DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm

NATIONAL REVIEW | REPORT #21-00175-19 | NOVEMBER 17, 2022

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Executive Summary

In 2019, an average of approximately 17 veterans died by suicide each day with 69 percent of veteran deaths by suicide due to self-inflicted firearms injury.[1] Further, although non-veteran firearm-involved suicide deaths decreased from 2001 to 2019, firearm-involved suicide deaths rose 3 percent among male veterans and 13 percent among female veterans.[2] Approximately 85 percent of individuals who attempt suicide with a firearm die from their injury and the time interval between deciding to act and attempting suicide may be just 5 or 10 minutes.[3] Simple interventions that educate and encourage veterans and caregivers on safe storage practices, such as use of a gun safe or lock box, and storing firearms unloaded and separate from ammunition, may increase the time between deciding to act and making a suicide attempt. These simple interventions may be critical in preventing suicide.

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration's (VHA) lethal means safety training, firearms access assessment, and safety planning compliance. Specifically, the OIG evaluated

- staff training compliance related to the assessment of lethal means access;
- suicide risk assessment, including firearms access information and storage discussions, prior to fatal firearm-related suicides and following non-fatal firearm-related suicide behavior;
- safety plan completion, integrating firearms access and storage discussions, prior to fatal firearm-related suicides and following non-fatal firearm-related suicide behavior; and
- survey results from VHA leaders, suicide prevention staff, and clinicians regarding perspectives on select suicide prevention procedures including lethal means interventions.

In November 2019, VHA implemented a suicide risk identification strategy that included a standardized suicide risk screening and, if a patient screened positive for suicide risk, comprehensive suicide risk evaluation (CSRE). The CSRE template prompts the clinician to

[1] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[2] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[3] Catherine L. Dempsey et al., "Association of Firearm Ownership, Use, Accessibility, and Storage Practices With Suicide Risk Among US Army Soldiers," JAMA Network Open, (June 7, 2019): 1-10.

assess the patient's access to lethal means and, depending on risk level, complete a safety plan.[4] A year later, VHA implemented a "one-time mandatory" Lethal Means Safety Education and Counseling for Providers course (LMS training) and required all "VHA health care providers," including Vet Center counselors, to complete the web-based training by January 31, 2021.[5] In March 2022, VHA implemented one-time LMS training within 90-days of employment for all new healthcare providers and any current provider who has not completed the course. In June 2022, VHA issued guidance indicating a target of 95 percent completion compliance with LMS training.[6]

Training Compliance

The OIG found that all 18 Veterans Integrated Service Networks (VISNs) and 5 Vet Center Districts achieved an average of greater than 90 percent compliance with suicide risk training requirements.[7] However, 6 of 18 VISNs fell below an average of 90 percent compliance with LMS training completion. Office of Mental Health and Suicide Prevention leaders told the OIG that medical center directors were responsible for monitoring training compliance. Of the 183 medical center and VISN leaders who completed the OIG survey, 150 (82 percent) reported monitoring lethal means training compliance and the majority (87 percent) of those who said they monitored lethal means training compliance delegated the responsibility to other staff including suicide prevention, mental health, and education staff.

In May 2022, VHA established more stringent oversight of suicide risk training that outlined medical center, VISN, and national oversight responsibilities for suicide risk training compliance and monitoring.[8] However, LMS training compliance was not identified in this enhanced oversight.[9] Given the high prevalence of firearm-related veteran suicides and that suicide

[4] VA Safety Plan Quick Guide for Clinicians. "What is a Safety Plan?" accessed April 25, 2022, https://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf. A safety plan is a concise and comprehensible written list of coping strategies and sources of support, developed with a patient for use before or during a crisis.

[5] VHA Assistant Under Secretary for Health for Operations, *Lethal Means Safety (LMS) Education and Counseling*, November 2, 2020. "Vet Centers (Readjustment Counseling)," accessed April 27, 2022, https://www.vetcenter.va.gov/index.asp. A health care provider was defined as "a full-time, part-time, or intermittent employee engaged in patient care as a Physician, Psychologist, Registered Nurse, Social Worker, Physician Assistant, Pharmacists, and Dentist, as well as any employee serving in the capacity of Case Manager or Vet Center Team Leader and Counselor." "Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active duty service members, including National Guard and Reserve components, and their families."

[6] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memo, *Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification,* June 9, 2022. Prior to the memo issuance, the OIG used a 90 percent compliance benchmark in this inspection.

[7] "Vet Centers (Readjustment Counseling)," accessed April 27, 2022, https://www.vetcenter.va.gov/index.asp."

[8] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022.

[9] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022.

prevention is the VA's "top clinical priority," the OIG would expect rigorous monitoring and action planning at the medical center, VISN, and national levels to address both suicide risk and LMS training deficiencies.[10] Further, the OIG would expect ongoing LMS training rather than a one-time course at the onset of employment with VHA.

Suicide Risk Identification Strategy and Safety Planning Practices

In 2018, VHA introduced a standardized three-stage suicide risk screening and assessment process consisting of a primary screen, secondary screen, and CSRE.[11] The CSRE includes

- assessment of suicidal ideation, behavior, and attempts; preparatory behavior; warning signs; risk; and protective factors;
- clinical impressions of acute and chronic suicide risk; and
- development of a risk mitigation plan.[12]

In 2018, VHA implemented a nationally standardized safety planning note template that includes documentation of firearms access.[13] VHA instructs clinicians to "[a]lways ask about access to firearms," and, if firearm safety was not discussed, document the reason that firearm safety was not discussed. VHA further instructs clinicians to consider "options for improving safe storage," with patients who report access to firearms.[14]

The OIG examined the electronic health records (EHRs) of 480 patients with fatal (65) and non-fatal (415) firearm-related suicide behavior events to evaluate compliance with suicide risk assessment and safety planning expectations. The OIG found that among 15 patients with fatal firearm-related suicide behavior events who required a CSRE prior to the event, three did not have documentation. Of the remaining 12 CSREs, 6 failed to include firearms access

[10] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf; "Suicide Prevention," VA, accessed April 27, 2022, https://www.mentalhealth.va.gov/suicide_prevention/.

[11] Deputy Under Secretary for Health for Operations and Management memo, *Suicide Risk Screening and Assessment Requirements,* May 23, 2018. Deputy Under Secretary for Health for Operations and Management memo, *Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation,* November 2, 2018. The May 23, 2018, memorandum refers to a comprehensive suicide risk assessment; however, the November 2, 2018, memorandum establishes the term CSRE.

[12] The CSRE template guides the completion of a risk mitigation plan that may include actions such as initiation of involuntary hospitalization, involvement of family in patient's care, lethal means safety counseling, increased symptom management, and safety plan update or completion.

[13] Deputy Under Secretary for Health for Operations and Management memo, *Suicide Prevention Safety Plan National CPRS Note Templates Implementation,* June 1, 2018.

[14] "Safety Plan Reminder Dialogue Template: Instruction Guide," VHA Office of Mental Health and Suicide Prevention SharePoint site.

information. Further, of the 6 suicide risk assessments with documented firearms access, 3 failed to discuss safe storage with the patient.

Among the 65 fatal firearm-related suicide events reviewed, 44 did not require a safety plan due to having no prior VHA mental health engagement or screening negative on a prior suicide risk screen. Of the 21 patients for whom the OIG would have expected a safety plan, 4 did not have a safety plan completed. Seventeen patients had a documented safety plan prior to their fatal suicide behavior event; however, 4 of the safety plans did not include firearms access information. Among the 13 safety plans that assessed firearms access, one did not address safe storage.

Among patients with non-fatal firearm suicide behavior events, the OIG found that VHA staff had a 92 percent compliance rate with the suicide risk screening completion and 90 percent compliance rate with CSRE completion. The OIG determined staff failed to include safe storage discussions in approximately 30 percent of CSRE mitigation plans when patients had reported access to firearms.

The OIG found that, following non-fatal suicide behavior events, 15 percent of EHRs did not have safety plans as expected and 4 percent of completed safety plans did not include firearms access information. Further, among patients who reported access to firearms, 21 percent did not document safe storage discussions when safety planning.

Ninety-five percent of medical center and VISN leaders reported monitoring compliance with the suicide risk identification strategy and the majority (87 percent) of them reported delegating this responsibility to suicide prevention or mental health staff. Leaders reported staff's feedback regarding perceived barriers to completing suicide risk identification strategy included taking too much time, changing requirements, being too repetitive, frustrating patients, and being confusing.

Given the prevalence of firearm-related suicidal behavior among veterans and the effectiveness of diminished access to firearms in the reduction of suicide, suicide risk assessment and safety planning should include both firearms access and discussion of safe storage. Failure to adequately assess firearms access and discuss safe storage of firearms may contribute to a failure to promote distance between the patient and firearms as a means of suicide.

Staff Perspectives on LMS Training and Lethal Means Interventions

All 174 suicide prevention staff surveyed completed LMS training and approximately 35 percent reported that completing the training affected the frequency with which they asked patients about firearms access and discussed safe storage. Nearly three-quarters reported that LMS training adequately prepared them for patient discussions related to firearms access and firearms storage. Over 90 percent of suicide prevention staff reported assessing firearms access and discussing safe storage with most or every patient when assessing suicide risk and safety planning.

However, fewer suicide prevention staff, approximately 85 percent, reported documenting firearms access and safe storage discussions.

Of the 3,094 clinicians surveyed, 10 percent did not complete the mandatory LMS training. Over one-third of clinician respondents who completed LMS training reported that completing the training affected the frequency with which they assessed firearms access and discussed safe storage with patients. The OIG found that among clinician respondents who completed the LMS training, 75 percent reported asking most or every patient about firearms access when assessing suicide risk and approximately 81 percent reported asking most or every patient about firearms access when safety planning. In contrast, among clinician respondents who did not complete the LMS training, 50 percent reported asking most or every patient about firearms access when assessing suicide risk and 56 percent reported asking most or every patient about firearms access when safety planning.

Approximately three-quarters of clinicians who completed LMS training and about half of clinicians who did not complete the training reported discussing firearms storage with patients during risk assessment and safety planning. Further, approximately 15 percent of clinicians who completed LMS training reported assessing firearms access and discussing safe storage with few or no patients, while about a third of clinicians who did not complete LMS training reported assessing firearms access and discussing safe storage with few or no patients. Additionally, about 60 percent of clinicians who completed the LMS training reported documenting firearms access information and safe storage discussions in patients' EHRs, while about a third of clinicians who did not complete the training reported documenting firearms access and safe storage discussions in patients' EHRs. Although the OIG would expect information about firearms access and safe storage discussions to be documented in all patients' EHRs, completion of LMS training appears to enhance the likelihood that clinicians initiate and document those critical discussions with patients.

Most clinicians reported that educational and cultural barriers such as mistrust of authority or government systems, fear of infringement of Second Amendment rights, and reluctance to give up means of self-protection were factors that might impede patient disclosure of firearms access.[15] Although LMS training appears to increase clinicians' confidence that discussions with patients about their firearms access and storage decreases a patient's suicide risk, educational and cultural factors may continue to be barriers to staff's engagement in firearms access and safe storage discussions with patients.

