Department of Veterans Affairs
Office of Inspector General

Review of Quality of Care Involving a Patient Suicide

Report No. 05-02562-124 **April 7, 2006**

VA Office of Inspector General
Washington, DC 20420

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

TO: Director, Veterans Integrated Service Network

SUBJECT: Healthcare Inspection – Review of Quality of Care Involving a Patient Suicide

1. Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) received a letter from a United States Senator requesting an investigation into the care that a young Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veteran received at a VA Medical Center (VAMC). This reservist committed suicide. The Senator's request was made on behalf of the patient's parents who expressed concerns regarding the quality of care received by their son. In addition, the parents alleged that the medical center refused to release all medical records related to their son's treatment. The purpose of the inspection was to determine the validity of the quality of care concerns and the alleged refusal to release all medical records pertaining to this patient's care.

2. Background

The medical center provides comprehensive mental health, outpatient primary medical care, and extended care services to a veteran population. Mental health services are provided in both outpatient and inpatient settings.

OHI received a letter from a Senator requesting an OIG investigation into the care of an OIF veteran who was treated at the VAMC and later committed suicide. The Senator's request was in response to an initial letter sent to the Senator by the patient's parents, requesting his full medical records and related materials. The parents believed there was incomplete disclosure.

The patient had been involuntarily admitted to the acute psychiatric unit at the VAMC on the Friday before a 3-day weekend. He had been admitted for treatment of depressive symptoms and for alcohol detoxification. On presentation he was intoxicated and was also assessed to be a danger to himself. He was hospitalized at the medical center for

4 days on a temporary involuntary basis. When discharged, he refused further VAMC care but chose to resume treatment with his private non-VA therapist. Four days after discharge, he was returned to the medical center grounds by family members due to their concern regarding his behavior, at which time he refused re-admission to the medical center. Although not readmitted at that time, several VAMC and Vet Center telephone contacts ensued regarding this patient. Three weeks after his hospitalization on the inpatient unit, the patient committed suicide at his home.

In July 2005, we interviewed the patient's family, and they expressed the following concerns regarding the patient's care at the VAMC.

- During the patient's stay on the acute psychiatry inpatient unit, the medical center staff seemed to focus exclusively on his need for alcohol rehabilitation. Once he was sober, and after he had been there for 72 hours, the parents questioned whether he was evaluated for further treatment needs pertaining to symptoms of post-traumatic stress disorder (PTSD) and depression.
- The milieu on the acute inpatient psychiatry unit, which the family contends was skewed toward older patients and patients with dementia or chronic mental illness, was ill-suited for the treatment of a young, non-chronically ill, OIF patient. They believed that this, in part, led to the patient's reluctance to be voluntarily re-admitted to the same acute psychiatric unit approximately 1 week later.
- Prior to the patient's discharge from the medical center, clinicians did not invite the family to a discharge planning meeting.
- Four days after discharge from the inpatient unit, when family members brought the patient to the medical center expressing concerns over his resumption of alcohol abuse, symptoms of depression, symptoms of PTSD, and recent suicidal ideation, medical center staff did not pursue involuntary hospitalization.
- After this visit to the medical center and prior to the patient's mother contacting the medical center 10 days later, no one from the VAMC called the patient or his family in order to check on his status or to try to convince him to seek admission at that point in time.

3. Scope and Methodology

We obtained and reviewed the patient's medical records (electronic and paper) pertaining to his care at the medical center. We reviewed quality management and administrative records including a Root Cause Analysis and the psychological morbidity and mortality review that were performed after the medical center was informed of the patient's suicide.

We reviewed medical center policies governing the evaluation and management of dangerous, violent, and suicidal behavior; psychiatric treatment plans; outpatient mental

health discharges and failure to report to appointments; assessments specific to detoxification admissions; assessments specific to psychiatric admissions; and assessments of patients receiving outpatient mental health services.

We reviewed the medical center's PTSD program handbook and extracts from the Briggs telephone triage protocol book.[1] We reviewed the View and Laboratory Report from the Office of the Chief Medical Examiner, Western Regional Office for the state in which the patient died.[2] In addition, we reviewed the case with the Medical Examiner's office.

We made two site visits to the medical center in the summer of 2005. In addition to interviewing the patient's family, we interviewed VAMC medical, nursing, and administrative staff involved in this patient's care. We inspected the acute psychiatric inpatient unit and the specialized inpatient PTSD unit. We inspected the medical center grounds, paying particular attention to the area in which VAMC staff interacted with the patient. In addition to receiving care at the VAMC, the patient was also seen and evaluated at a VA Readjustment Counseling Service Vet Center (Vet Center) in the area.[3] We inspected the Vet Center and spoke with the clinicians who saw the patient there. The patient also had an ongoing relationship with a private non-VA therapist in the local area. With authorization from the patient's parents, we interviewed the private therapist. The patient's parents provided us with a copy of the medical records of the private therapist's care of their son. In addition, we interviewed the patient's private primary care physician.

We reviewed the sections governing mental health in the General Law of the State in which the patient resided. The version reviewed pertained to laws in effect in January 2004. We consulted legal counsel of the Office of Inspector General, Department of Veterans Affairs, regarding the legal interpretation, applicable legal standard, and rule of law in practice in the State in which the patient resided. We requested consultation regarding applicability of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provisions to military reservists receiving treatment in VA facilities. We also reviewed Sections 5701, 5705, and 7332 of Title 38 of the United States Code, which govern the release of protected medical records. In addition, we obtained and reviewed the investigative report completed by the patient's branch of service in relation to his death.

In accordance with our authority under the Inspector General Act, the focus of this report is limited solely to the patient's care at the VAMC and the Vet Center. The inspection

[1] A text which provides guidelines for generally accepted practices of nursing triage.
[2] In cases where the cause of death appears obvious, the medical examiner, at his or her discretion, may elect to view the body but not to perform an autopsy. Jurisdiction for the Western Regional Office includes the county in which the patient died.
[3] Vet Centers are community based counseling centers providing readjustment counseling to war zone veterans of any era.

was performed in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

4. Inspection Results – Case Review

The patient was a young male who had been in good health growing up, with the exception of an episode of pneumonia as a child. In his teens, the patient was treated by a private therapist for a period of a few months. The private therapist indicated that the patient was seen at that time for substance abuse and general adolescent-adult issues. He reportedly did not have a history of affective, psychotic, or anxiety disorder.

In his late teens the patient enlisted as a military reservist. Three years later he was activated and deployed to the Middle East in support of Operation Iraqi Freedom. Upon cessation of offensive operations in Iraq, the patient returned stateside. That summer the patient was honorably discharged from active duty. His reserve unit resumed assembling for drill in the early fall.

His parents reported to us that after returning home from Iraq, the patient pursued a business program at his local community college. The patient's alcohol use progressively increased. His parents first noticed signs of distress approximately 5 months after his return home. They recalled that he was tearful and "had a meltdown." The patient's father reported that the patient seemed fine the next day. Over the next few months, the family reported that he began talking with them about his dreams of being in an alley and fearing that the enemy was coming after him. By early spring, the patient was experiencing panic attacks, impaired sleep, startle responses (startling at loud or unexpected noises), and feeling as though others were looking at him. At times, when alone in his room, he would think that he was hearing military helicopters. In addition, he began having difficulty finishing his courses at the local community college.

