PODCAST TRANSCRIPT
Two Reports on the Veterans Crisis Line: *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died* and *Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*

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Introduction:

Hello, listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at va.gov/oig.

Kelli Toure:

This is Kelli Toure. I am an associate director of mental health programs within the VA Office of Inspector General. With me today is Nhien Dutkin, a mental health system specialist.

Nhien, we are here to discuss two reports related to the Veterans Crisis Line. *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died* was published in November 2020. The second report is *Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*, which was published in April 2021.

In response to the deficiencies in the management of Veterans Crisis Line callers identified in these reports, the Senate Veterans Affairs Committee introduced legislation to enhance training for Veterans Crisis Line staff.

Nhien, would you tell us about the Veterans Crisis Line, also called the VCL?

Nhien Dutkin:

Hello Kelli. Thank you for inviting me here today. In 2007, the Veterans Health Administration established the National Veterans Suicide Prevention Hotline, now known as the Veterans Crisis Line or the VCL, in response to the Joshua Omvig Veterans Suicide Prevention Act. The Act mandated that VHA provide mental health services 24 hours a day, 7 days a week, and operate a toll-free hotline for veterans. The VCL is a free and confidential hotline resource available to veterans, service members, and members of the National Guard and Reserve even if they are not registered with the VA or enrolled in VA health care. Their family members may also use the VCL. All they need to do is call 1-800-273-8255 and press 1. Trained responders provide support to callers and, when applicable, initiate an emergency dispatch response. Responders are required to have a bachelor's degree in a mental health-related field although they may not be a licensed professional.

Kelli Toure:

Thank you. What prompted the OIG to pursue these two healthcare inspections related to the VCL?

Nhien Dutkin:

The November 2020 report addresses a complaint the OIG received regarding VCL staff failing to initiate an emergency rescue for a veteran who died the day the veteran called the VCL. The April 2021 report focuses on a complaint that VCL staff did not effectively manage responses to two callers with homicidal ideation.

Kelli Toure:

Let's start with the first report. Why did the veteran contact the VCL?

Nhien Dutkin:

In 2018, the veteran told a VCL responder about having survivor guilt and frustration with the July 4th fireworks. The veteran also reported a suicide attempt in 2016, thoughts of suicide during the prior two months, and having a gun at the time of the call. Further, the veteran reported alcohol use and taking over-the-counter antihistamines that same day. Antihistamines, such as Benadryl, are medications used to treat allergies that can cause drowsiness.

Kelli Toure:

What else happened during this call?

Nhien Dutkin:

The responder documented that the call disconnected several times, and after two unsuccessful attempts, the responder reached the veteran. The veteran told the responder that the call dropped because they took two to four doses of over-the-counter antihistamines and that taking those medications was not out

of the ordinary because it helped with sleep. The veteran ended the call abruptly. The responder called back but the veteran answered and hung up within seconds.

Kelli Toure:

The veteran telephoned the VCL again and spoke to a different responder a few minutes later, right?

Nhien Dutkin:

Yes, that is correct. The veteran told the second responder that they did not want the police to come to the house and acknowledged telling the prior responder about having a gun in their mouth. During the call with the second responder the veteran denied current suicidal ideation or a "means to carry out this plan to shoot." The responder asked about homicidal ideation and the veteran stated that "if the police show up at my house, there will be" and said there was a "shoot out" the last time police were called.

Kelli Toure:

And I understand that the veteran disconnected the call and the second responder made four unsuccessful attempts to recontact the veteran.

Nhien Dutkin:

That's right. The second responder then spoke with a supervisor. The second responder documented that they stopped attempting to call because the first responder had discussed how the veteran could stay safe and submitted a referral for the suicide prevention coordinator at the veteran's local VA medical center.

The veteran died sometime between the last VCL contact in the morning and when the police department called the medical examiner that afternoon. The medical examiner listed the veteran's death as acute combined intoxication from alcohol, antidepressant medication, a cough suppressant, and an antihistamine. The medical examiner noted the manner of death was "best classified as undetermined" because the veteran's intention to overdose was uncertain.

Kelli Toure:

Did the responders consider whether the veteran would be at risk of an overdose?

Nhien Dutkin:

Both responders documented that the veteran was intoxicated, but they did not adequately assess the extent of the veteran's alcohol or other drug use, including the use of over-the-counter medications that can contribute to an intentional or unintentional overdose. The responders failed to consider the veteran's potential overdose risk and to initiate an emergency dispatch.

Kelli Toure:

What would you have expected the responders in this situation to do?

Nhien Dutkin:

As part of our inspection, we interviewed five national non-VHA crisis line subject matter experts. When presented with a scenario like this, four of the subject matter experts recommended initiating a rescue. All subject matter experts supported responders screening for substance use as part of a suicide risk assessment.

Kelli Toure:

The veteran had reported to both responders that they had a gun, but both responders failed to clarify the veteran's access to lethal means, right?

Nhien Dutkin:

Yes, we would have expected the responders to assess and mitigate the veteran's access to lethal means more actively, especially since the veteran reported having a gun intended for self-harm.

Kelli Toure:

That is concerning. I understand that VCL requires responders to complete and document a collaborative safety plan with callers at risk for self-harm. Did the two responders do that with this veteran?

Nhien Dutkin:

Well, the first responder documented safety planning with the veteran; however, we found that neither responder developed a plan to keep the veteran safe. Because of the first responder's inaccurate documentation suggesting that there was a safety plan in place, the second responder did not initiate an emergency rescue plan.

Based on the veteran's intoxication, high risk for suicide, and reported access to a gun, we would have expected an emergency rescue to be initiated. 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.