[15] Constitution Annotated, "Constitution of the United States, Second Amendment," accessed August 1, 2022, https://constitution.congress.gov/constitution/amendment-2/. The text of the Second Amendment includes "the right of the people to keep and bear Arms."

The OIG made seven recommendations to the Under Secretary for Health related to compliance with suicide risk and LMS training requirements; evaluation of VISN and Office of Mental Health and Suicide Prevention oversight for suicide risk training compliance and consideration of oversight for LMS training; evaluation of the adequacy of the one-time LMS training; completion of CSREs including the discussion and documentation of firearms access and safe storage; completion of safety plans including the discussion and documentation of firearms access and safe storage; evaluation of staff's perceived barriers to completion of the suicide risk identification strategy; and evaluation of educational and cultural barriers to staff conducting and documenting patient discussions related to firearms access and safe storage practices.

Comments

The Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see appendix F). The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

CSRE	comprehensive suicide risk evaluation
EHR	electronic health record
LMS	Lethal Means Safety Education and Counseling for Providers
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration's (VHA) lethal means safety training, firearms access assessment, and safety planning compliance. Specifically, the OIG evaluated

- staff training compliance related to the assessment of lethal means access;
- suicide risk assessment, including firearms access assessment and storage discussions, prior to fatal firearm-related suicides and following non-fatal firearm-related suicide behavior;
- safety plan completion, integrating firearms access and storage discussions, prior to fatal firearm-related suicides and following non-fatal firearm-related suicide behavior; and
- survey results from VHA leaders, suicide prevention staff, and clinicians regarding perspectives on select suicide prevention procedures, including lethal means interventions.

Background

Since 2016, the VA has conducted annual national "suicide surveillance" to inform suicide prevention efforts.[1] In 2021, VA reported that from 2001 through 2019, the number of adult deaths by suicide increased by 55 percent with veteran deaths increasing by 4.5 percent.[2] However, during that period, the veteran population decreased by 23.1 percent while the U.S. adult population increased by 26.2 percent. In consideration of the population differences, the age- and sex-adjusted suicide mortality rate in the non-veteran U.S. population increased 19.7 percent, while the veteran suicide mortality rate increased 57.2 percent from 2001 through 2019.[3] In 2019, an average of approximately 17 veterans died by suicide each day.[4]

[1] VA Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020, accessed March 11, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf.

[2] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[3] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[4] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

In 2019, 69.2 percent of deaths by suicide among veterans were due to self-inflicted firearms injury, compared to 47.9 percent in the non-veteran population.[5] Whereas firearm-involved suicide deaths decreased from 2001 to 2019 in the U.S. non-veteran population, suicide deaths involving a firearm rose approximately 3 percent among male veterans and 13 percent among female veterans.[6]

Lethal Means Assessment and Safe Storage

In 2018, VA published a 10-year national suicide prevention strategic plan that included 14 goals and 43 objectives intended to "promote wellness, increase protection, reduce risk, and promote effective treatment and recovery." One of the identified goals was to promote efforts to reduce lethal means access among veterans at risk for suicide and encourage clinicians to routinely assess lethal means access.[7]

Firearm as a means of suicide is associated with high fatality rates.[8] Approximately 85 percent of individuals who attempt suicide with a firearm die from their injury.[9] Additionally, the time interval between deciding to act and attempting suicide may be just 5 or 10 minutes.[10] A study of 135 individuals who died by suicide found that individuals storing a loaded gun or publicly carrying a gun was associated with a four-fold increase in the likelihood of death by suicide.[11] Thus, increasing the time between deciding to act and making a suicide attempt, including making it difficult to access lethal means such as a firearm, may be critical in preventing suicide. Safe firearm storage practices promote separation of individuals at risk of suicide from lethal means. Safe firearm storage practices may include

- education and counseling related to safe firearm storage, such as use of a gun safe or lock box;
- storage in a gun safe or lock box; and

[5] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[6] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[7] VA Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide 2018-2028.*

[8] Catherine L. Dempsey et al., "Association of Firearm Ownership, Use, Accessibility, and Storage Practices With Suicide Risk Among US Army Soldiers," JAMA Network Open, (June 7, 2019): 1-10.

[9] Jennifer M. Boggs et al., "General Medical, Mental Health, and Demographic Risk Factors Associated With Suicide by Firearm Compared With Other Means," Psychiatric Services, (June 2018): 677-684.

[10] Jennifer M. Boggs et al., "General Medical, Mental Health, and Demographic Risk Factors Associated With Suicide by Firearm Compared With Other Means," Psychiatric Services, (June 2018): 677-684.

[11] Catherine L. Dempsey et al., "Association of Firearm Ownership, Use, Accessibility, and Storage Practices With Suicide Risk Among US Army Soldiers," JAMA Network Open, (June 7, 2019): 1-10.

- storing the firearm unloaded and separate from ammunition.

Training Requirements

Beginning in August 2008, VHA implemented a "mandatory training of appropriate VHA health care providers on suicide risk and intervention" (suicide risk training) within 90 days of entering the position.[12] The Office of Mental Health, Center for Excellence and VHA Employee Education System developed a "web-based learning program for VHA that educates appropriate health care providers on suicide risks and interventions, and incorporates the best practices for suicide prevention."[13]

In 2014, VA released a new requirement for online suicide risk training every three years for all clinical staff, and every two years for non-clinical staff.[14] In 2017, VHA increased the frequency of mandatory suicide risk and intervention training for both clinical and non-clinical staff to annually.[15]

The Assistant Under Secretary for Health, Clinical Services told the OIG that prior to 2011, the suicide risk training did "not include any mention of lethal means." Starting in 2011, suicide risk training noted that veterans "are more likely than the general population to use firearms as a means for suicide," and in 2017, suicide risk training mentioned that "[s]afe storage of lethal means reduces suicide." Office of Mental Health and Suicide Prevention leaders told the OIG that prior to November 2020, no suicide risk training included guidance regarding assessing lethal means access and safe storage.

In November 2020, VHA required all "VHA health care providers," including Vet Center counselors, to complete a web-based "one-time mandatory" Lethal Means Safety Education and

[12] VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008. This directive was rescinded and replaced by VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014. A health care provider was defined as "a full-time, part-time, or intermittent employee engaged in patient care as a Physician, Psychologist, Registered Nurse, Social Worker, Physician Assistant, Pharmacists, and Dentist, as well as any employee serving in the capacity of Case Manager or Vet Center Team Leader and Counselor."

[13] VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008. This directive was rescinded and replaced by VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014.

[14] Department of Defense (DoD) and VA, "Joint Fact Sheet: DoD and VA Take New Steps to Support the Mental Health Needs of Service Members and Veterans," August 26, 2014. VHA Directive 1071*, Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014. VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008. A 2014 revision to VHA policy did not include change in the requirements as outlined in the 2008 directive.

[15] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. This directive was rescinded and replaced by VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022. The 2017 and 2022 directives included required training annually and the 2022 directive clarified the requirement for clinicians.

Counseling for Providers course (LMS training) by January 31, 2021.[16] The LMS training included information about the "purpose of [lethal means safety] Counseling, including how to work with Veterans and their friends and family to facilitate [lethal means safety] during high risk periods." The LMS training detailed the rationale for lethal means safety counseling and included firearm safety specifically. In March 2022, VHA extended the one-time LMS training and required all "new" healthcare providers to complete the LMS training within 90 days of entering the position and current providers who had not yet done so, complete the course "within 90 days of assignment."[17] (See figure 1.) In February 2021, Office of Mental Health and Suicide Prevention leaders told the OIG that the suicide risk and LMS training "completion expectation is 100 percent." In May 2022, VHA amended the suicide risk training policy and outlined medical center, Veterans Integrated Service Network (VISN), and national oversight responsibilities for suicide risk training compliance and monitoring.[18] In June 2022, VHA issued guidance indicating a target of 95 percent training completion compliance with suicide risk and LMS training.[19]

[16] VHA Assistant Under Secretary for Health for Operations, *Lethal Means Safety (LMS) Education and Counseling*, November 2, 2020. "Vet Centers (Readjustment Counseling)," accessed April 27, 2022, https://www.vetcenter.va.gov/index.asp. "Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active duty service members, including National Guard and Reserve components, and their families."

[17] Assistant under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memo, *Lethal Means Safety (LMS) Education and Counseling,* March 17, 2022.

[18] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022.

[19] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memo, *Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification,* June 9, 2022. Prior to the memo issuance, the OIG used a 90 percent compliance benchmark in this inspection.

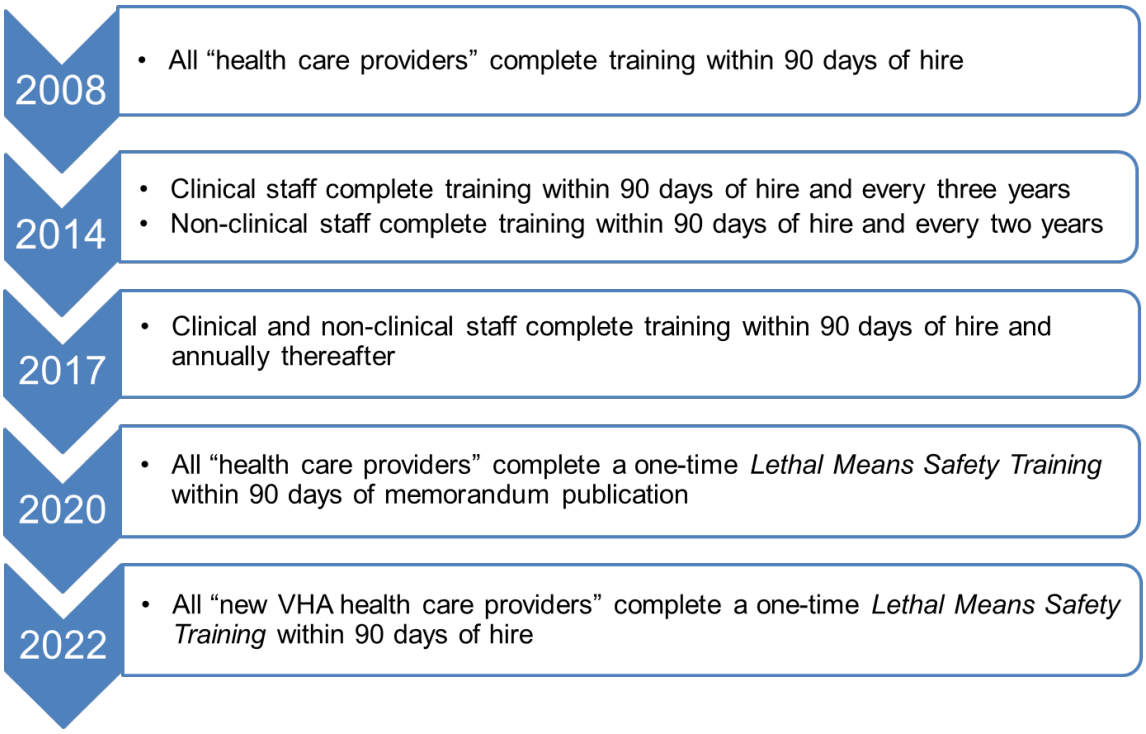

Figure 1. *VHA training requirements.*
Source: VHA directives and memoranda.[20]

Suicide Risk Identification Strategy

In 2018, VHA introduced a standardized three-stage suicide risk screening and assessment process consisting of a primary screen, secondary screen, and comprehensive suicide risk evaluation (CSRE).[21] (See figure 2.) The suicide risk screening and CSRE process was fully

[20] VHA Directive 2008-051; Department of Defense (DoD) and VA, "Joint Fact Sheet: DoD and VA Take New Steps to Support the Mental Health Needs of Service Members and Veterans," August 26, 2014. VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022. VHA Assistant Under Secretary for Health for Operations, *Lethal Means Safety (LMS) Education and Counseling,* November 2, 2020. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), *Lethal Means Safety (LMS) Education and Counseling,* March 17, 2022.

