and any duty restrictions or recommendations for administrative separation or medical evaluation board. For security evaluations, mental health professionals are frequently asked to judge whether there is any concern that the condition could impair judgment or affect the service member's ability to safeguard security, what the prognosis is, and whether there is compliance with treatment. Commanders are not provided medical records or other more detailed information such as mental health process notes, medication lists, or any other information that they do not have a specific need to know.

RECOMMENDATION 7. The issue of confidentiality of health records of OIF/OEF service members who receive care through the VHA should be clarified both for patient consent-to-care and for general dissemination to Reserve and Guard service members contemplating utilizing VHA medical system services to which they are entitled.

Dissemination and implementation of such policies should also be clarified for VHA providers. OIF/OEF service members who receive care in VHA should be guaranteed the same balanced level of confidentiality that they receive at military treatment facilities within DoD. VHA clinicians need to clearly understand what type of information a military Commander is entitled to receive from VHA through the unit's medics; this will ensure that they provide a consistent message to OIF/OEF Reserve Component service members that is both informative and reassuring.

FINDING 8. The introduction of Suicide Prevention Coordinators (SPCs) at each VA medical center is a major innovation that holds great promise for preventing suicide among veterans; however, there is insufficient information on optimal staffing levels of SPCs.

The introduction of Suicide Prevention Coordinators at each VA medical center is a major innovation that holds great promise for preventing suicide among veterans. The link between the SPCs and the veterans suicide prevention hotline, which connects callers to mental health providers at the VA Center of Excellence at Canandaigua, represents the most extensive national effort to connect suicide hotline callers with appropriate care. Although no staffing model for SPCs was presented at the meeting, the fact that there is currently only one SPC at each VHA facility—regardless of the number of veterans served—and that this may limit the effectiveness of the program, was discussed.

SPCs are responsible for promoting awareness, conducting community outreach, training providers and guides, flagging high risk patients, conducting individual case management, and developing local suicide prevention strategies. VHA staff reported that an informal verbal survey of SPCs indicated that they felt they could effectively manage a community of up to 20,000

patients. However, some SPCs are currently attempting to case manage up to 150 high risk patients, which precludes them from fulfilling other SPC roles. Specifically, the ability of SPCs to do community outreach may be impaired by the magnitude of their other responsibilities. Staffing may need to be increased to allow for this function to be adequately performed, in keeping with the requirement in the Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110) that the SPCs "work with local emergency rooms, police departments, mental health organizations, and veterans service organizations to engage in outreach to veterans and improve the coordination of mental health care to veterans." These SPC functions are likely vital for successful outreach to veterans in high risk settings such as emergency departments or in the justice system

RECOMMENDATION 8. In order to maximize the effectiveness of the Suicide Prevention Coordinators program, it is recommended that there be ongoing evaluation of the roles and workloads of the SPC positions.

Findings from these evaluations should be used to optimize VHA staffing requirements (including for the larger community-based outpatient clinics), as well as for meeting the community outreach requirements of the Joshua Omvig Veterans Suicide Prevention Act. In order to meet these requirements, larger VA medical centers may need to expand the single staff SPC model to one that has sufficient capacity to meet the outreach and care management requirements (e.g., a Suicide Prevention Team). The VHA is also encouraged to evaluate the impact of the SPCs in enhancing risk communication and improving continuity of care.

Other Considerations

The Work Group also identified a number of additional recommendations that do not fit into the above categories.

1. Adopt a standard nomenclature/definition for suicide and suicide attempt that is consistent with other federal organizations, such as the CDC, and the scientific community.

2. Prepare a single document that details the comprehensive suicide prevention strategic plan outlined to the Work Group in different briefs and documents in order to facilitate more efficient review of suicide prevention progress.