The patient's family reported that by mid-spring, they had noticed a change in his behavior when he would drink. They reported to us that his alcohol use had escalated to the extent that it was causing discord with family and his girlfriend of several years.

The patient's mother contacted the private psychotherapist who had treated the patient at one point in his teens. At the suggestion of his parents, the patient visited his private primary care physician in his local community. The patient started on the anti-anxiety medication clonazepam and the antidepressant medication fluoxetine. Five days later the patient was seen by the private therapist for an initial visit. During a therapy session the following week, the patient expressed that he had "suicidal thoughts off and on." However, he was able to contract with the therapist for his safety, stating he "would not take his own life because he loved his family too much." Psychotherapy sessions were increased in frequency thereafter.

The next day, the patient's private therapist telephoned the patient's father and discussed the patient's condition. According to the therapist's records, the patient's father was advised to "keep a close eye on him," and they discussed the benefits of more intensive treatment or hospitalization for the patient "if he could be guided to it." On the following day, the patient's private therapist documented that the patient presented for a therapy session with the smell of alcohol on his breath. The therapist drove the patient to his (the patient's) home where he spoke with the patient's father about his (the therapist's) concerns. The next day, the therapist contacted the patient's college instructors and advisors and requested, on behalf of the patient, that the patient be withdrawn from classes. Four days later, the therapist introduced the patient to a veteran who spoke with the patient. The meeting reportedly "helped the patient digest the impact of PTSD as well as to think of the VA hospital as an option." On that same date, the therapist spoke to the patient about the potential benefit of being hospitalized for further evaluation and to address the patient's substance use. The private therapist's records indicate the patient was resistant to hospitalization. Three days later the patient was seen again by the private therapist. During this session, the therapist discussed more intensive treatment at the VA or elsewhere. The patient denied suicidal intent at that time. The private therapist talked to the patient about reaching for help as needed.

The following day, the patient's father telephoned the medical center's Administrative Officer of the Day (AOD)—a non-clinical staff member—requesting services for his son. The father was advised by the AOD to bring the patient to the medical center. The patient was seen in the Admission and Disposition (A&D) department of the medical center in the early evening. The patient was accompanied by his father and girlfriend. The patient's father reported to VAMC staff that the patient had been exhibiting dramatically changed behavior, had been drinking along with his medication, had been verbalizing suicidal ideation on that day, and had been having anger issues. At presentation to the A&D area, the patient was found to have a contusion (bruise) of his right hand as a result of punching a dresser at his home. He was intoxicated (breathalyzer reading of 0.320 g/dl) and verbalized suicidal thoughts with a plan to harm himself.[4] He reportedly stated that he had selected a tree at which to hurt himself, had brought home a hose to choke himself, wanted to drink more, and would not contract for safety. He reported experiencing vivid memories from his tour in Iraq and hearing a voice saying "get up."

The psychiatric nurse in A&D reported that the patient was rambling about things he had seen and done in the Middle East and documented that the "patient continues to feel like hurting himself and others." In addition, the patient was noted to state concerns that information he gave to VAMC staff be kept private. He initially endorsed wanting help but expressed fear that his branch of service would find out about his hospitalization,

[4] The breathalyzer test is an indirect measure of the blood alcohol level. No alcohol in the blood would measure zero. In the State in which the patient resided, a blood alcohol concentration of 0.320g/dl is greater than would be considered legally intoxicated.

with consequent negative ramifications for his military career. In our interview, the psychiatric nurse reported that:

> He [the patient] did not want the [branch of service in which he was a reservist] or anybody to know anything because I had brought a release of information down to him and explained that to him and he refused to sign that. He said that "There's nobody that I want any information given out to, and especially to the military," because he was adamant that—adamant about that even downstairs that he didn't want the [branch of service] knowing because he wanted to continue his career and stay in the [branch of service] at that time.

The medical officer of the day (MOD) noted that the "patient is a clear and present danger to self and others from PTSD, depression with psychotic features, and suicidal ideation, acute alcohol intoxication with risk of alcohol poisoning upon return home tonight." The MOD and psychiatric nurse requested consultation with and evaluation of the patient by the Psychiatric Officer of the Day (POD). The AOD and the psychiatric nurse reported that after a 10–15 minute conversation with the POD, the patient ran from the A&D area. The POD recommended that the patient not be allowed to leave the grounds and that he should be admitted on an *Application for and Authorization of Temporary Involuntary Hospitalization.*[5]

The patient was apprehended across the street from the A&D area by the medical center police and the psychiatric nurse. During the encounter, the patient informed the psychiatric nurse that he was going "to end it all" and he struck out at the psychiatric nurse. The patient was escorted to the acute inpatient psychiatric unit, where he was involuntarily admitted. The patient's admitting provisional Axis I diagnosis was major depression with psychotic features.[6]

On admission to the inpatient psychiatry unit he was placed on special observation status.[7] The patient was given haloperidol (an anti-psychotic medication) and lorazepam (an anti-anxiety medication) and was placed on a detoxification protocol. In the nursing inpatient assessment, the patient endorsed experiencing nightmares, difficulty with sleep, and difficulty handling stress.

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[5] A legal document (under General Law of the State in which patient resided) used to request involuntary hospitalization of a patient so as to avoid the likelihood of serious harm by reason of mental illness.

[6] American Psychiatric Association (2000). Multiaxial assessment from DSM-IV-R (*Diagnostic and Statistical Manual*, 4th ed. rev.).

Axis I	Clinical Disorders and Other Conditions
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

[7] Requires constant, vigilant, high-quality observation, intervention, and documentation.

Laboratory studies on admission showed a urine drug test that was positive for benzodiazepine and cannabis. A urinalysis, complete blood count, thyroid stimulating hormone level, rapid plasma regain,[8] and complete metabolic profile were essentially within normal limits. The patient was prescribed chlordiazepoxide and lorazepam on an as needed (PRN)[9] basis and was also prescribed PRN haloperidol. He was continued on the antidepressant fluoxetine, which had initially been started by his private, primary care physician.

The patient had been admitted to the hospital on the Friday of a holiday weekend. The patient was assessed by nursing staff and the MOD throughout the weekend. The patient contracted for his safety with the nursing staff, but remained on special observation when he was alone or in his room. Otherwise, the patient was directed to be in the dayroom where he could be observed in the milieu and receive safety checks every 15 minutes.

The patient's family and girlfriend visited. On the day after admission, a nurse on the unit discussed with the patient's mother "his options and made it very clear that he would not be accepted to any PTSD unit until he agreed to get his substance abuse problem under control."

The MOD noted on the Sunday of the holiday weekend that "the pt [patient is] without complaint [and] denies suicidal thoughts at this time. Wants to smoke." On Monday the MOD documented that the patient was "doing well," did not admit to suicidal ideation, had some isolating behaviors per nursing, was not requiring PRN medications, and was medically stable.