[21] Deputy Under Secretary for Health for Operations and Management memo, *Suicide Risk Screening and Assessment Requirements,* May 23, 2018. Deputy Under Secretary for Health for Operations and Management memo, *Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation,* November 2, 2018. The May 23, 2018, memorandum refers to a comprehensive suicide risk assessment; however, the November 2, 2018, memorandum establishes the term CSRE. The primary screen is the Patient Health Questionnaire-9 (PHQ-9) and the secondary screen is the Columbia-Suicide Severity Rating Scale (C-SSRS).

implemented in November 2019.[22] The suicide risk screening might not be completed for patients with treatment occurring prior to implementation of the suicide risk identification strategy, or when a secondary screen or CSRE has been completed. Additionally, VHA recommends that providers skip the suicide risk screening and complete the CSRE when "risk is already identified."

The CSRE includes

- assessment of suicidal ideation, behavior, and attempts; preparatory behavior; warning signs; risk; and protective factors;
- clinical impressions of acute and chronic suicide risk; and
- development of a risk mitigation plan.[23]

As part of the suicidal ideation assessment, the CSRE template prompts the clinician to assess the patient's access to lethal means and instructs, "specifically inquire about firearms and if present, you can comment on the [number] and storage." The CSRE template also includes lethal means access, including firearms as a possible risk factor, and lethal means safety counseling and provision of gun locks as a possible risk mitigation or safety plan strategy.

[22] Deputy Under Secretary for Health for Operations and Management memo, *Update to Suicide Risk Screening and Assessment Requirements*, September 20, 2018. Deputy Under Secretary for Health for Operations and Management memo, *Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018. Acting Deputy Under Secretary for Health for Operations and Management memo, *Eliminating Veteran Suicide: Update on Suicide Risk Screening and Evaluation*, February 22, 2019. Deputy Under Secretary for Health for Operations and Management (10N) memo, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) initiatives,* October 17, 2019.

[23] The CSRE template guides the completion of a risk mitigation plan that may include actions such as initiation of involuntary hospitalization, involvement of family in patient's care, lethal means safety counseling, increased symptom management, and safety plan update or completion.

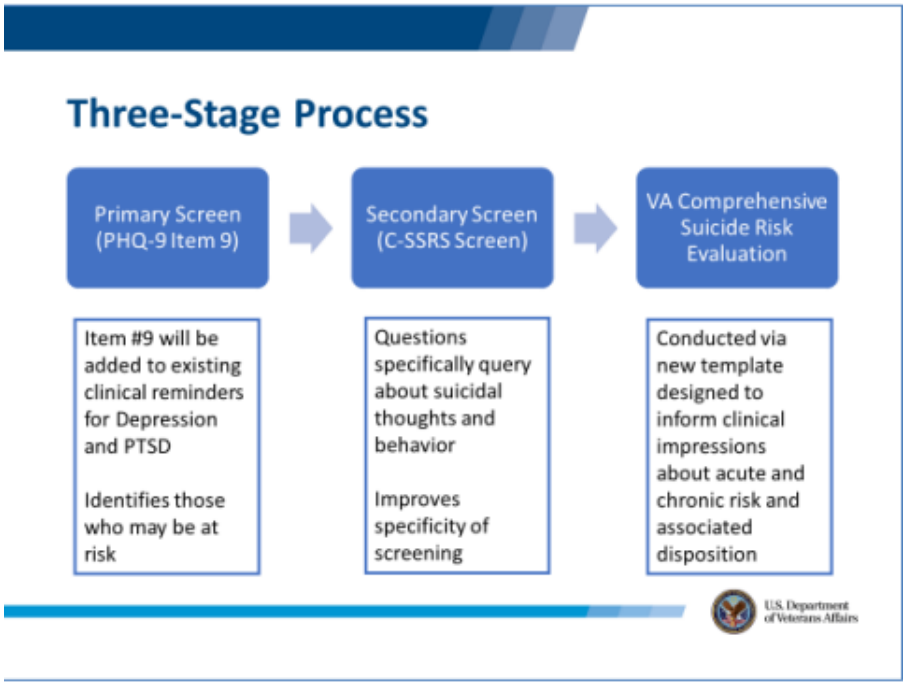

Figure 2. *Copy of VHA suicide risk identification strategy.*
Source: VA, "Department of Veterans Affairs Suicide Risk Identification Strategy Minimum Requirements by Setting Updated: 9/17/2019," June 18, 2020.

In November 2020, VHA eliminated the primary screen and established a two-stage process suicide risk identification strategy and required annual suicide risk screening of all patients receiving VHA care.[24] At that time, VHA advised that all facilities were "expected to complete 100 % of required" CSREs.[25] In June 2022, VHA issued guidance that identified a 95 percent compliance target for CSRE completion following a positive suicide risk screen.[26]

Safety Planning

The CSRE may prompt completion of a safety plan. Additionally, VHA instructs clinicians to develop a safety plan with patients who made a recent suicide attempt or expressed suicidal

[24] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020. VHA transitioned from the three- to the two-stage process on December 28, 2020. The revised guidance did not apply to the OIG's electronic health record reviews of patient suicide behavior events from October 1, 2018, through September 30, 2020.

[25] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memo, *Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification,* June 9, 2022.

[26] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memo, *Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification,* June 9, 2022.

ideation.[27] The safety plan is a written list of coping strategies and sources of support for patients to use before or during a crisis. The safety plan should be concise and comprehensible, and patients should be included in its development.[28] In 2018, VHA implemented a nationally standardized safety planning note template that includes documentation of firearms access.[29] VHA instructs clinicians to "[a]lways ask about access to firearms," and, if firearm safety was not discussed, document the reason that firearm safety was not discussed. VHA further instructs clinicians to consider "options for improving safe storage," with patients who report access to firearms.[30]

Prior OIG Reports and Congressional Hearings

From July 2020 through May 2022, the OIG published six healthcare inspection reports related to deaths involving a firearm.

From April 2019 through November 2021, six Congressional hearings highlighted the importance of lethal means safety in VHA's suicide prevention strategy. The focus of the hearings included the importance of firearms safety to reduce veteran suicides and the expansion of lethal means safety training. See appendix A for additional information regarding prior OIG reports and Congressional hearings.

Scope and Methodology

The OIG reviewed suicide risk and LMS training compliance records from 139 VHA medical centers in all 18 VISNs, and five Vet Center Districts. The OIG conducted electronic health record (EHR) reviews of a sample of 480 patients from across the 18 VISNs, identified by VHA-provided data as having a firearm-related suicide behavior event from October 1, 2018, through September 30, 2020. (See appendix B for suicide behavior events by VISN.) Of the 480 patients reviewed, 65 died by suicide using a firearm and 415 engaged in non-fatal suicidal behavior using a firearm.

The OIG team also conducted a national survey of VHA leaders, suicide prevention staff, and mental health, primary care, and emergency department clinicians to assess perspectives on select suicide prevention procedures including lethal means interventions. The OIG did not independently review the survey results to assess the validity of the reported data. The OIG team also reviewed relevant VHA policies related to suicide risk assessment, suicide risk and LMS

[27] "Suicide Prevention Safety Plan Template FAQ," May 24, 2019.

[28] VA Safety Plan Quick Guide for Clinicians. "What is a Safety Plan?" accessed April 25, 2022, https://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf.

[29] Deputy Under Secretary for Health for Operations and Management memo, *Suicide Prevention Safety Plan National CPRS Note Templates Implementation,* June 1, 2018.

[30] "Safety Plan Reminder Dialogue Template: Instruction Guide," VHA Office of Mental Health and Suicide Prevention SharePoint site.

training, and safety planning. The OIG interviewed VHA's Office of Mental Health and Suicide Prevention leaders.

Survey Development and Distribution

The OIG deployed anonymous surveys to 461 VHA leaders including VISN mental health officers, medical center directors, chiefs of staff, and mental health associate chiefs of staff. The survey focused on compliance monitoring of lethal means safety training and suicide risk assessment procedures, how leaders addressed identified deficiencies, and feedback on the suicide risk assessment process received from staff. The OIG received 220 (48 percent) completed surveys and excluded 23 surveys in which the respondent reported serving in a role other than targeted leaders and 14 surveys in which the respondent reported serving in the role for six months or less. The OIG analyzed results from 183 completed surveys.

The OIG deployed an anonymous survey to approximately 21,900 mental health clinicians, 13,500 primary care clinicians, 4,400 emergency department clinicians, and 900 suicide prevention staff.[31] The OIG received surveys from 4,170 respondents. The OIG excluded 902 surveys based on exclusion criteria.[32] The OIG analyzed 3,268 completed surveys from 174 suicide prevention staff and 3,094 mental health, primary care, or emergency department clinicians.[33] (See appendix C for additional information about suicide prevention staff and clinician respondents.)

The survey inquired about clinicians' beliefs about the adequacy of the lethal means training, how training influenced clinician behavior, additional lethal means training, clinician decision-making related to discussions of firearms access and safe storage, and the frequency of discussions regarding firearms access and safe storage. Suicide prevention staff were also asked about clinicians' requests for additional training, and expectations of clinicians in mental health, primary care, and emergency department settings.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology

[31] For the purposes of the survey, the OIG defined clinician as any of the following disciplines: physician, physician assistant, nurse practitioner, psychologist, social worker, or nurse. In consultation with the Deputy Assistant Under Secretary for Health–Clinical Services, the OIG deployed the survey to suicide prevention coordinators and case managers via a distribution list maintained by Office of Mental Health and Suicide Prevention staff to ensure the most accurate and comprehensive list.

[32] The OIG excluded 460 respondents who did not answer the item related to LMS training, 432 respondents who reported not providing direct patient care, seven respondents for whom greater than 50 percent of survey questions were blank, and three respondents who provided inconsistent information regarding their role.