3. The VHA framework for suicide prevention should consider a public health approach that goes beyond secondary and tertiary prevention. Current interventions focus on veterans exhibiting some form of destructive behavior, suicidal self-disclosure, or a positive depression or PTSD screen. In their presentations, Drs. Ten Have and Caine recommended a VHA and DoD population-level culture change that includes a public health framework in addition to an etiologic focus on the growing heterogeneous military and veteran populations. The VA could explore ways to strengthen resilience and build connectedness in the military and veteran communities and their families as a universal prevention approach, and then more effectively target selective and indicated groups with higher levels of risk.

4. The portfolio for suicide research across VHA should be expanded, with suicide prevention prioritized as a research area. Top priorities for research may include clinical trials of therapeutic modalities (e.g. cognitive-behavioral therapy), primary care interventions, effectiveness studies and program evaluations to determine the clinical utility and risk/cost/benefit relationships of new policies and interventions, epidemiological studies to resolve conflicting results, and validation of suicide screening instruments. As the SPCs are now identifying large numbers of veterans who are attempting suicide each month, and since we know that suicide attempts are the single most powerful predictor of death by suicide, the VA should consider supporting multisite research focused on reducing long-term mortality and morbidity in this population—and in particular on reducing death by suicide and suicide re-attempts. Importantly, the collection of timely information on suicide attempt status also allows for dynamic surveillance of suicide prevention efforts. Such a multisite study, which would be very difficult to conduct in a setting other than the VHA, would be of immense value, potentially yielding significant applications for the nation's health care system as a whole. This knowledge could also benefit veterans who do not access VHA services, but are seen in community hospitals and other settings across the country.

5. Consider establishing an Advisory Board of key VHA stakeholders involved in suicide prevention, education, treatment, and research to monitor and evaluate suicide programs and policies on an ongoing basis, establish research priorities, and provide advice to senior VHA leadership on existing and new initiatives.

6. The VA's efforts to reach out to community emergency departments to improve care for active service and veterans at risk for suicidal behavior are encouraged. The VA should move forward with plans to work collaboratively with other federal agencies and with community hospitals to identify veterans in non-VA emergency departments (EDs). Research has demonstrated that those who attempt suicide and are evaluated in EDs have both high rates of suicide and low rates of follow-up with outpatient services following ED discharge. Development of evidence-based interventions that can be used with veterans in both VA and community EDs should be a priority.

7. The VA should continue its efforts to promote training in implementing suicide prevention programs. Current training efforts are two pronged: training of health care professionals designed to enhance competencies in suicide risk assessment, management, and treatment, and "guide" or gatekeeper training designed to train the non-clinical VA workforce on how to recognize and respond to warning signs of suicide. These training efforts should be complemented with the training of researchers in the skills necessary to evaluate the impact of clinician training and program implementation efforts. The VA's program of clinical training in safety planning is an excellent starting point for education efforts, but continuing education in suicide risk assessment, management, and treatment should be an ongoing effort, improved by research on and evaluation of clinician training, practice implementation, and patient outcomes.

8. Promising follow-up interventions designed to prevent veterans identified as being at risk from "falling through the cracks" should be evaluated and, if deemed effective, implemented further. One example of such an intervention is the use of caring letters based on the studies by Jerome Motto and Gregory Carter (e.g., Motto & Bostrom, 2001; Carter, Clover,

Whyte, Dawson, & D'Este, 2005) to maintain contact with veterans who have been identified as being at high risk. Another effort involves making follow-up calls to veterans who accessed the veterans hotline but did not accept linkage to a SPC.

9. The VA should work collaboratively with other federal agencies to understand and evaluate the implications of new technologies for suicide prevention (e.g. social networking, text messaging, etc).

10. The VA should design and disseminate psychoeducation materials for families of veterans who are at risk for suicide, particularly those hospitalized for suicide attempts.

11. For veterans who exhibit chronic suicidal behavior, and who do not respond to short-term therapies, more intensive modalities of treatment should be considered, such as dialectical behavior therapy, intensive case management, assertive community treatment, or other evidence-based interventions. Additionally, the evaluation of intensive outpatient alternatives to hospitalization should be promoted.