The patient was evaluated by the attending ward psychiatrist on the following morning. In our interview, the attending psychiatrist described the patient's affect at that time as bright and his behavior as appropriate. The patient requested discharge from the VAMC. He reportedly endorsed plans to finish college and continue his career with the military. He had been detoxified from alcohol while at the medical center. The patient's detoxification was noted to be unremarkable, and the patient was medically cleared in terms of alcohol withdrawal. The psychiatrist noted the following in the patient's medical record:

> Pt's examination is in no apparent distress; nothing unusual was found; no limitations in any of the domains assessed; no evidence or signs of a thought, major affective, cognitive or behavioral disorder were elicited. No obvious indications of psychosis or organicity. Speech is relevant as to content and spontaneous as to delivery. Pt. [patient] denied any suicidal or homicidal thoughts. Pt. denied any prior sxs [symptoms] of depression/psychosis. He didn't want to go further on any possible PTSD

[8] A blood test that detects exposure to syphilis. Syphilis can cause neurologic and/or psychiatric symptoms.
[9] PRN is an abbreviation for *pro re nata* which, in medical usage, means on an as needed basis.

> sxs. He said he would address those issues with his [private] therapist. No signs of alcohol withdrawal sxs.… He has requested his discharge. Pt. currently is not an imminent danger to harm self or others. Patient to be discharged today to his parents. No medication or appointments per patient request.

He was discharged from the acute psychiatric unit on the Tuesday following the holiday weekend, with final diagnosis of mood disorder due to substance abuse, alcohol intoxication, marijuana dependence, alcohol dependence, and nicotine dependence. The attending psychiatrist reported that the auditory hallucinations that the patient had endorsed on admission had resolved and were felt to have been secondary to alcohol use. Inpatient staff recommended an alcohol rehabilitation program, but the patient declined this aftercare option, reportedly stating that he would do it on his own and that he had a good support system. Consequently, the plan for aftercare was for the patient to follow up with his private therapist. He declined follow-up with mental health services at the VAMC. The patient also declined medication prescriptions. The ward psychiatrist recalled the veteran stating, "I have my private doctor. I have my private psychotherapist, and I am going to work with the program, but I don't want anything here because I don't want to ruin my career." His mother recalled receiving a telephone call at home from the patient informing her of his discharge and asking her to pick him up downstairs at the VAMC.

According to the patient's family, the patient resumed drinking alcohol on an almost daily basis after his discharge from the medical center. His mother reported that the patient wanted to take more clonazepam. He told his family that the VAMC instructed him to take up to four 0.5 mg tablets of clonazepam per day. His mother reported that she and her husband knew that this was not the case; they called the patient's private primary care physician's office in order to verify his actual prescribed dose of clonazepam. The family subsequently secured his medications and attempted to dispense them daily.

The patient was seen by his private therapist 3 days after discharge from the medical center. At the patient's request, one of the patient's private clinicians called the patient's reserve unit to request that he (the patient) be excused from that weekend's upcoming drills. The clinician notified the reserve unit that the patient was under his care and was being treated for depression. Reportedly, the clinician stated that the patient was a little shaken up, but the condition was not major, and that the patient should not go to the range or handle weapons, but that he should be better in a few months.

Four days after discharge from the medical center, the patient's father and sister telephoned a psychiatric staff nurse at the VAMC who had developed some rapport with the patient during the patient's hospitalization. The patient's father stated that the patient was "out of control" and drinking large amounts of alcohol with clonazepam. The family reported that the patient voiced thoughts of suicide. The patient's sister informed the

triage nurse in this telephone call that the patient showed her a rope with which he planned to hang himself. His family also reported that the patient was threatening to "beat family members up." The patient's father got back on the phone with the staff nurse who could hear the patient screaming in the background. His father stated that he was going to call the police. The patient subsequently agreed to go with his sister to speak with someone at the medical center. Although the patient's family indicated that they told the patient that they just wanted him to go to the medical center to talk to someone and that they did not want to commit him, they reported that they did, in fact, hope that he would be committed or that he would agree to come into the hospital. The patient told his family that he did not want his father coming with him to the medical center and that he would not get into the car if his father were to come. In addition, he stipulated that he would only go if his sister hit the whiffle ball to him ten times, which she did. The patient was subsequently brought to the facility by his two siblings, his girlfriend, his grandfather, and a brother-in-law.

Upon arrival at the VAMC grounds, the patient initially stayed in the car. He refused to speak with a doctor. He indicated that he was only willing to speak with a specific psychiatric staff nurse. This nurse had been notified that the patient was coming to the medical center and, as requested, came down from his unit to speak with the patient. The patient sat down on a brick wall outside of the A&D area but refused to enter the building. Subsequently, this staff nurse met with the patient in this area and attempted to get the patient to agree to be admitted to the medical center.

The nursing clinical coordinator who was present noted that the patient stated that he (the patient) had consumed one beer, and the nursing clinical coordinator noted that the patient was "obviously abusing alcohol and this is confirmed by his family. The vet denies alcohol abuse stating that he had only one beer and would only admit that he was feeling the effects of the klonopin [clonazepam]." The psychiatric nurse and the nursing clinical coordinator described the patient's demeanor as calm and in control. The psychiatric nurse reported that the patient was able to hold an appropriate conversation and was fairly clear and oriented. They recalled that the patient, in a calm manner, denied feeling hostile or angry. He denied homicidal and suicidal ideation and refused voluntary admission. The patient stated that he did not want any help from the VAMC but preferred to seek help as an outpatient with his private clinician.

The psychiatric nurse reported that he (the nurse) unsuccessfully attempted to elicit a verbal or behavioral reaction from the patient that would allow the clinicians to pursue involuntary hospitalization. The nursing clinical coordinator noted that the patient "offered no grounds to seek a commitment or placement under protective custody by the VA police." The POD was available for telephone consultation and, if needed, an on-site evaluation for involuntary admission. Yet because the patient had been refusing to speak with a physician and in light of his denial of suicidal or homicidal ideation, the psychiatric nurse, clinical nurse coordinator, and the MOD did not believe that

consultation with the POD would impact the patient's eligibility for involuntary admission. The patient's family was advised to call 911 or the police if the veteran acted out at home, became aggressive, or threatened harm to self or to others. The nursing clinical coordinator noted that the family was very disappointed with the decision not to commit the patient and felt the VA "should keep him until he is better." Prior to the patient and his family departing the VAMC grounds, his siblings called his father to apprise the patient's father of the situation. Before the patient and his family left the VAMC grounds, his father called the crisis line at a local, non-VA affiliated community mental health center in order to try to get help there for the patient. The patient's father reported to us that as soon as he mentioned alcohol to the mental health center employee with whom he was speaking on the phone, he was told "I am sorry I can't help you."