[33] Three clinicians provided contradictory information related to their status as suicide prevention coordinator and the OIG included the clinicians in the clinician and not the suicide prevention coordinator survey analyses.

and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Results

Although VHA leaders reported an expectation of 100 percent training completion, the OIG found that 6 of 18 VISNs achieved less than 90 percent compliance with LMS training. For 15 applicable fatal suicide behavior events, the OIG found that 3 did not have a required CSRE. Nine of the remaining 12 events did not include the expected firearms access information or safe storage discussion. The OIG determined that following non-fatal suicide behavior events, staff did not adhere to suicide risk identification procedures as expected and failed to include safe storage in approximately 30 percent of CSRE mitigation plans when patients had reported access to firearms. Further, staff did not complete safety plans with 4 of 21 patients prior to a fatal suicide event and 60 of 400 patients (15 percent) after a non-fatal event. Eighteen percent of safety plans completed after a non-fatal event did not include safe storage discussions.

Training Compliance

The OIG evaluated training compliance with suicide risk and LMS training requirements within VHA's 18 VISNs and 5 Vet Center Districts. The OIG found that all VISN and Vet Center Districts achieved an average of greater than 90 percent compliance with annual suicide risk training requirements.[34] Four VISNs (2, 7, 19, and 23) demonstrated over 90 percent compliance across all medical centers. However, six VISNs fell below an average of 90 percent compliance with LMS training completion.[35] (See table 1.) See appendix D for the medical centers that achieved less than 90 percent compliance.

[34] "Veterans Integrated Services Networks (VISNs)," U.S. Department of Veterans Affairs, accessed June 15, 2022, https://www.va.gov/HEALTH/visns.asp. As of June 15, 2022, VHA does not have VISN 3, 11, 13, 14, or 18.

[35] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memo, *Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification,* June 9, 2022. Although the OIG reviewed data from prior to the June 2022 establishment of a 95 percent compliance with LMS training completion, it is noted that 10 VISNs fell below an average of 95 percent.

Table 1. LMS Training Compliance by VISN

VISN	Percent Compliant
1	94
2	96
4	95
5	**86**
6	**87**
7	98
8	94
9	95
10	94
12	**87**
15	96
16	96
17	**87**
19	96
20	93
21	**89**
22	**88**
23	97
Vet Center Districts	92

Source: VHA-provided compliance data as of April 26, 2021.

Recognizing that lethal means safety education, including safe storage of firearms, "can save lives and decrease risk of suicide," VHA required one-time LMS training in November 2020.[36] VHA required current healthcare providers to complete training by January 31, 2021, and did not require LMS training of new employees. In March 2022, VHA implemented one-time LMS training within 90-days of employment for all new healthcare providers and any current provider who had not completed the course.

Office of Mental Health and Suicide Prevention leaders told the OIG that the expected completion rate for suicide risk and LMS training was 100 percent. Additionally, these leaders reported that medical center directors were responsible for monitoring training compliance, "individual supervisors" typically monitored staff compliance, and "completion metrics that are reviewed nationally, however the national office is not responsible for local compliance." Office of Mental Health and Suicide Prevention leaders also told the OIG that staff who were noncompliant with suicide risk and LMS training requirements were "subject to the processes set up by each site to rectify their delinquency" and "Facilities" were responsible for monitoring

[36] VHA Assistant Under Secretary for Health for Operations, *Lethal Means Safety (LMS) Education and Counseling*, November 2, 2020.

follow-up actions to ensure compliance. In May 2022, VHA amended the suicide risk training policy and outlined oversight responsibilities including that the (1) medical center director is responsible for tracking and reporting suicide risk training compliance to the VISN Director; (2) VISN Director is responsible for reviewing compliance reports to ensure all health care providers complete required suicide risk training; and (3) Executive Director, Office of Mental Health and Suicide Prevention is responsible to ensure corrective action in response to non-compliance.[37]

The OIG determined that, as of July 2021, the majority of medical center directors delegated monitoring and oversight of LMS training to other leaders and staff. In May 2022, VHA established more stringent oversight of suicide risk training. However, LMS training compliance was not identified in this oversight plan. [38] Given the high prevalence of firearm-related veteran suicides and that suicide prevention is the VA's "top clinical priority," the OIG would expect rigorous monitoring and action planning at the medical center, VISN, and national levels to address both suicide risk and LMS training deficiencies.[39] Further, the OIG would expect ongoing LMS training rather than a one-time course at the onset of employment with VHA.

Suicide Risk Identification Strategy and Safety Planning Practices

Suicide Risk Identification Strategy

The OIG examined the EHRs of

- 65 patients with fatal firearm-related suicides to determine whether VHA staff completed the required suicide risk identification strategy process, and
- 415 patients with non-fatal suicide behavior events to determine whether VHA staff appropriately conducted the suicide risk identification strategy process following the non-fatal event.

Fatal Suicide Behavior Events

Of the 65 fatal suicide behavior events, 50 did not require a CSRE due to negative risk screens or no prior VHA treatment. Three patients did not have documentation of required CSREs. Twelve patients who screened positive on suicide risk screenings appropriately had CSREs documented prior to their fatal suicide behavior event. However, 6 of the 12 completed CSREs failed to document firearms access information. The other six documented the patients' access to firearms; however, three of the six failed to discuss safe storage of the firearms. (See figure 3.)

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[37] VHA Directive 1071, *Mandatory Suicide Risk and intervention Training*, May 11, 2022.

[38] VHA Directive 1071, *Mandatory Suicide Risk and intervention Training*, May 11, 2022.

[39] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf; "Suicide Prevention," U.S. Department of Veterans Affairs, accessed April 27, 2022, https://www.mentalhealth.va.gov/suicide_prevention/.

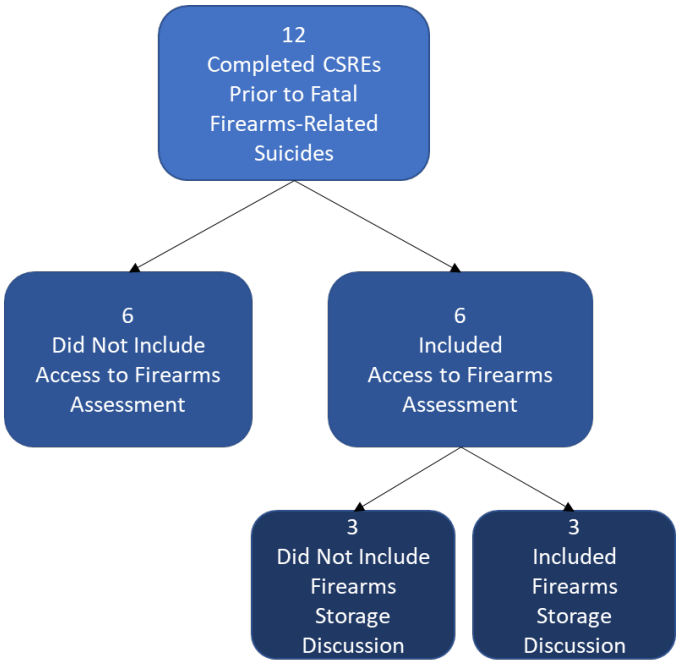

Figure 3. *CSRE completion prior to fatal firearm-related suicides.*
Source: OIG EHR review of VHA-provided suicide behavior events.

Non-Fatal Suicide Behavior Events

The OIG reviewed 415 non-fatal suicide behavior events, 232 that occurred prior to and 183 that occurred after full implementation of the suicide risk identification strategy in November 2019.

Among non-fatal suicide behavior events that occurred after full implementation of suicide risk identification strategy, the OIG found that VHA staff had a 92 percent compliance rate with the suicide risk screen completion and 90 percent compliance rate (153 of 170 applicable patients) with CSRE completion.[40] Additionally, for patients identified as having a non-fatal firearm-related suicide behavior event, the OIG identified two areas in need of improvement. For the 17 patients for whom staff did not complete a CSRE as required, the OIG would have expected staff to have completed suicide risk mitigation or safety planning. However, the OIG found that for 8 of the 17 patients, staff did not conduct safety planning. Additionally, the OIG determined staff failed to include safe storage in approximately 30 percent of CSRE mitigation plans when patients had reported access to firearms. (See figure 4.)

[40] For 13 of the 183 non-fatal suicide behavior events that occurred after implementation of the suicide risk identification strategy, the OIG did not expect a completed CSRE because the patient completed a negative suicide risk screen (11) or VHA staff were unable to contact the patient after the event (2).

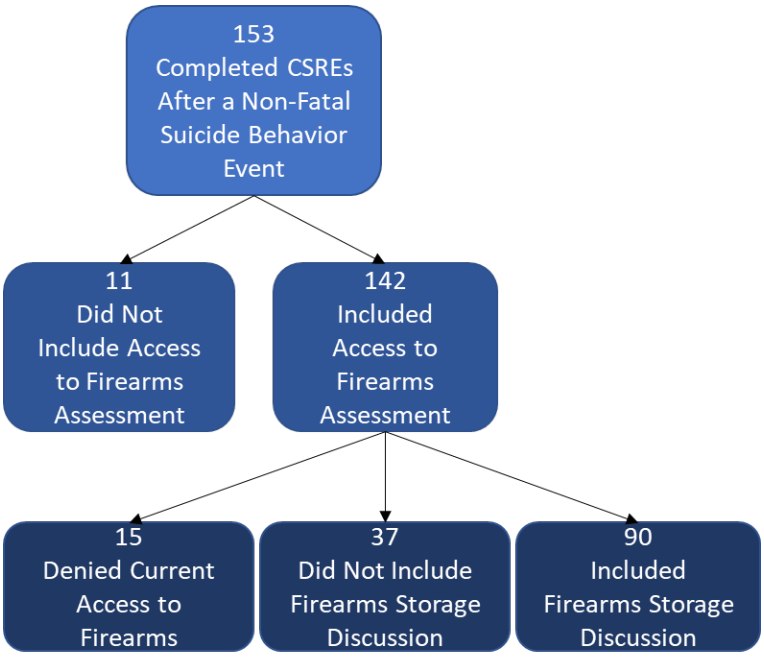

Figure 4. *CSRE completion after non-fatal firearm-related suicide behavior events. Source: OIG EHR review of VHA-provided suicide behavior events.*

Safety Planning

Fatal Suicide Behavior Events

Among the 65 fatal firearm-related suicide events reviewed, 44 did not require a safety plan due to having no prior VHA mental health engagement or screening negative on a prior suicide risk screen. The OIG would have expected a safety plan for the remaining 21 patients. However, the OIG found no evidence of a safety plan in 4 of the 21 patients' EHRs.[41] On average, the four patients with deficient safety planning died by suicide 48 days after the OIG would have expected VHA to have completed a safety plan with the patient. Additionally, among the 17 patients with fatal suicide behavior events and a prior documented safety plan, four did not include firearms access information. Among the 13 safety plans that included assessment of firearms access, one safety plan did not address firearms storage.[42] (See figure 5.)