12. The VA should review approaches for better integrating VA chaplaincy and pastoral care services and traditional mental health services. Care should be taken to assure that there is a balance between ensuring confidentiality in dealing with VHA-entitled service members whose mental health conditions may be affected by issues associated with combat, and providing adequate training for clergy to improve their appropriate referrals for additional assessment and possible treatment. The Work Group further recommends that the VA collaborate with other public and private partners to reach out to faith-based communities that can assist veterans at risk.

13. The Work Group recommends that the VA implement a gun safety program directed at veterans with children in the home, both as a child safety measure and as a suicide prevention effort. Efforts to improve gun safety through increased use of gun locks can be an important suicide prevention effort that can be disseminated as part of DoD and VA culture and practice. The Work Group was pleased that the VA is considering implementing such a program.

14. The Work Group recommends that the VA analyze entitlement changes required to allow treatment of combat-related conditions to reduce suicides in un-entitled veteran populations. Currently, VA treatment of mental health and substance use disorders in some combat veterans is not allowed because the category of their discharge, such as dishonorable discharge. Congressional authorization to treat some combat conditions in this population may enhance their outcomes and reduce suicides.

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APPENDIX A

VA Blue Ribbon Work Group and Expert Panel on Suicide Prevention

Agenda
Developing Evidence-Based Recommendations for VA's Suicide Prevention Program
June 11 - 13, 2008

June 11, 2008

10:00 a.m.	Introduction of the Honorable Michael J. Kussman, MD, Under Secretary for Health	Dr. Ira Katz
10:05 a.m.	Introduction of the Honorable James B. Peake, MD, Secretary of Veterans Affairs	Dr. Michael Kussman
10:10 a.m.	Charge to the Blue Ribbon Work Group and the Expert Panel Q & A	Secretary James B. Peake
11:00 a.m.	VA Staff Presentations:	
	Introduction and Orientation Brief Overview of Epidemiology Patient Safety Approaches Findings on VHA Utilizers Mental Health Vet Center: Outreach Programs Research thru ORD Research thru OMH (MIRECC/COE) Summary	Dr. Ira Katz Dr. Han Kang Dr. Peter Mills Dr. Fred Blow Dr. Antonette Zeiss Dr. Alfonso Batres Dr. Janet Kemp Dr. Cheryl Oros Dr. Kerry Knox Dr. Ira Katz
1:00 p.m.	Working lunch and continued presentations	
2:00 p.m.	Q & A and discussion of VA programs	
	Interactive Presentations from the Expert Panel:	
3:00 p.m. 4:00 p.m.	Overview Epidemiology: Findings & Lessons Statistical & Methodological Issues	Dr. Eric Caine Dr. Dan Blazer Dr. Mark Kaplan Dr. Thomas TenHave Dr. Robert Gibbons
6:00 p.m.	Adjourn	

Jun 12, 2008

8:00 a.m.	Convene over breakfast	
	Interactive Presentations from Expert Panel Continues:	
8:30 a.m.	Assessment and Psychological Interventions	Dr. Gregory Brown Dr. David Jobes
10:00 a.m.	Biology, Pharmacology, Neuropsychology	Dr. Jan Fawcett Dr. Eric Caine
11:00 a.m.	Clinical Interventions Outside of Mental Health Settings	Dr. Martha Bruce
12:00 noon	Developing consensus:	
	Surveillance and Monitoring Assessment Identifying Individuals at Risk Universal, Selected, and Indicated Interventions Education and Training Quality Monitoring/Improvement Research Partnerships	
5:00 p.m.	Summary of Consensus and Controversies	Dr. Eric Caine
5:30 p.m.	Adjourn	

June 13, 2008

8:30 a.m.	Blue Ribbon Work Group Convenes Toward Consensus on Recommendations
12:00 noon	Adjourn