Ten days later, the patient's mother contacted the VAMC medical triage desk. She expressed concern to the triage nurse that the patient was drinking while taking his antidepressant medications, and she said that he "feels as though there are things crawling on him." The patient's mother was advised to have the patient come in as a walk-in to the Psychiatric Day Clinic. The patient's mother reportedly verbalized understanding and "will try to get the vet to come in or be seen privately."

The triage desk nurse contacted the VAMC's patient representative who, in turn, spoke with the patient's mother and a VAMC clinician in the Mental Health Clinic. The patient's mother told the patient representative that the patient was unwilling to come to the facility because he feared that he would be locked up and because he felt that his issues were not addressed when he had been on the inpatient unit. In addition, his mother reported that the patient feared that his behavior would get back to his reserve unit and that they would consider him weak. The patient representative asked if a clinician from the Mental Health Clinic could call the patient's mother regarding her (the patient's mother's) concerns. The patient representative was advised by the clinician from the Mental Health Clinic that the patient should come into the Psychiatric Day Clinic for an evaluation.

In view of both the veteran's reluctance to return to the VAMC and his apparent need for further mental health services, the patient representative then facilitated connection between the patient, his family, and the Vet Center. The patient representative, after speaking to the veteran, contacted the Vet Center later that day and requested an appointment for the patient. An appointment was initially offered for the following day. Documentation from the Vet Center's combat veteran outreach coordinator indicates that he contacted the patient the next day. However, the patient reported a lack of available transportation and the appointment was therefore re-scheduled for the following week to be held at the patient's home.

Two days after the mother's call to the medical center triage desk, the patient's father telephoned the patient representative, under the impression that the outreach staff had not yet contacted his son. His father reported that the patient had been sober for a few days

and had verbalized to his parents a potential willingness to pursue further treatment. After meeting with the patient representative from the VAMC, the Vet Center Supervisor called and spoke to the patient's mother, who expressed her concerns regarding the patient's symptoms, including insomnia, alcohol abuse, poor concentration, and verbalizations of suicidal ideation. The Vet Center Supervisor discussed the Vet Center's services and availability of the VAMC's inpatient PTSD program. He also discussed an inpatient PTSD program at a VAMC in a neighboring state. An appointment was scheduled for the patient to be seen by the combat veteran outreach coordinator at the Vet Center on the following day rather than the following week.

The combat veteran outreach coordinator met with the patient at the Vet Center and conducted an intake assessment. The patient was accompanied by his father, and at the patient's request, the father sat in on the assessment. The coordinator spoke with the patient and his father for approximately 2 hours. The coordinator described the veteran to us as being very pleasant and conversant. The coordinator documented sleep problems, issues with traumatic experiences while in the Middle East, and homecoming issues. In addition, he noted issues with alcoholism, and anger problems. The coordinator documented that the patient was cooperative and maintained good eye contact. His motor activity was described as tense. The patient reported a poor appetite, difficulty falling asleep, and awakening from sleep due to the feeling that someone was touching him on the shoulder. Every half hour throughout their conversation, the patient needed to go out and smoke while simultaneously drinking black coffee. He endorsed difficulty with feeling tired but not wanting to fall asleep for fear that he would experience disturbing nightmares and visions. The patient reported that 2 weeks prior to this assessment, his relationship with his girlfriend of many years had come to a break. The coordinator noted that a few weeks earlier the patient reported having had suicidal thoughts with a plan to hang himself from a particular tree. However, at the time of this assessment, the patient denied current ideas or active plans to commit suicide.

The coordinator recalled that during that assessment, the patient reported dissatisfaction with his stay on the VAMC acute psychiatric unit because he could not smoke and because he found himself lonely there, in that he "did not find someone he could engage with in terms of, you know, like the veteran of Iraq talking to another veteran of Iraq…he found himself around a whole bunch of Vietnam veterans…. [Vietnam] happened so long ago." The disposition of that meeting was that the patient "is to monitor mood, he is to log sleep pattern. He is to seek this counselor next week [He is] To call this counselor in the event he becomes anxious or stressed. [He is] To remain abstinent." In addition to making a follow-up appointment, the coordinator gave the patient his pager number.

On the day of the assessment at the Vet Center, the patient spoke by phone with the VAMC patient representative and conditionally agreed to let her set up a Mental Health Clinic appointment at the VAMC. He told the patient representative that he was agreeable to working with the veterans outreach program until he felt comfortable

returning to the VAMC. An appointment was scheduled by the Mental Health Clinic for approximately 3 weeks later.

Three days later, the patient was seen by his private therapist. At that visit, the patient reportedly contracted for safety with his therapist. That evening, the patient's father called the readjustment counselor at the Vet Center reporting that the patient wanted him to go get him something to drink. The patient's father voiced concern about the patient's drinking but stated that if he did not obtain the requested alcohol, there would be disruption all night. The counselor spoke with the patient, who stated that he wanted to drink as he was upset, bothered by memories, and could not sleep. He agreed to not press his father for more alcohol, to call the following morning to let the Vet Center staff know how he was, and to make an appointment with the combat veteran outreach coordinator.

Later that same evening, the patient's family called the Vet Center again concerned that the patient had shown his father a place where he had been thinking of hanging himself. The patient was unwilling to go anywhere with his father to seek help. The readjustment counselor advised the patient's family to call the police for assistance. His family expressed reluctance to call the police. The readjustment counselor noted that the family member responded, "If I do that, there will be trouble." The readjustment counselor then inquired about the availability of weapons in the home. The family reported there were no guns, but there were several knives in the home and that the patient had threatened to use knives if the police came to the house.

The readjustment counselor then spoke with the patient on the phone. The patient was not threatening suicide but reported feeling "fed up." The readjustment counselor and the patient talked a long time about his feelings. They talked about his feelings that "there was no one who he believes can help him or cares enough to help him." The patient reportedly "did admit that he hasn't really looked hard to see what options for help exist." The readjustment counselor confirmed with the patient that he (the patient) would call in the morning to make an appointment. The readjustment counselor spoke again with the patient's family "stressing" that if the patient's family felt concern for the patient's safety, they should call the police. The following morning the readjustment counselor discussed these phone calls with the combat veteran outreach coordinator.

The combat veteran outreach coordinator spoke with the patient who reported that he had "not been doing good." The combat veteran outreach coordinator documented in the patient's Vet Center record that the patient was short/brief and seemed as if he were angry. When asked how he was doing "all he answered was fine." The patient did not have transportation to visit the Vet Center that day. The combat veteran outreach coordinator arranged to visit the patient at his home later that day. The coordinator and the patient's private therapist spoke later that day regarding background history and coordination of care. In addition, they shared concerns about the patient. Records indicate that the plan was to try to steer the patient toward agreeing to treatment at an intensive inpatient treatment program. They discussed inpatient PTSD programs at

VAMCs in neighboring states. Later, that day, the coordinator phoned the patient again. Receiving no answer, he left a voice mail message for the patient indicating he was leaving the office to come to the patient's home. However, he was unable to find the patient's home and called from a gas station to request assistance, but there was again no answer.