[41] The four patients with deficient safety planning were receiving care at the Oklahoma City VA Health Care System, OK; Cheyenne VA Medical Center, WY; Cincinnati VA Medical Center, OH; and Mann-Grandstaff VA Medical Center, Spokane, WA.

[42] The patient's EHR indicated a positive initial suicide risk screen and completed safety plan, which documented access to a firearm, 53 days prior to the fatal suicide behavior event.

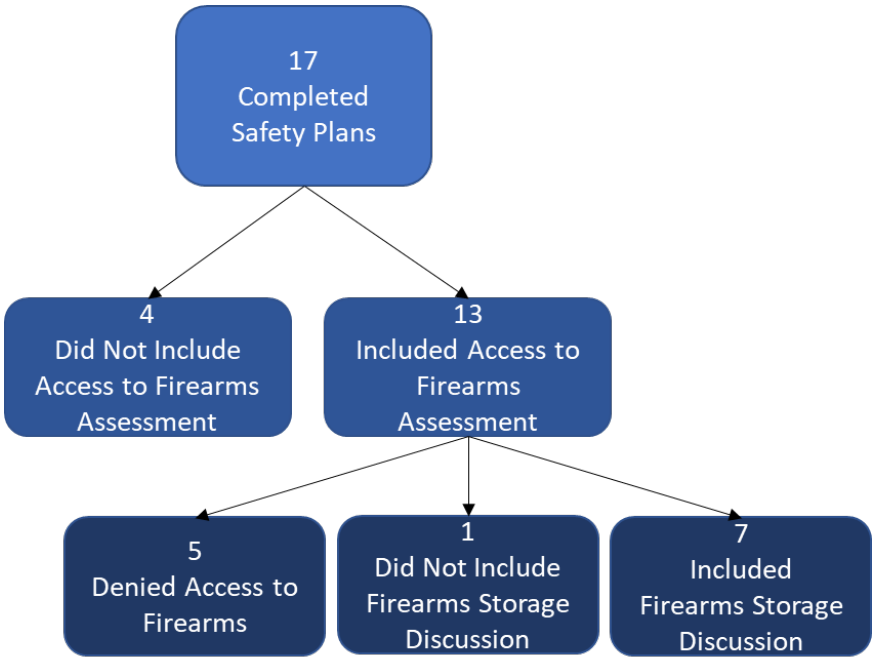

Figure 5. *Safety plan completion prior to fatal firearm-related suicides.*
Source: OIG EHR review of VHA-provided suicide behavior events.

Non-Fatal Suicide Behavior Events

Among the 415 patients with non-fatal suicide behavior events, the OIG did not expect safety plans for 15 patients due to the patient's refusal to complete a safety plan or staff's inability to contact the patient after the suicide behavior event.

Of the remaining 400 patients, 60 (15 percent) EHRs did not contain safety plans as expected and 340 (85 percent) had documented safety plans. Among the 340 completed safety plans, 14 (4 percent) did not document firearms access and 326 (96 percent) included firearms access information. Of the 326 safety plans that included firearms access information, 48 (15 percent) denied access to firearms and thus safe storage discussions were not expected. Of the remaining 278 applicable safety plans, 59 (21 percent) did not contain documentation of a discussion of safe storage, and 219 (78 percent) documented a discussion of safe storage. (See figure 6.)

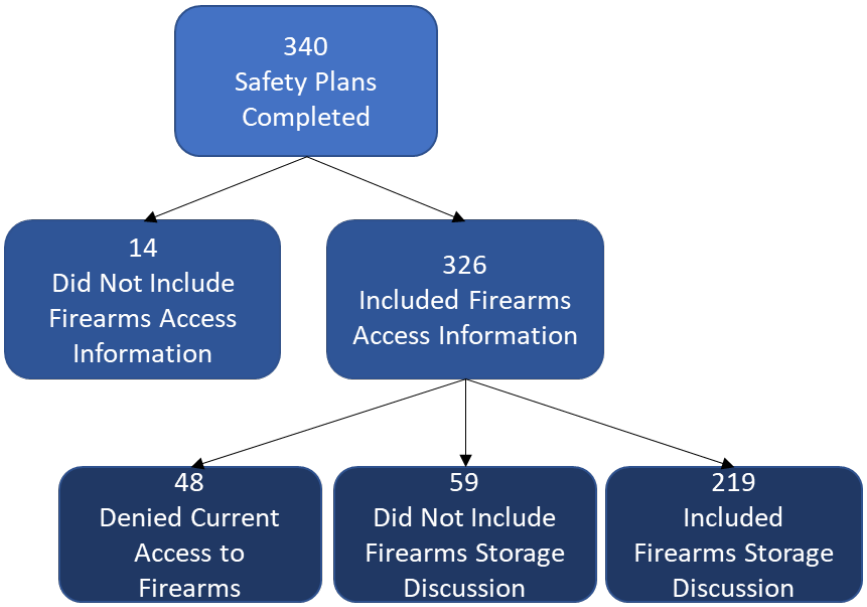

Figure 6. *Safety plan completion after non-fatal firearm-related suicide behavior events. Source: OIG EHR review of VHA-provided suicide behavior event data.*

Given the prevalence of firearm-related suicidal behavior among veterans, and the effectiveness of diminished access to firearms in the reduction of suicide, safety planning should include both firearms access and safe storage discussion. Failure to discuss safe storage of firearms may contribute to a failure to promote distance between the patient and access to firearms as a means of suicide.

Survey Analysis

The OIG found that most VHA leaders (87 percent) delegated the responsibility for monitoring lethal means training and suicide risk identification strategy compliance to other medical center staff.[43] Greater than 90 percent of suicide prevention staff reported assessing firearms access and discussing safe storage with most or every patient. The OIG found that approximately 81percent of clinicians who completed LMS training reported that they assessed firearms access with most or every patient when safety planning compared to 56 percent of clinicians who did not complete LMS training. Similarly, approximately three-quarters of clinicians who completed LMS training and about half of clinicians who did not complete LMS training reported discussing firearms storage with patients during risk assessment and safety planning. Further, approximately 20 percent of clinicians who completed LMS training and 45 percent of clinicians who did not

[43] Although the Office of Mental Health and Suicide Prevention identified medical center directors as responsible for training compliance, medical center directors may delegate this responsibility to other leaders. VHA leader survey respondents included medical center directors, chiefs of staff, mental health assistant chiefs of staffs, and VISN mental health officers.

complete the training reported documenting firearm-related discussions in few or no patients' EHRs.

VHA Leaders Survey

Of the 183 medical center and VISN leaders who completed the survey, 150 (82 percent) reported monitoring lethal means training compliance and the majority (87 percent) of them delegated the responsibility to other staff including suicide prevention, mental health, and education staff. Ninety-five percent of medical center and VISN leaders reported monitoring compliance with the suicide risk identification strategy and the majority (87 percent) of them reported delegating this responsibility to suicide prevention or mental health staff.

Leaders reported staff's feedback regarding perceived barriers to completing suicide risk identification strategy included taking too much time, changing requirements, being too repetitive, frustrating patients, and being confusing. (See table 2.)

Table 2. Clinician-Perceived Barriers to Completing the Suicide Risk Identification Strategy

Barriers	Number	Percent
Takes too much time	115	63
Requirements keep changing	101	55
Is too repetitive	76	42
Is frustrating for patients	70	38
Is confusing	66	36

Source: OIG analysis of the VHA leader survey.

Given the importance of clinicians' completion of the suicide risk identification strategy to identify patients at risk of suicide, the OIG would expect VHA leaders to further evaluate and address clinicians' perceived barriers to completing the suicide risk identification strategy.

Suicide Prevention Staff Survey

All 174 suicide prevention staff surveyed completed LMS training and approximately 60 (35 percent) reported that completing the training affected the frequency with which they asked patients about firearms access and discussed safe storage. Most of those reported that the training increased the frequency with which they asked about firearms access (95 percent) and discussed safe storage (97 percent).

Approximately three-quarters of suicide prevention staff reported that LMS training adequately prepared them for patient discussions related to firearms access and firearms storage. Forty-seven percent of suicide prevention staff reported completing additional lethal means assessment trainings.

When asked what influences the decision whether to discuss firearms access and storage with patients, 98 of 174 suicide prevention staff (56 percent) reported assuming that every patient has access to firearms, 11 of 174 (six percent) reported not wanting to make patients angry or uncomfortable, and five percent reported being concerned it will harm rapport. (See table 3.)

Table 3. Factors that Influence Suicide Prevention Staff's Decision to Discuss Firearms Access and Safe Storage

Factor	Number	Percent
I assume every patient has access to firearms	98	56
I do not want to make patients angry or uncomfortable	11	6
I am concerned it will harm rapport	8	5
I am uncomfortable discussing firearms with patients	4	2
I typically refer to a mental health specialist	2	1
I am unsure of the legal outcome if I ask	1	1

Source: OIG analysis of the suicide prevention staff survey responses.

Ninety-three percent of suicide prevention staff reported asking most or every patient about firearms access when assessing a patient's suicide risk and 95 percent reported discussing firearms access with most or every patient when safety planning with a patient. (See table 4.)

Table 4. Firearms Access During Suicide Risk Assessment and Safety Planning

	Suicide Risk Assessment		Safety Planning	
Frequency	Number	Percent	Number	Percent
Every	104	60	142	82
Most	57	33	24	14
Some	12	7	7	4
Few	0	0	0	0
None	1	0.6	1	0.6

Source: OIG analysis of the suicide prevention staff survey responses.

Similarly, 91 and 93 percent of suicide prevention staff reported discussing safe storage with most or every patient during suicide risk assessments and when safety planning, respectively. (See table 5.) However, fewer suicide prevention staff, approximately 85 percent, reported documenting these discussions with most or every patient. (See table 6.)

Table 5. Firearms Storage Discussions During Suicide Assessment and Safety Planning

	Suicide Risk Assessment		Safety Planning	
Frequency	Number	Percent	Number	Percent
Every	104	60	135	78
Most	54	31	26	15
Some	14	8	10	6
Few	1	0.6	1	0.6
None	1	0.6	2	1

Source: OIG analysis of the suicide prevention staff survey responses.

Table 6. Documentation of Firearms Access Information and Safe Storage Discussions

	Firearms Access		Safe Storage	
Frequency	Number	Percent	Number	Percent
Every	85	49	81	47
Most	60	34	65	37
Some	24	14	22	13
Few	2	1	3	2
None	3	2	3	2

Source: OIG analysis of the suicide prevention staff survey responses.

Suicide prevention staff reported their understanding of patient concerns that might impede disclosure of firearms access. The majority of respondents indicated mistrust of authority or

government systems, reluctance to give up means of self-protection, fear of infringement on Second Amendment rights, and lack of understanding of elevated risk due to firearms access as possible barriers for patients to disclosing firearms access.[44] (See table 7.)

Table 7. Reasons Patients May Not Answer Questions Related to Firearms Access Honestly

Reasons	Number	Percent
Mistrust of authority or government systems	146	84
Reluctance to give up means of self-protection	145	83
Fear of infringement of Second Amendment Rights	144	83
Lack of understanding of elevated risk due to firearms access	105	60
Reluctance to give up means of potential suicide	64	37

Source: OIG analysis of the suicide prevention staff survey responses.