Kelli Toure:

Thank you, Nhien, for discussing this report.

Now let's turn to the April 2021 report, which discusses two different callers who expressed homicidal ideation. In VCL staff's management of the first caller, who was a veteran, you found similar concerns about VCL staff not initiating a rescue. Can you talk more about the VCL contact with this veteran?

Nhien Dutkin:

Yes. The responder documented that the veteran reported being upset with a family member, who we will refer to as family member 1, for taking the veteran's medications away. The veteran denied homicidal thoughts but reported sitting alone in the home with a gun for protection and thoughts of shooting family member 1 in self-defense if necessary. The veteran requested that the responder contact another family member, who we will refer to as family member 2.

Kelli Toure:

Then what happened?

Nhien Dutkin:

The responder ended the call and talked to a supervisor. After an unsuccessful attempt to recontact the veteran, the responder telephoned family member 2. Family member 2 told the responder that the veteran shot family member 1. The following day a VA suicide prevention coordinator documented that the veteran "shot and killed" family member 1 and was incarcerated.

Kelli Toure:

That is devastating. You found that the responder's management of the veteran's call was insufficient and delayed and that the responder failed to take action to prevent family member 1's death.

Nhien Dutkin:

Yes. We found that the responder did not evaluate the veteran's homicidal thoughts or access to a firearm. Nor did the responder complete an adequate plan to ensure the safety of the veteran and family member 1, as required by the VCL.

Kelli Toure:

So, as in the first report, there was a failure to complete a thorough assessment, including the veteran's level of risk and whether there was any plan to harm themselves or others.

Nhien Dutkin:

Yes, in both reports we found that VCL responders did not adequately assess suicide or homicide risk factors or have an adequate plan to ensure safety. Completing an assessment may have revealed additional information that may have warranted further action with the veteran and changed the course of events.

Kelli Toure:

What would you have expected to happen in this case?

Nhien Dutkin:

The veteran was unable to develop a safety plan on their own and declined the responder's suggestion to watch television. Since the veteran reported having a firearm and thoughts of harming a family member also in the residence, we would have expected the responder to examine options for how to restrict the veteran's access to the firearm, thereby reducing the risk of harm to self and others, and to explore safety options with the veteran. The subject matter experts agreed that emergency rescue services should have been initiated.

Kelli Toure:

Thank you for discussing this tragic case. You had mentioned that the April 2021 report investigated two callers. Can you tell us about the second caller?

Nhien Dutkin:

Certainly. In the second case, the caller contacted the VCL anonymously and reported to a responder that they were having suicidal thoughts and homicidal thoughts toward a family member and then disconnected the call. The caller telephoned the VCL again and spoke to another responder who completed a safety plan with the caller and documented that the call ended normally. Meanwhile the initial responder unsuccessfully attempted to recontact the caller and asked another VCL staff member to initiate a rescue. The rescue continued into the following day, and two additional VCL staff became involved. One of the additional VCL staff contacted the police the day after the initial call and requested that another VCL responder contact the caller. This responder's outreach efforts were unsuccessful, and a supervisor discontinued emergency dispatch.

Kelli Toure:

Did you identify any concerns in the management of this caller?

Nhien Dutkin:

Yes, we did. Two VCL staff members failed to dispatch local emergency services after a responder requested a rescue. Further, staff did not initiate an emergency rescue until six and a half hours after the responder's request. We concluded that inadequate communication between responders may have contributed to a failure to identify the caller's location for the emergency dispatch efforts. We also identified deficiencies in VCL leaders' oversight, including a failure to complete a thorough review of the caller's rescue management.

Kelli Toure:

Related to oversight, both reports we have discussed today highlight quality assurance concerns at the VCL. Specifically, as required, VCL leaders implemented a silent monitoring protocol in which VCL

specialists monitor telephone calls, chats, and text communications to evaluate the quality of responders' work and identify areas of improvement. What issues with the silent monitoring program did you find?

Nhien Dutkin:

We found that VCL leaders did not track silent monitor results for trends in staff deficiencies over time. This lack of information about staff performance over time may have contributed to inadequate performance improvement and quality assurance initiatives, including supervisory review.

In addition, in the second report we found that the VCL specialists did not complete the expected number of silent monitored calls for the responders who managed both callers. VCL leaders' failure to ensure that sufficient silent monitored calls were conducted for all staff may lead to unidentified deficiencies in staff performance.

Kelli Toure:

Can you tell us about the recommendations you made to the VCL director in each report?

Nhien Dutkin:

The November 2020 report had eight recommendations, including a review of the veteran's contacts and follow up with administrative actions as warranted, an evaluation of the current responder training on lethal means, and new policy and training for assessment of callers' substance use and overdose risk. The recommendations also included the use of a standardized safety plan template, completion of safety planning per VCL standards, and criteria for supervisor follow-up including silent monitoring criteria.

In the April 2021 report, the 11 recommendations included establishment of quality management and disclosure processes, a review of both callers' contacts and follow-up with administrative actions as warranted, VCL leaders' expectations and benchmarks regarding silent monitored calls, processes to promote responders' communication, and strengthening of supervisory oversight of VCL staff.

Kelli Toure:

Nhien, thank you for exploring the issues related to both inspections. VA has submitted action plans to address the deficiencies, and the OIG will follow up on the planned actions until they are completed. As I mentioned at the beginning of this podcast, the Senate Veterans Affairs Committee introduced legislation in response to these reports that included requirements for enhanced responder training on how to properly assess risks and take action with high-risk callers, implementation of an extended safety planning pilot program, and increased quality review and management of VCL calls and processes.

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