In the early evening, the veteran's father returned home from work and found the patient in the basement. He had committed suicide. The combat veteran outreach coordinator received a telephone call from the patient's private therapist the following day to inform him of the suicide. At the discretion of the State Medical Examiner no autopsy was performed.

Following the patient's death, his parents completed a VAMC Release of Information form requesting all computer records regarding the patient's care at the VAMC. The patient's parents were provided a copy of the patient's medical records. In the early winter of 2004, the Associate Director at the VAMC received a letter from the patient's father requesting any and all written documents, statements, and records regarding his son. The patient's father received a letter 1 week later, from the Privacy/Freedom of Information Act (FOIA) Officer indicating that the information requested was overly broad. The letter asked the patient's father to provide clarification of the records sought. Two weeks later, the patient's father phoned the Privacy/FOIA Officer and sent her a letter requesting, under FOIA, all records regarding his son "including but not limited to the psychological autopsy and systems failure analysis." The patient's father subsequently received a letter from the VAMC citing exemption for these materials under Section 5705 of Title 38 of the United States Code. The patient's father was informed that a request to appeal this determination could be sent to the VA's Office of General Counsel in Washington, DC. In response, the patient's father wrote the Privacy/FOIA Officer at the VAMC stating that "you assured us that due to the death of our son, changes were being made, but then when we ask—you fail to explain…regretfully you are forcing our hand to possibly pursue this matter through other forums."

The patient's family spoke with an aide from one of their Senators. In response, the Senator sent a letter to the VA concerning a request he had received from the patient's family. The Veterans Integrated Service Network (VISN) Director (for the region in which the patient was treated) sent a letter to the Senator indicating that the Psychological Morbidity and Mortality Review, which would contain the psychological autopsy and a review of the procedures followed, is exempt from disclosure under Section 5705 of Title 38 of the United States Code. In June 2005, after learning of the existence of the Office of Inspector General from the aide in the Senator's office, the patient's parents wrote a letter to the Senator requesting that the OIG conduct an investigation into the death of their son and the VAMC's refusal to release all medical records relating to his treatment.

5. Inspection Results – Findings and Conclusions

This inspection raises both quality of care and legal issues which are intertwined. The discussion that ensues will necessarily incorporate consideration of both clinical psychiatry and the laws of the state in which the VAMC is located as relevant to the care of this patient.

Involuntary commitment of psychiatric patients is an extremely controversial and legally complex concept that is often laden with debate and social misconceptions. Clinicians, lawmakers, policy analysts, and advocacy groups are challenged with the need to balance the states' responsibility to protect its people and society at large from dangerous psychiatric patients (police powers), and the states' responsibility to care for those mentally ill who cannot care for themselves (parens patriae), with the desire to protect and respect individual civil liberties and to provide care through the least restrictive treatment alternative and/or environment.

The American Psychiatric Association (APA) model commitment law described in the 1992 APA Task Force Report 34: Consent to Voluntary Hospitalization, attempted to set some clinical standards regarding involuntary commitment. Subsequently, many jurisdictions have included parts of the APA model commitment law into their mental health statutes. Often these laws require that one or more physicians determine that:

- A patient has a severe mental illness.
- Because of the mental illness a patient poses a substantial threat or likelihood of serious bodily harm to self or others.
- A patient is unable to survive safely in the community.
- A patient has impaired judgment or lacks capacity to understand the need for such care and treatment.
- Hospitalization is the least restrictive alternative.
- Hospitalization will reasonably improve the patient's condition or at least prevent deterioration.[10]

Issue 1: Admission Process

We found that under the provisions of State law, the basis for involuntary admission to a psychiatric facility is that a patient is given an opportunity to apply for voluntary admission and refuses and that the failure to hospitalize this patient would create a likelihood of serious harm by mental illness. Likelihood of serious harm is defined as one or more of the following:

[10] Petit, Jorge R., *Handbook of Emergency Psychiatry*, Philadelphia, PA: Lippincott, Williams & Wilkins, 2004.

- A substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at, suicide or serious bodily harm.
- A substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them.
- A very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

Since involuntary hospitalization ultimately results in denial of an individual's liberty, the State's standard of proof to involuntarily admit or hospitalize a person is that the likelihood of serious harm is deemed imminent and beyond a reasonable doubt.

The State case law reads: "Involuntary commitment must be supported by a showing by the State of imminent danger of harm; this is to assure that the individual's potential for doing harm to himself or others is great enough to justify such a massive curtailment of liberty." In addition, "in requiring that the likelihood of serious harm also be imminent, the Supreme Judicial Court added a requirement to the statutory language of General Law of [the State], which did not define the 'likelihood of serious harm' to include imminent harm…the Supreme Judicial Court added this requirement because it was linked to the standard of proof beyond a reasonable doubt (since events in the more distant future can less reliably be predicted), and to the danger of harm that is needed to justify the involuntary confinement of a person."

Under the State law, if after examining a person a licensed physician, psychiatric nurse mental health clinical specialist, or qualified licensed psychologist has reason to believe that failure to hospitalize that person would create a likelihood of serious harm by reason of mental illness, then the practitioner may restrain or authorize restraint of the person and may apply for the hospitalization of that person for up to a 72-hour period at a public or private facility.

Alternatively, any person may make application to the district court for a 72-hour commitment of a mentally ill person for whom the failure to confine would cause a likelihood of serious harm. After hearing evidence, a district court justice may issue a warrant for the apprehension and appearance before him of the alleged mentally ill person. Following apprehension, the court would have the person examined by a psychologist or a psychiatrist designated to have authority to admit to a facility. If the psychiatrist or psychologist reports that the failure to hospitalize would create a likelihood of serious harm by reason of mental illness, then the court may order the person committed to a facility for up to 72 hours.

The patient was admitted to the hospital on the Friday of a holiday weekend. On presentation to the VAMC he had a contusion visible on his right hand from having punched a dresser at home prior to his arrival at the VAMC. He was inebriated with a breathalyzer reading of 0.320g/dl (greater than legally intoxicated) and was verbalizing suicidal thoughts with a plan to hang himself. In addition, he endorsed auditory hallucinations. He bolted from the examining area of the VAMC during evaluation and, when apprehended, again verbalized suicidal ideation and physically struck out at staff. In light of the patient's verbalizations and actions in the A&D area, the MOD noted the patient to be a "clear and present danger to self and others" and completed an application for involuntary admission. The POD examined the patient, noted that the patient had a plan and intention to harm himself, and indicated there was at that time no less restrictive placement that was appropriate for the patient and to which he was willing to go, and authorized the patient's temporary involuntary hospitalization.

Conclusion: Admission Process

When the patient initially presented to the VAMC, he verbalized suicidal ideation and exhibited behavior that would lead a reasonable practitioner to determine that the failure to hospitalize would create a likelihood of serious harm by mental illness. We concluded that his involuntary admission was appropriate.