Ninety-one percent of suicide prevention staff believed that staff members' discussion about firearms access and safe storage with patients changed a patient's likelihood of dying by suicide. Ninety-nine percent of those suicide prevention staff believed it would decrease a patient's risk.[45]

Nearly a quarter of suicide prevention staff respondents indicated that mental health staff requested additional lethal means training, whereas 7 and 5 percent of primary care and emergency department staff requested additional training, respectively. (See table 8.)

Table 8. Requests for Additional Lethal Means Training

Staff Setting	Number	Percent
Mental Health Staff	42	24
Primary Care Staff	13	7
Emergency Department Staff	9	5

Source: OIG analysis of the suicide prevention staff survey responses.

Approximately a quarter of suicide prevention staff reported having different expectations of lethal means assessment components for emergency department, primary care, and mental health clinicians. Of those, over half expected emergency department staff and primary care clinicians to refer patients to mental health clinicians.

[44] Constitution Annotated, "Constitution of the United States, Second Amendment," accessed August 1, 2022, https://constitution.congress.gov/constitution/amendment-2/. The text of the Second Amendment includes "the right of the people to keep and bear Arms."

[45] Two suicide prevention staff reported a belief that firearms access and storage discussions would increase a patient's likelihood of dying by suicide. Given the respondents were anonymous, the OIG was unable to determine the validity or rationale for these responses.

Clinician Survey

Of the 3,094 clinician respondents, 27 percent were physicians, 25 percent were psychologists, and the remaining were registered nurses, social workers, nurse practitioners, counselors, nurse managers, or physician assistants. Among the clinician respondents, 2,985 reported providing services in one clinical setting and 109 reported providing services in two or more clinical settings (see appendix E for additional analyses by clinical setting).[46]

Nearly 10 percent of clinicians reported not completing LMS training. Almost all respondents (99 percent) who did not complete the training were in their positions at the time VHA required this training to be completed.[47]

Of the almost 2,800 clinicians who completed LMS training, 37 percent reported that the training affected the frequency with which they asked patients about firearms access, and 98 percent reported an increase in assessment of firearms access. Similarly, 36 percent of clinicians reported that LMS training affected the frequency with which they discussed safe storage with patients, most reporting increased frequency of discussions.

Nearly half of clinicians reported that the assumption that every patient has access to firearms influences their decision to discuss firearms access and storage with patients and almost 20 percent reported typically referring patients to a mental health specialist. Less than 10 percent of clinicians reported other concerns including harming rapport, making patients angry or uncomfortable, or not thinking it is relevant to patient risk. (See table 9.)

Table 9. Factors that Influence Clinicians' Decision to Discuss Firearms Access and Safe Storage

Factor	Number	Percent
I assume every patient has access to firearms	1393	45
I typically refer to a mental health specialist	588	19
I typically refer to a Suicide Prevention Coordinator	278	9
I am concerned it will harm rapport	252	8
I do not want to make patients angry or uncomfortable	233	8
I am uncomfortable discussing firearms with patients	121	4
I do not think it will make a difference to the patient's outcome	89	3
I am unsure of the legal outcome if I ask	83	3
I do not think it is relevant to assessing patient risk	41	1

[46] The three clinical settings included in OIG analyses were mental health, primary care, and emergency department. Three clinicians reported working in an unspecified "other" setting in addition to one of these three clinical settings.

[47] On November 2, 2020, VHA required health care providers to complete lethal means training by January 31, 2021. The Executive Assistant to the VHA Chief Learning Office provided the OIG compliance data as of April 26, 2021. The OIG would expect any healthcare providers in the role for greater than six months at the time of the survey to have completed the training.

Source: OIG analysis of the clinician survey responses.

The OIG assessed clinicians' reported frequency with which they assess firearms access during suicide risk assessments and safety planning. Of clinicians who completed the lethal means training, 75 percent reported that they asked most or every patient about firearms access in the context of a risk assessment. Among clinicians who did not complete the training, 50 percent reported that they assessed firearms access with most or every patient during risk assessments. Nearly a third of clinicians who did not complete the training reported assessing firearms access with few or no patients when assessing risk compared to 10 percent of clinicians who completed the training. (See table 10.)

Table 10. Training Completion and Firearms Access Assessment During Suicide Risk Assessment

	Completed Training		Did Not Complete Training	
Frequency	Number	Percent	Number	Percent
Every	1420	51	101	33
Most	675	24	51	17
Some	411	15	61	20
Few	193	7	48	16
None	93	3	41	14

Source: OIG analysis of clinician survey responses.

The majority (approximately 81 percent) of clinicians who completed the training reported that they assessed firearms access with most or every patient when safety planning. Whereas 56 percent of clinicians who did not complete the training reportedly assessed firearms access with most or every patient. Similar to survey results regarding risk assessments, about a third of clinicians who did not complete the training reported assessing firearms access with few or no patients when safety planning compared to 11 percent of clinicians who completed training. (See table 11.)

Table 11. Training Completion and Firearms Access Assessment During Safety Planning

	Completed Training		Did Not Complete Training	
Frequency	Number	Percent	Number	Percent
Every	1804	65	123	41
Most	434	16	45	15
Some	238	9	38	12
Few	155	6	39	13
None	161	6	57	19

Source: OIG analysis of clinician survey responses.

The OIG found that approximately three-quarters of clinicians who completed the training and about half of clinicians who did not complete the training reported discussing firearms storage with patients during risk assessment and safety planning. About 15 percent of clinicians who completed the training reported discussing firearms storage with few or no patients during risk assessment and safety planning, while approximately a third of clinicians who did not complete the training reported discussing firearms storage with few or no patients. (See tables 12 and 13.)

Table 12. Firearms Storage Discussions During Suicide Risk Assessment

	Completed Training		Did Not Complete Training	
Frequency	Number	Percent	Number	Percent
Every	1311	47	96	32
Most	648	23	46	15
Some	432	15	52	17
Few	241	9	47	16
None	160	6	61	20

Source: OIG analysis of clinician survey responses.

Table 13. Firearms Storage Discussions During Safety Planning

	Completed Training		Did Not Complete Training	
Frequency	Number	Percent	Number	Percent
Every	1591	57	113	37
Most	499	18	41	14
Some	301	11	40	13
Few	204	7	40	13
None	197	7	68	23

Source: OIG analysis of clinician survey responses.

The OIG also inquired about clinicians' documentation practices related to firearms access and safe storage discussions. About 60 percent of clinicians who completed LMS training reported documenting firearms access information and safe storage discussions in patients' EHRs, while about a third of clinicians who did not complete the training reported documenting discussions in patients' EHRs. Approximately 20 percent of clinicians who completed LMS training and 45 percent of clinicians who did not complete the training reported documenting discussions in few or no patients' EHRs. (See tables 14 and 15.)

Table 14. Documentation of Firearms Access Assessment

	Completed Training		Did Not Complete Training	
Frequency	Number	Percent	Number	Percent
Every	984	35	73	24
Most	669	24	37	12
Some	613	22	60	20
Few	340	12	62	21
None	186	7	70	23

Source: OIG analysis of clinician survey responses.

Table 15. Documentation of Firearms Safe Storage Discussions

	Completed Training		Did Not Complete Training	
Frequency	Number	Percent	Number	Percent
Every	893	33	66	22
Most	682	24	38	13
Some	630	23	61	20
Few	350	13	51	17
None	237	8	86	28

Source: OIG analysis of clinician survey responses.

Although the OIG would expect firearms access information and safe storage discussion to be documented in applicable patients' EHRs, completion of LMS training appears to enhance the likelihood that clinicians initiate and document those critical discussions with patients. However, even for those who reported completing LMS training, approximately 20 percent of clinicians reported documenting firearms access assessment and safe storage discussions in few or no patients' EHRs. The survey did not ask clinicians about the rationale for not documenting these discussions, therefore, the OIG was unable to determine the barriers to documenting firearm-related discussions.

Most clinicians reported that educational and cultural barriers such as mistrust of authority or government systems, fear of infringement of Second Amendment rights, and reluctance to give up means of self-protection were factors that might impede patient disclosure of firearms access. (See table 16.)

Table 16. Reasons Patients May Not Answer Firearms Access-Related Questions Honestly

Frequency	Number	Percent
Mistrust of authority or government systems	2423	78
Fear of infringement of Second Amendment rights	2299	74
Reluctance to give up means of self-protection	2215	72
Lack of understanding of elevated risk due to firearms access	1310	42
Reluctance to give up means of potential suicide	851	28

Source: OIG analysis of clinician survey responses.

Among clinicians who completed LMS training, 25 percent did not believe that discussing firearms access and storage changed a patient's likelihood of dying by suicide. However, among clinicians who did not complete the LMS training, 39 percent did not believe discussion regarding firearms access and safe storage changed a patient's likelihood of dying by suicide. Although LMS training appears to increase clinicians' confidence that discussions with patients about their firearms access and storage decreases a patient's suicide risk, educational and cultural factors may continue to be barriers to staff's engagement in firearms access and safe storage discussions with patients.

Conclusion

The OIG found that all 18 VISNs and five Vet Center Districts achieved an average of greater than 90 percent compliance with suicide risk training requirements. However, 6 of 18 VISNs fell below an average of 90 percent compliance with LMS training completion.

The OIG determined that, as of July 2021, the majority of medical center directors delegated monitoring and oversight of training to other leaders and staff. In May 2022, VHA established more stringent oversight of suicide risk training. However, LMS training compliance was not identified in this oversight plan.[48] Given the high prevalence of firearm-related veteran suicides and that suicide prevention is the VA's "top clinical priority," the OIG would expect rigorous monitoring and action planning at the medical center, VISN, and national levels to address both suicide risk and LMS training deficiencies.[49] Further, the OIG would expect ongoing LMS training rather than a one-time course at the onset of employment with VHA.

The OIG examined the EHRs of 480 patients with fatal (65) and non-fatal (415) firearm-related suicide events to evaluate compliance with suicide risk assessment and safety planning

[48] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022.

[49] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021, accessed September 9, 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf; "Suicide Prevention," U.S. Department of Veterans Affairs, accessed April 27, 2022, https://www.mentalhealth.va.gov/suicide_prevention/.

expectations. The OIG found that among 15 patients with fatal firearm-related suicide behavior events who required a CSRE prior to the event, three did not have documentation. Of the remaining 12 completed CSREs, 6 failed to document assessment of firearms access. Further, of the six suicide risk assessments with documented firearms access, three failed to document discussion of safe storage with the patient.

Among 21 patients for whom the OIG would have expected a safety plan, 4 did not have a safety plan completed. Seventeen patients had a documented safety plan prior to their fatal suicide behavior event; however, four safety plans did not include firearms access information. Among the 13 safety plans that documented firearms access, one did not address safe storage.