Issue 2: Inpatient Stay

The patient was admitted for medical detoxification and observation to an acute inpatient psychiatric unit and was on special observation during his hospitalization. He received treatment for alcohol detoxification. He was continued on the antidepressant fluoxetine which he had been taking at home. The patient was assessed by nursing staff and the MOD during the weekend that he was hospitalized. The MOD's documentation included evaluation of medical stability and assessment of the patient for suicidal ideation. We found that it was not medical center policy for a psychiatrist to see patients on the acute inpatient psychiatry unit during weekends and holidays.

The ward psychiatrist interviewed and evaluated the patient on the Tuesday following the holiday weekend. In our interview, the attending psychiatrist described the focus of the acute inpatient psychiatric unit to be crisis intervention, medication adjustment, and detoxification. She reported that the ward admits a variety of patients including those with dementia, depression, mania, schizophrenia, and traumatic brain injury. Although patients with PTSD are admitted to the ward for acute suicidal ideation, excessive anxiety, or marked exacerbation of their PTSD symptoms, intensive PTSD treatment does not take place on the ward. She noted that there is another ward at the medical center that has a treatment program specific to treatment of patients with PTSD.

Conclusion: Inpatient Stay

In many acute treatment paradigms, including those in private and university settings, it would not be unusual for acute alcohol detoxification to precede formalized therapy for mood, anxiety, or psychotic symptoms. Initial focus in the acute inpatient setting often includes monitoring for and pharmacologic treatment of physiologic and clinical symptoms suggestive of alcohol withdrawal or impending delirium tremens (alcohol withdrawal delirium).[11] It is not uncommon to defer definitive treatment for mood and anxiety symptoms until completion of alcohol detoxification. At that point, the persistence of mood and anxiety symptoms on serial re-assessment may reflect the presence of an underlying mood or anxiety disorder.

On the day of discharge the psychiatrist noted that the patient was not exhibiting signs of withdrawal or major affective disorder on examination. The patient declined discussion of post-traumatic stress disorder symptoms, stating that he desired to follow up with his private therapist for this issue. He requested and was discharged from the medical center, effectively precluding further serial re-examination of mood and anxiety symptoms after that time.

The VA/Department of Defense (DoD) Practice Guideline for the Treatment of Post-Traumatic Stress notes that antidepressants, particularly selective serotonin reuptake inhibitors (SSRI's), have proved effective in the pharmacologic treatment of PTSD and have been recommended as first-line agents in treatment guidelines. Cognitive therapy is a structured, present-oriented psychotherapy that has been shown to be an effective intervention for patients with PTSD.[12] During hospitalization, the patient was maintained on fluoxetine, which is a member of the SSRI family of medications. Cognitive therapy is usually conducted on an outpatient time limited basis over several months.

We concluded that the VAMC did what they could for this patient under these circumstances. We also concluded that because the VAMC is a medical center that primarily offers psychiatric care, it would be advantageous for a psychiatrist to see patients on the acute inpatient unit on a daily basis including weekends and holidays.

[11] Delirium tremens (alcohol withdrawal delirium or DTs) is a severe complication of alcohol withdrawal that may occur in up to 5 percent of patients withdrawing from alcohol. DTs may occur within a week and most often within 24–72 hours of decreasing or discontinuing alcohol consumption in a patient who has developed a physiologic dependence on alcohol. A patient in DTs may show distractibility, disorganized thinking, shifting levels of consciousness, marked autonomic hyperactivity (increased pulse, blood pressure, respiratory rate and temperature), tremors, visual and/or tactile hallucinations, tremulousness and shifting psychomotor activity from periods of lethargy to periods of restlessness and agitation. Untreated, mortality may be as high as 20 percent. (Petit, Jorge R., *Handbook of Emergency Psychiatry*, Philadelphia, PA: Lippincott, Williams & Wilkins, 2004.)

[12] VA/DoD Clinical Practice Guideline Working Group, *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress,* Washington, DC: Veterans Health Administration, Department of Veterans Affairs and Health Affairs, Department of Defense, 2003. pp. .I-5 and I-20.

Issue 3: Discharge Process

Under State law, a person who is admitted to a psychiatric facility on an involuntary basis will be discharged at the end of 72 hours, unless it is determined that the failure to hospitalize at that point would create a likelihood of serious harm by mental illness. If the facility superintendent determines that failure to hospitalize would create a likelihood of serious harm, then the facility superintendent can petition the district court in whose jurisdiction the facility is located for commitment of the patient to the facility.

On the fourth day of hospitalization, the patient requested discharge from the hospital. The psychiatrist who examined him that day noted no signs of psychosis, major affective disorder, cognitive behavioral disorder or organicity. He denied suicidal and homicidal ideation and was "currently not an imminent danger to harm self or others." Had the psychiatrist felt that failure to hospitalize the patient would create a likelihood of serious harm by reason of mental illness, a petition to the district court for commitment to the facility could have been filed with the court. The attending psychiatrist reported that "All of these people [psychiatric unit staff] were checked by me about that, to see if there is anything that could show me that I could keep the patient in my ward against his will. That was—I was looking, is there something that he gave me that I can take him to court and continue, just to protect him, but I couldn't find anything."

Conclusion: Discharge Process

By the time the patient requested discharge on the fourth day of hospitalization, he was not exhibiting behavior that would justify applying for a court ordered commitment under the provisions of State law.

Issue 4: Referral to a Specialized Inpatient PTSD Program

The VAMC offers a specialized inpatient PTSD treatment program located at the medical center. Key points for admission into the program include:

- The need for a patient to remain active in outpatient treatment for PTSD. The criteria specify that a patient must go to outpatient treatment for PTSD at least two times a month.
- The patient must stay completely alcohol and street drug free. (Medical center staff reported that, at the time the subject of this report was in the hospital, the expectation prior to admission was sobriety for several months.)
- The patient must be off all benzodiazepine[13] medications such as diazepam, clonazepam, alprazolam, temezapam, etc. for at least 30 days before program admission.

[13] A class of medication used to treat anxiety or for detoxification from alcohol.

The VA/Department of Defense (DoD) Practice Guideline for the Treatment of Post–Traumatic Stress, Module B, suggests that for patients with PTSD and substance abuse (SA), "integrated treatment should be considered. Substance abuse patients with PTSD should be educated about the relationships between PTSD and substance abuse, referred for concurrent PTSD treatment or provided with integrated PTSD/SA treatment. Substance abuse-PTSD patients should receive follow-up care that includes a continued focus on PTSD issues." The module notes that therapies that integrate treatment for PTSD and substance abuse are now being developed and evaluated in random controlled trials.

Conclusion: Referral to a Specialized Inpatient PTSD Program

The potential benefit from a specialized therapeutic program is diminished if a patient is acutely intoxicated or chronically inebriated. In this case, the patient had the option to receive SA and PTSD treatment as an outpatient at the VAMC. However, he declined follow-up treatment at the VAMC and opted to follow up with his private therapist in the community. However, we note that if the patient, a returning OIF veteran, had desired specialized inpatient PTSD treatment at the VAMC once detoxified, he would not have satisfied usual criteria for admission to the specialized ward and may not have been able to access care in the program at that time.