Among patients with non-fatal firearm suicide behavior events, the OIG found that VHA staff had a 92 percent compliance rate with suicide risk screening completion and 90 percent compliance rate with CSRE completion. However, the OIG found that for 8 of the 17 patients without the required CSRE, staff also did not conduct safety planning. Additionally, the OIG determined staff failed to include safe storage discussions in approximately 30 percent of CSRE mitigation plans when patients had reported access to firearms.

The OIG found that following non-fatal suicide behavior events, 15 percent of EHRs did not have safety plans as expected and 4 percent of completed safety plans did not include firearms access information. Further, among patients who reported access to firearms, 21 percent of the safety plans did not document safe storage discussions when safety planning.

Given the prevalence of firearm-related suicidal behavior among veterans and the effectiveness of diminished access to firearms in the reduction of suicide, suicide risk assessment and safety planning should include both firearms access information and discussion of safe storage. Failure to adequately assess firearms access and discuss safe storage of firearms may contribute to a failure to promote distance between the patient and access to firearms as a means of suicide.

Of 174 suicide prevention staff surveyed, approximately 56 percent reported that completing LMS training affected the frequency with which they asked patients about firearms access and discussed safe storage, and nearly three-quarters reported that LMS training adequately prepared them for patient discussions related to firearms access and firearms storage. While over 90 percent of suicide prevention staff reported assessing firearms access and discussing safe storage with most or every patient when assessing suicide risk and safety planning, approximately 85 percent reported documenting firearms access information and safe storage discussions.

Of the 3,094 clinicians surveyed, 10 percent did not complete the mandatory LMS training. Over one-third of clinician respondents who completed LMS training reported that it affected the frequency with which they assessed firearms access and discussed safe storage with patients. The OIG found that among clinician respondents who completed LMS training, 75 percent reported asking most or every patient about firearms access when assessing suicide risk and

approximately 81 percent reported asking most or every patient about firearms access when safety planning. In contrast, among clinician respondents who did not complete LMS training, 50 percent reported asking most or every patient about firearms access when assessing suicide risk and 56 percent reported asking most or every patient about firearms access when safety planning.

Approximately three-quarters of clinicians who completed LMS training and about half of clinicians who did not complete the training reported discussing firearms storage with patients during risk assessment and safety planning. Further, while approximately 15 percent of clinicians who completed LMS training reported assessing firearms access and discussing safe storage with few or no patients, about one-third of clinicians who did not complete LMS training reported assessing firearms access and discussing safe storage with few or no patients. Additionally, about 60 percent of clinicians who completed LMS training reported documenting firearms access assessments and safe storage discussions in patients' EHRs, while about one-third of clinicians who did not complete the training reported documenting firearms access and safe storage discussions in patients' EHRs. Although the OIG would expect of firearms access and safe storage discussion to be documented in applicable patients' EHRs, completion of LMS training appears to enhance the likelihood that clinicians initiate and document those critical discussions with patients.

Most clinicians reported that educational and cultural barriers such as mistrust of authority or government systems, and reluctance to give up means of self-protection were factors that might impede patient disclosure of firearms access. Although LMS training appears to increase clinicians' confidence that discussions with patients about their firearms access and storage decreases a patient's suicide risk, educational and cultural factors may continue to be barriers to staff's engagement in firearms access and safe storage discussions with patients.

Recommendations 1–7

1. The Under Secretary for Health ensures compliance with suicide risk and lethal means safety training requirements.

2. The Under Secretary for Health evaluates the efficacy of the May 2022 Veterans Integrated Service Network and Office of Mental Health and Suicide Prevention oversight structure for suicide risk training and considers inclusion of an oversight structure for lethal means safety training compliance.

3. The Under Secretary for Health evaluates the adequacy of the one-time lethal means safety training requirement and takes action as appropriate.

4. The Under Secretary for Health ensures clinician completion of comprehensive suicide risk evaluations including the discussion and documentation of firearms access and safe storage as required, and monitors compliance.

5. The Under Secretary for Health ensures clinician completion of safety plans including the discussion and documentation of firearms access and safe storage, as applicable, and monitors compliance.

6. The Under Secretary for Health evaluates staff's perceived barriers to completion of the suicide risk identification strategy and takes action as appropriate.

7. The Under Secretary for Health considers initiatives to evaluate and address educational and cultural barriers to conducting and documenting patient discussions related to firearms access and safe storage practices.

Appendix A: Prior OIG Reports and Congressional Hearings

Table A.1. Prior OIG Reports Including a Firearm-Related Death

	Report
1	VA Office of Inspector General, *Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center*, Report No. 19-07507-214, July 28, 2020.
2	VA Office of Inspector General, *Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California*, Report No. 21-00271-258, September 23, 2021.
3	VA Office of Inspector General, *Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas*, Report No. 20-02993-181, July 15, 2021.
4	VA Office of Inspector General, *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*, Report No. 20-00545-115, April 15, 2021.
5	VA Office of Inspector General, *Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri*, Report No. 20-01521-48, January 5, 2021.
6	VA Office of Inspector General, *Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania*, Report No. 21-01712-144, May 3, 2022.

Source: OIG compilation of OIG reports published from July 2020 through May 2022.

Table A.2. Congressional Hearings Including Lethal Means Safety

	Hearing
1	*Hearing on Tragic Trends: Suicide Prevention Among Veterans, House Committee on Veterans' Affairs*, 116th Cong. (April 29, 2019).
2	*Hearing on Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach, House Committee on Veterans' Affairs*, 116th Cong. (January 29, 2020) (statement of Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, VA Office of Inspector General).
3	*Hearing on Veterans Health Legislation, House Committee on Veterans' Affairs*, 116th Cong. (September 10, 2020).
4	*Hearing on Coping During COVID: Veterans' Mental Health and Implementation of the Hannon Act, Senate Committee on Veterans' Affairs*, 117th Cong. (March 24, 2021).
5	*Hearing on Veteran Suicide Prevention, House Committee on Veterans' Affairs*, 117th Cong. (September 22, 2021).
6	*Hearing on An End-of-Year Look at the State of VA, Senate Committee on Veterans' Affairs*, 117th Cong. (December 1, 2021).

Source: OIG analysis of Congressional hearing transcripts.

Appendix B: Suicide Behavior Events Data

Table B.1. Suicidal Events per VISN

VISN	October 1, 2018, through September 30, 2019	October 1, 2019, through September 30, 2020	Total
1	7	3	10
2	6	6	12
4	8	8	16
5	7	11	18
6	7	12	19
7	11	11	22
8	14	19	33
9	15	14	29
10	24	16	40
12	7	9	16
15	8	11	19
16	20	16	36
17	11	28	39
19	25	29	54
20	20	10	30
21	10	10	20
22	16	24	40
23	10	17	27
TOTAL	**226**	**254**	**480**

Source: OIG analysis of random sample of 480 suicide events from VHA-provided data.

Appendix C: Survey Data Tables

Table C.1. Discipline of Suicide Prevention Staff Survey Respondents

Discipline	Number	Percent
Master's Level Counselor	4	2
Nurse Practitioner	1	1
Psychologist	19	11
Registered Nurse	12	7
Social Worker	138	79

Source: OIG analysis of the suicide prevention staff survey responses.

Table C.2. Suicide Prevention Staff Survey Respondents Time in the Role

Time in Role	Number	Percent
0-6 months	8	5
7-12 months	20	11
13-24 months	24	14
25-36 months	33	19
More than 36 months	89	51

Source: OIG analysis of the clinician survey responses.

Table C.3. Discipline of Clinician Survey Respondents

Discipline	Number	Percent
Master's Level Counselor	63	2
Nurse Manager	53	2
Nurse Practitioner	248	8
Physician	845	27
Physician Assistant	51	2
Psychologist	760	25
Registered Nurse	547	18
Social Worker	527	17

**Source: OIG analysis of the clinician survey responses.*

Table C.4. Clinician Survey Respondents Time in Their Role

Discipline	Number	Percent
0–6 months	91	3
7–12 months	290	9
13–24 months	429	14
25–36 months	323	10
More than 36 months	1961	63

Source: OIG analysis of the clinician survey responses.

Appendix D: Training Compliance

Table D.1. Medical Centers with Less than 90 Percent LMS Training Compliance

VISN	Medical Center	Percent
1	VA Boston Healthcare System, Massachusetts	88
4	Wilmington VA Medical Center, Delaware	87
5	Baltimore VA Medical Center, Maryland	85
5	Washington DC VA Medical Center	75
6	Durham VA Medical Center, North Carolina	80
6	Hampton VA Medical Center, Virginia	86
6	Hunter Holmes McGuire VA Medical Center, Richmond, Virginia	87
8	Miami VA Healthcare System, Florida	86
9	Lexington VA Health Care System, Kentucky	88
10	John D. Dingell VA Medical Center, Detroit, Michigan	86
10	VA Ann Arbor Healthcare System, Michigan	81
12	Jesse Brown VA Medical Center, Chicago, Illinois	80
12	Edward Hines Jr. VA Hospital, Hines, Illinois	83
12	William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin	72
15	VA St. Louis Health Care System, Missouri	89
16	G.V. (Sonny) Montgomery VA Medical Center, Alabama	82
17	El Paso VA Health Care System, Texas	88
17	Central Texas Veterans Health Care System	87
17	VA North Texas Health Care System	80
20	VA Portland Health Care System, Oregon	89
20	Mann-Grandstaff VA Medical Center, Washington	88
21	San Francisco VA Health Care System, California	87
21	VA Northern California Health Care System	82
22	Phoenix VA Health Care System, Arizona	83
22	New Mexico VA Health Care System	89
22	VA Greater Los Angeles Healthcare System, California	76
22	VA San Diego Healthcare System, California	86

Source: VHA-provided training compliance data as of April 26, 2021.

Appendix E: Clinician Survey Analyses

The OIG included clinician respondents who reported providing services in one clinical area resulting in 2,985 survey responses from 1,913 mental health, 786 primary care, and 286 emergency department clinicians.

Table E.1. Lethal Means Safety (LMS) Training Completion

	Mental Health	Primary Care	Emergency Department
Completed LMS Training	1788 (93 percent)	670 (85 percent)	230 (80 percent)

Source: OIG analysis of the clinician survey responses.

Table E.2. Firearms Access Assessment and Safe Storage Discussion during Suicide Risk Assessment

	Mental Health	Primary Care	Emergency Department
Assessed Firearms Access with Most or All Patients			
Completed LMS Training	1497 (84 percent)	371 (55 percent)	137 (60 percent)
Did Not Complete LMS Training	87 (70 percent)	46 (40 percent)	15 (27 percent)
Assessed Firearms Access with Few or No Patients			
Completed LMS Training	87 (5 percent)	151 (23 percent)	45 (20 percent)
Did Not Complete LMS Training	19 (15 percent)	45 (39 percent)	24 (43 percent)
Discussed Safe Storage with Most or All Patients			
Completed LMS Training	1423 (80 percent)	355 (53 percent)	98 (43 percent)
Did Not Complete LMS Training	81 (65 percent)	48 (41 percent)	9 (16 percent)
Discussed Safe Storage with Few or No Patients			
Completed LMS Training	118 (7 percent)	196 (29 percent)	80 (35 percent)
Did Not Complete LMS Training	17 (14 percent)	50 (43 percent)	41 (73 percent)

Source: OIG analysis of the clinician survey responses.