Issue 5: Impact of Ward Milieu

The patient expressed to several people that while nurses on the inpatient psychiatric ward to which the patient had been admitted were nice to him, he felt uncomfortable on the ward because "you got really crazy people up there." The ward reportedly tends to have a mix of patients, including those actively hallucinating and responding to internal stimuli from schizophrenia and those with incontinence and agitation in the context of dementia. In addition, we were told by the ward nurse and the patient's family that most of the patients were older than this veteran and there was not an OEF/OIF peer group of patients present on the ward. In addition, the patient's parents reported that the patient told them that while on the inpatient unit he felt "like a prisoner rather than a veteran." They reported that the patient was discontented by not being able to go on smoke breaks and to attend holiday related, off-ward activities due to his special observation status. We found that it was not medical center policy for a psychiatrist to see patients on the acute inpatient psychiatry unit during weekends and holidays.

Conclusion: Impact of Ward Milieu

The National Center for PTSD *Iraq War Clinician Guide* indicates that "in the treatment of chronic PTSD, veterans often report that perhaps their most valued experience was the opportunity to connect in friendship and support with other vets. This is unlikely to be different for returning Iraq War veterans, who may benefit greatly from connection both

with each other and with veterans of other conflicts." [14] Although we do not know if other OEF/OIF veterans would prefer or benefit from the presence of OEF/OIF-era-specific peers and programming on an inpatient unit, we found that this issue was a concern for this particular patient. It may have influenced his request for discharge following his involuntary commitment; furthermore, it may also have had a significant impact on his willingness to be readmitted later.

Because he had voiced suicidal ideation on presentation to the A&D area and on admission to the inpatient unit, the patient was maintained on special observation. As a result he was unable to go on smoke breaks or to attend off-ward holiday activities. Depending on the patient's clinical examination at the time, if a psychiatrist had been required to see patients on weekends and holidays, then an opportunity may have existed to liberalize the patient's observation status during the holiday weekend. In addition, the presence of a psychiatrist on the weekend may have facilitated development of therapeutic alliance. It would be purely a matter of speculation, however, as to whether the presence of a psychiatrist during the weekend would have resulted in liberalization of the patient's observation status and whether his view of hospitalization would have subsequently differed.

Issue 6: Arrangement of a Discharge Planning Meeting with Family

On the day of discharge, the patient signed a release of information authorizing contact with his mother. We could not find evidence that the patient's parents were invited to a discharge planning meeting to discuss aftercare arrangements.

Conclusion: Arrangement of a Discharge Planning Meeting with Family

In the context of a returning OIF veteran who was new to the VA system, ward clinicians missed a chance to invite the patient's family to a discharge planning meeting. On the day of discharge the patient had signed an authorization to release information to his mother. A discharge planning meeting could have provided an opportunity to further discuss treatment options, enhance communication, and to clarify patient and family concerns. In addition, this type of meeting might have provided an opportunity to facilitate greater patient receptivity and "buy-in" for additional VAMC treatment options.

Issue 7: Contact with Patient's Private Health Care Practitioners

The patient declined follow up at the VAMC; therefore, no aftercare appointment was scheduled with the mental health clinic at the VAMC. The patient indicated that he would follow up with his private therapist. On the evening of hospitalization, the patient

[14] Schnurr, Ph.D., Paula P., National Center for PTSD and COL Stephen J. Cozza, MC, USA, Walter Reed Army Medical Center, editors, *Iraq War Clinician Guide, 2nd edition*, Department of Veterans Affairs National Center for PTSD, June 2004. pp. .36-37.

was asked to sign a release of information authorizing VAMC staff to speak with outside providers. However, he declined to sign.

Conclusion: Contact with Patient's Private Health Care Practitioners

The patient declined follow up at the VAMC mental health clinic. Although communication with the patient's outside therapist and primary care physician would have been preferable, the patient did not sign an authorization for release of information to these individuals.

Issue 8: Patient Declined Admission

When the veteran returned to the grounds of the VAMC 4 days after being discharged, nursing staff urged him to enter the hospital building to speak with a physician. He remained outside the area of the building but agreed to speak with a nurse who had cared for him during his recent prior admission and with whom he had developed some rapport. He refused to enter the building or to speak with the physician. He was described by clinical staff as calm, in control, and capable of holding an appropriate conversation. He denied being a danger to himself or others. The patient had expressed dissatisfaction with not being able to go on smoke breaks and feeling like he was not trusted during his inpatient hospitalization. The nurse explained to the patient that he would try to make arrangements for the patient to go on smoke breaks, to be on the ward without restriction, and to "make it as comfortable for him as we could…." Despite the nurse's attempt to persuade the patient to be admitted to the VAMC on a voluntary basis, the patient declined.

Conclusion: Patient Declined Admission

In contrast to his first presentation and subsequent admission to the medical center a week earlier, the behavior documented in the progress note for the encounter outside of the A&D area 4 days after his discharge does not support a finding that the failure to hospitalize would create a likelihood of serious harm by mental illness that is needed to support a 72-hour involuntary admission. The patient was not observed by clinical staff to be agitated, threatening, or psychotic. He denied suicidal and homicidal ideation. However, this must remain a qualified conclusion since the patient was not formally examined by a physician, psychiatric nurse mental health clinical specialist, or a qualified psychologist, who are the medical professionals authorized under the applicable section of the state law to restrain or authorize the restraint of a person and apply for involuntary admission.

While clinical staff appeared genuinely concerned and spent considerable time with the patient outside of the A&D area, they did not avail themselves of the opportunity to call the POD. Although the description of the patient's verbal and behavioral presentation

during his encounter with the nurse, nursing clinical coordinator, and MOD does not satisfy criteria needed to support application for involuntary admission, the POD was the best equipped to take ultimate responsibility for the final determination as to whether the patient could be admitted against his will. We concluded that the POD should have been consulted.

Issue 9: Communication with Patient and Family Following the Interaction Outside of the A&D Area

The medical center did not initiate contact with the patient or his family between the time of the encounter outside of A&D on medical center grounds and the time of his mother's phone call to the medical center triage desk 10 days later. The patient representative was contacted and in turn asked if a clinician from the mental health clinic could call the patient's mother regarding her (the patient's mother's) concerns. The patient representative was advised by the clinician from the mental health clinic that the patient should come into the Psychiatric Day Clinic for an evaluation. The patient's mother had told the patient representative that the patient was unwilling to come to the facility. Because of both the veteran's reluctance to return to the VAMC and his apparent need for further mental health services, the patient representative then facilitated connection between the patient, his family, and the Vet Center. The patient representative contacted the Vet Center on that day and requested an appointment for the patient; as a result of that call, the patient and his family were contacted and offered an appointment at the Vet Center.

Conclusion: Communication with Patient and Family Following the Interaction Outside of the A&D Area

Following the interaction outside of A&D, initiation of a follow-up phone call by VAMC staff to the patient and/or family would have provided an opportunity to exceed usual care and to provide outreach. In doing so, the medical center would have been afforded an opportunity to convey ongoing interest in and concern for the patient and his family, to verify that the patient was, in fact, pursuing aftercare with non-VA providers, and to attempt to re-engage the patient in contemplation of more intensive treatment options available at the VAMC, one of the region's other VA medical centers, or elsewhere. While a follow-up phone call would have afforded the VAMC the opportunity for outreach, it is speculative whether the outcome would have been affected.

Issue 10: Interaction with the Vet Center Clinicians

The patient and his father met with the combat veteran outreach coordinator at the Vet Center. The coordinator spoke with the patient and his father for approximately 2 hours. During this assessment process, the patient denied current ideas or active plans for suicide. Subsequent to the assessment at the Vet Center, the patient did not have any

face-to-face meetings with VA personnel. The patient was seen by his private therapist 3 days later. At that visit, he reportedly contracted for safety. Later that evening, the patient's father spoke with the readjustment counselor at the Vet Center, expressing concerns about the patient, and was advised to call the police. The readjustment counselor subsequently spoke with the patient on the phone. The patient reported his belief that there was no one who could help him or cared enough to help him, but he denied suicidal ideation. The next morning, the combat veteran outreach coordinator spoke to the patient on the telephone. The patient reported that he had "not been doing good" but, when questioned if he was having any ideas of harming himself, replied "no." On the day of the patient's death, the combat veteran outreach coordinator communicated and discussed coordination of care with the patient's private therapist.

Conclusion: Interaction with the Vet Center Clinicians

The records of the patient's conversations with Vet Center personnel do not provide support for an involuntary admission under the State statute.

Issue 11: Disclosure of Records

We found that the family requested and received the patient's medical record. However, the family did not receive copies of internal patient care reviews, such as a Root Cause Analysis and psychiatric morbidity and mortality report that were performed by medical center clinicians under the auspices of its quality assurance program. Quality assurance records are designed to assist a health care facility to improve the quality of patient care; the confidentiality of these records is designed to facilitate that patient care improvement. The VAMC's inability to release these internal quality assurance documents to the patient's family was not specific to this patient. Rather, it is the usual standard and practice followed by hospitals, not only within the VA system, but also by those in the academic, state, and private sectors. Such documents are considered protected quality assurance records and are exempt from disclosure under Section 5705 of Title 38 of the United States Code. There is no discretion on the part of the facility regarding the release of quality assurance material; the statute authorizes release in only a few, extremely specific instances, which were not present here.

Conclusion: Disclosure of Records

We concluded that the medical center provided the family with the medical record but properly withheld internal quality assurance documents. Had VAMC staff been clearer in communicating the rationale, the patient's family may have understood that they had already received all documents that could legally be released to them.

6. Changes Made by the VAMC

Following this patient's death, we found that the following actions have already been undertaken by the VAMC:

1. A social worker was assigned to serve as the point of contact for treatment of all OEF/OIF veterans; this social worker is available to see OEF/OIF veterans immediately in urgent situations and within 1-2 weeks of initial presentation in non-urgent situations.

2. The point of contact for administrative and other concerns for OEF/OIF is the facility patient representative.

3. Staff who may have contact with a OEF/OIF veterans have been educated regarding the different program options, as one may be more acceptable than others to certain veterans.

4. All on-call physicians have been instructed to call the POD regarding potential admissions, emphasizing the need to make such a call when the decision is made not to admit a patient. This practice was reinforced by a memorandum from the Chief of Staff.

5. Night on-call physicians and off-tour Nursing Supervisors have been instructed to report to the Psychiatry Day Clinic any instance of patients who are not admitted to the hospital for that day. The clinician in the Psychiatry Day Clinic will make a follow-up phone call to these patients the following day to inquire about their status and to offer further services.

6. A mental health clinician has been designated as a liaison to the Vet Center so that a freer flow of communication exists between the two systems. The liaison has begun regular meetings with a similarly designated clinician from the Vet Center.

7. Recommendations

Recommended Improvement Action 1. The VISN Director should ensure that the VAMC Director takes action to ensure that the on-call Medical Officer of the Day is actively involved in, and the Psychiatric Officer of the Day is consulted, as necessary, on all cases in which suicidal or homicidal ideation is an issue.

Recommended Improvement Action 2. The VISN Director should ensure that the VAMC Director takes action to ensure that the VAMC clinical staff leadership re-evaluates admission criteria for newly diagnosed PTSD patients to the specialized inpatient PTSD program.

Recommended Improvement Action 3. The VISN Director should ensure that the VAMC Director takes action to ensure that newly admitted and/or patients admitted to

the inpatient psychiatry unit on a temporary involuntary hold are evaluated by a psychiatrist on a daily basis, including on weekends and holidays.

8. Director's Comments

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action 1.

The VISN Director should ensure that the VAMC Director takes action to ensure that the on-call Medical Officer of the Day is actively involved in, and the Psychiatric Officer of the Day is consulted, as necessary, on all cases in which suicidal or homicidal ideation is an issue.

Concur Target Completion Date: Completed

The Medical Center has established a procedure whereby the on-call MOD is to call the POD to review all possible admissions, with particular attention paid to cases where suicidal or homicidal ideation is present. This procedure has been communicated with all psychiatrists, AOD and fee-basis MODs. Additionally, emphasis has been placed on the importance of discussing cases with the POD when the decision has been made not to admit a patient, as these are patients who may be considered to be at higher risk. All patients who present requesting admission, but are not hospitalized, are entered into a log in the Admission & Discharge area. This log is reviewed on a daily basis by a Mental Health clinician and a phone call is made to the veterans listed inquiring about their condition ensuring follow up is offered and/or provided.

Recommended Improvement Action 2.

The VISN Director should ensure that the VAMC Director takes action to ensure that the VAMC clinical staff leadership re-evaluate admission criteria for newly diagnosed PTSD patients to the specialized inpatient PTSD program.

Concur Target Completion Date: October 1, 2006

The PTSD inpatient unit is in the process of redesigning its treatment program to accomplish the following objectives:

1. Increase access for recently diagnosed PTSD patients.

2. Design a program to concurrently treat substance abuse and PTSD (a dual-diagnosis track within the spectrum of treatments).
3. Creation of a PTSD Clinical Team that would provide accessible, outpatient PTSD treatment to all patients thus preventing hospitalizations.

Recommended Improvement Action 3.

The VISN Director should ensure that the VAMC Director takes action to ensure that newly admitted and/or patients admitted to the inpatient psychiatry unit on a temporary involuntary hold are evaluated by a psychiatrist on a daily basis, including on weekends and holidays.

Concur Target Completion Date: March 3, 2006

A local policy is being developed that addresses the need for newly admitted and/or patients admitted to the inpatient psychiatry unit on a temporary involuntary admission are evaluated by a psychiatrist on a daily basis, including weekends and holidays. This policy will become effective on March 3, 2006. In addition, the VISN Mental Health Service Line is developing a similar policy for all VISN facilities.

9. OIG Comments

The Director agreed with the findings and recommendations, and their proposed actions are appropriate and responsive. We will follow up on the implementation of the planned actions until they are completed.

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

Appendix A

OIG Contact and Staff Acknowledgments

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Appendix B

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