Table E.3. Firearms Access Assessment and Safe Storage Discussion when Safety Planning

	Mental Health	Primary Care	Emergency Department
Assessed Firearms Access with Most or All Patients			
Completed LMS Training	1630 (91 percent)	388 (58 percent)	124 (54 percent)
Did Not Complete LMS Training	97 (78 percent)	51 (44 percent)	15 (27 percent)
Assessed Firearms Access with Few or No Patients			
Completed LMS Training	79 (4 percent)	173 (26 percent)	63 (27 percent)
Did Not Complete LMS Training	13 (10 percent)	47 (41 percent)	36 (64 percent)
Discussed Safe Storage with Most or All Patients			
Completed LMS Training	1542 (86 percent)	358 (53 percent)	105 (46 percent)
Did Not Complete LMS Training	91 (73 percent)	46 (40 percent)	12 (21 percent)
Discussed Safe Storage with Few or No Patients			
Completed LMS Training	105 (6 percent)	209 (31 percent)	81 (35 percent)
Did Not Complete LMS Training	13 (10 percent)	54 (47 percent)	41 (73 percent)

Source: OIG analysis of the clinician survey responses.

Table E.4. Documentation of Firearms Access and Safe Storage

	Mental Health	Primary Care	Emergency Department
Documented Firearms Access Assessment for Most or all Patients			
Completed LMS Training	1273 (71 percent)	225 (34 percent)	80 (35 percent)
Did Not Complete LMS Training	72 (58 percent)	28 (24 percent)	7 (13 percent)
Documented Firearms Access Assessment for Few or No Patients			
Completed LMS Training	156 (9 percent)	277 (41 percent)	87 (38 percent)
Did Not Complete LMS Training	25 (20 percent)	67 (58 percent)	39 (70 percent)

Documented Safe Storage Discussion for Most or all Patients			
Completed LMS Training	1206 (67 percent)	223 (33 percent)	78 (34 percent)
Did Not Complete LMS Training	64 (51 percent)	31 (27 percent)	6 (11 percent)
Documented Safe Storage Discussion for Few or No Patients			
Completed LMS Training	191 (11 percent)	285 (43 percent)	98 (43 percent)
Did Not Complete LMS Training	23 (18 percent)	69 (59 percent)	45 (80 percent)

Source: OIG analysis of the clinician survey responses.

Appendix F: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 12, 2022

From: Office of the Under Secretary for Health (10)

Subj: OIG Draft Report: Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm (OIG-2021-00175-HI-1071) (VIEWS # 8374244)

To: Assistant Inspector General for of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on lethal means safety training. The Veterans Health Administration (VHA) concurs with OIG's recommendations and provides action plans in the attachment.
2. Over 70% of Veteran suicides are related to firearms. Most suicidal crises are brief, and the time from decision to action can be less than one hour. We can save lives if it takes longer for a person to access the means to harm themselves after the moment they have the impulse to act. Lethal means safety related to firearm secure storage is a critical priority within the Department of Veterans Affairs (VA) National Strategy for Preventing Veteran Suicide. VA has prioritized lethal means safety related to firearms across multiple initiatives, including the Suicide Prevention Now initiative, large national communications campaigns (e.g., www.KeepItSecure.net), focused staff training, and gun lock distribution. Independent of this OIG review, the Office of Mental Health and Suicide Prevention (OMHSP) identified the need for enhanced oversight of facility staff's completion of Suicide Prevention Trainings, including Lethal Means Safety. Since October 2021, VHA has included this topic in site visit reviews of suicide prevention programming.
3. OMHSP has addressed training compliance during Veterans Integrated Service Network (VISN) site visits, with special emphasis on facility-level assignment and compliance tracking of Lethal Means Safety, Suicide Prevention, and Safety Planning courses for relevant clinical staff. With re-issuance of the operational memorandum related to the lethal means safety course in March 2022, OMHSP communicated the need for training compliance with VISN Chief Mental Health Officers, VISN Suicide Prevention Leads and facility Suicide Prevention Teams. Currently, VA only requires completion of the full lethal means safety course one time; however, lethal means content is incorporated in the existing mandatory annual course that broadly covers suicide prevention. VA has made Lethal Means Safety training a critical focus area in its Agency Priority Goal, which also includes focus on training of community providers.
4. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm

(OIG-2021-00175-HI-1071)

Recommendation 1. The Under Secretary for Health ensures compliance with suicide risk and lethal means safety training requirements.

VHA Comments: Concur. The Veterans Health Administration (VHA) currently monitors, tracks, and reports the completion of suicide prevention trainings mandated by VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022, and VHA Memorandum 2022-03-14, Lethal Means Safety (LMS) Education and Counseling, dated March 17, 2022. VHA agrees training compliance is essential for suicide prevention and is actively converting applicable policy and guidance documents into a broad, enterprise-wide VA directive which will incorporate LMS training. This directive will be designed to improve monitoring of completion of mandatory trainings with support materials to assist local supervisors for ensuring compliance for both suicide risk and LMS trainings. While this directive is in development, the Office of Mental Health and Suicide Prevention (OMHSP), in collaboration with the Assistant Under Secretary for Health for Operations, will develop and issue interim guidance for improved oversight via a memorandum to Veteran Integrated Service Networks (VISNs). This guidance will require VISNs to attest they ensured their facilities have operationalized a local process for monitoring compliance in completion of required suicide risk and lethal means training. To close this recommendation, VHA will provide a copy of the draft directive, a copy of the issued memo, and VISN attestations of local compliance tracking.

Status: In progress Target Completion Date: September 2023

Recommendation 2. The Under Secretary for Health evaluates the efficacy of the May 2022 Veterans Integrated Service Network and Office of Mental Health and Suicide Prevention oversight structure for suicide risk training and considers inclusion of an oversight structure for lethal means safety training compliance.

VHA Comments: Concur. OMHSP agrees evaluation of training completion and compliance oversight structure is vital to quality control and improvements for mandatory trainings for suicide risk and LMS training. OMHSP will convene a meeting of subject matter experts (SME) within suicide prevention training, field staff, and employee education to review the efficacy of oversight of suicide risk training and provide recommendations to the SMEs developing a VA wide directive for mandatory

suicide prevention training. The draft directive will reflect improved oversight processes. OMHSP will provide OIG with a draft of the proposed VA directive and a summary of oversight structure.

Status: In progress Target Completion Date: September 2023

Recommendation 3. The Under Secretary for Health evaluates the adequacy of the one-time lethal means safety training requirement and takes action as appropriate.

VHA Comments: Concur. The current LMS training includes survey data that is used to inform evaluation of training adequacy. Further evaluation will be conducted to help inform future updates and training efforts. This will include providing a summary of Employee Education System (EES) evaluation data available to date, which will be used by OMHSP to identify areas for improvement. Components of LMS training are also infused within the annual required Skills Training for Evaluation and Management of Suicide (STEMS) training. OMHSP and EES will review additional outcome questions to further evaluate the LMS components within this annual training for areas for strengthening in further revision of this annual training. OMHSP will provide OIG with a summary of the post-evaluation survey analysis of the LMS training, including any recommendations or actions taken as a result of this analysis.

Status: In progress Target Completion Date: September 2023

Recommendation 4. The Under Secretary for Health ensures clinician completion of comprehensive suicide risk evaluations including the discussion and documentation of firearms access and safe storage as required, and monitors compliance.

VHA Comments: Concur. Currently, the Comprehensive Suicide Risk Evaluation (CSRE) electronic health record (EHR) template records completion of lethal means safety assessment. However, it does not specifically mandate documentation of inquired firearm access or safe storage processes. To resolve the recommendation, VHA will update the template to specifically require documentation of assessment for firearm access and safe storage discussion (as clinically indicated), as well as provide a method within the template for documenting firearms access and safe storage discussion. This updated template can then be used to assess for compliance with lethal means safety discussion broadly and to assess the review of said discussion of firearm access and safe storage.

Status: In progress Target Completion Date: September 2023

Recommendation 5. The Under Secretary for Health ensures clinician completion of safety plans including the discussion and documentation of firearms access and safe storage, as applicable, and monitors compliance.

VHA Comments: Concur. OMHSP agrees with the importance of clinician compliance with documenting firearms access and safe storage, as applicable, as part of safety plan completion. Completion of the discussion and documentation of firearms access

and safe storage within the safety plan is not currently monitored as an independent metric nationally. VHA has identified certain data points within the electronic health record that demonstrates discussion and documentation of firearms access and secure storage.

OMHSP is conducting virtual VISN site visits and incorporating this data into the site visit process to assist facilities in monitoring safety plan completion.

To close this recommendation, OMHSP will provide evidence of a method to monitor compliance of firearm access discussion and secure storage discussion in safety planning that VISNs/facilities can use for local oversight.

Status: In progress Target Completion Date: September 2023

Recommendation 6. The Under Secretary for Health evaluates staff's perceived barriers to completion of the suicide risk identification strategy and takes action as appropriate.

VHA Comments: Concur. OMHSP acknowledges staff's perceived barriers to completion of the suicide risk identification strategy. In February of 2022, VHA Internal Audit began conducting a review of the Risk ID process to assist with implementation and process improvement efforts. Initial findings from this internal audit provided feedback from frontline staff related to implementation challenges for suicide risk screening. OMHSP is also currently supporting the Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) in a study of suicide risk identification rollout implementation. This includes providing performance feedback to all facilities through the Risk ID Power BI dashboard and monthly summary reports as well as intensive facilitation support to local facilities working to improve suicide risk identification implementation. OMHSP will partner with the Rocky Mountain MIRECC to identify local lessons learned on barriers identified through these studies, along with mitigation strategies developed to address these barriers. These strategies will then be shared on national technical assistance calls to assist facilities in local risk identification implementation. OMHSP will provide evidence of sharing these mitigation strategies on national calls to OIG.

Status: In progress Target Completion Date: September 2023

Recommendation 7. The Under Secretary for Health considers initiatives to evaluate and address educational and cultural barriers to conducting and documenting patient discussions related to firearms access and safe storage practices.

VHA Comments: Concur. OMHSP is currently developing a pilot competency-based lethal means training curriculum for primary care teams, which aims to improve skills, comfort, confidence and overcome cultural and knowledge barriers to having secure storage discussions with Veterans and their family members. Experts from VHA Primary Care, Mental Health, Suicide Prevention, are working with individuals with expertise in implementation science and evaluation to develop this hands-on training which will address common challenges to implementation of lethal means safety counseling related to firearms. OMHSP will provide OIG with a copy of the written proposal for this

pilot in primary care settings aiming to address cultural and educational challenges to primary care providers having discussions with their patients about firearm secure storage and suicide prevention.

Status: In progress Target Completion Date: September 2023

OIG Contact and Staff Acknowledgments

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