



Report to the Chairman, Committee on
Veterans' Affairs, House of
Representatives

September 2020

VETERAN SUICIDE

VA Needs Accurate Data and Comprehensive Analyses to Better Understand On- Campus Suicides

Accessible Version

GAO Highlights

Highlights of [GAO-20-664](#), a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA established suicide prevention as its highest clinical priority. In recent years, there have been reports of veterans dying by suicide on VA campuses—in locations such as inpatient settings, parking lots, and on the grounds of cemeteries.

GAO was asked to review veteran deaths by suicide on VA campuses. This report examines (1) VA's process to track the number of veterans that died by suicide on VA campuses, and (2) steps VA has taken to address these types of suicides.

GAO reviewed the sources of information VHA uses to identify and analyze on-campus veteran suicides, VA and VHA strategic plans and policies related to suicide prevention and reporting, and federal internal control standards. GAO also interviewed VA and VHA central office officials, and officials from three medical facilities that GAO selected because they reportedly had on-campus veteran suicides between fiscal years 2018 and 2019.

What GAO Recommends

GAO is making three recommendations, including that VA improve its process to accurately identify all on-campus veteran suicides and conduct more comprehensive analyses of these occurrences. VA did not concur with one of GAO's recommendations related to conducting root cause analyses. GAO continues to believe that this recommendation is valid, as discussed in the report.

View [GAO-20-664](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

September 2020

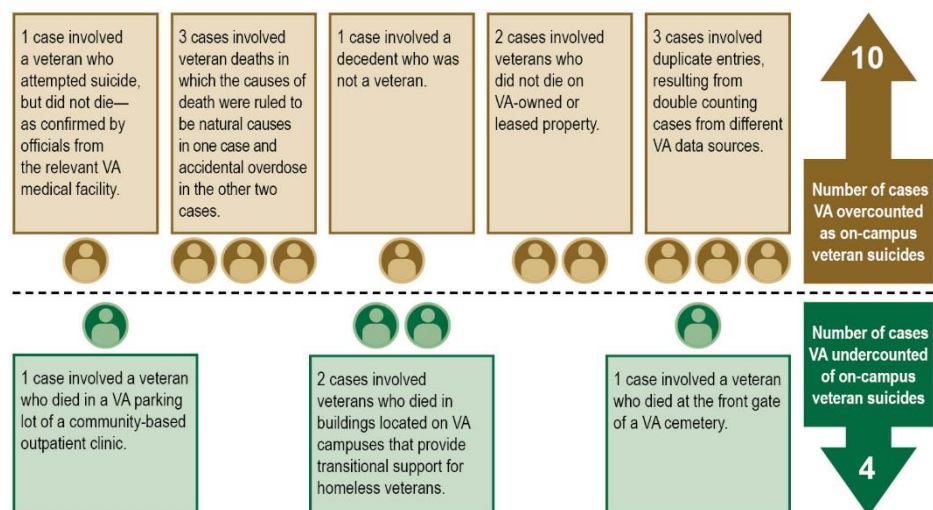
VETERAN SUICIDE

VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides

What GAO Found

The Department of Veterans Affairs' (VA) process for identifying on-campus suicides does not include a step for ensuring the accuracy of the number of suicides identified. As a result, its numbers are inaccurate. VA's Veterans Health Administration (VHA) first started tracking on-campus veteran suicides in October 2017, and uses the results to inform VA leadership and Congress. GAO reviewed the data and found errors in the 55 on-campus veteran suicides VHA identified for fiscal years 2018 and 2019, including 10 overcounts (deaths that should not have been reported but were) and four undercounts (deaths that should have been reported but were not).

Examples of Errors on the Department of Veterans Affairs' (VA) List of 55 On-Campus Veteran Suicides for Fiscal Years 2018 and 2019 (as of September 2019)



Source: GAO analysis of VA data. | GAO-20-664

VA has taken some steps to address on-campus veteran suicides, such as issuing guidance and staff training. However, GAO found that the analyses informing these efforts are limited. Specifically, VHA

- requires root cause analyses—processes to determine what can be done to prevent recurrences of incidents—for some but not all on-campus veteran suicides. According to VHA officials, only 25 percent of on-campus suicides from October 2017 to April 2019 met the criteria for a root cause analysis.
- does not make use of all relevant information VA collects about these deaths, such as clinical and demographic data collected through other VA suicide prevention efforts. VHA officials said they could not link the different sources of information, but GAO found that selected medical facilities could do so.

Without accurate information on the number of suicides and comprehensive analyses of the underlying causes, VA does not have a full understanding of the prevalence and nature of on-campus suicides, hindering its ability to address them.

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Abbreviations

BHAP	Behavioral Health Autopsy Program
COVID-19	Coronavirus Disease 2019
NCA	National Cemetery Administration
OMHSP	Office of Mental Health and Suicide Prevention
PREVENTS	President's Roadmap to Empower Veterans and End a National Tragedy of Suicide

RCA	root cause analysis
REACH VET	Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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September 9, 2020

The Honorable Mark Takano
Chairman
Committee on Veterans' Affairs
House of Representatives

Dear Chairman Takano:

Suicide is a public health problem facing all populations, particularly veterans. According to the Centers for Disease Control and Prevention, suicide was the tenth leading cause of death in the United States in 2018. However, according to the Department of Veterans Affairs (VA), the rate of suicide is higher for veterans than non-veterans. In September 2019, VA reported that veterans accounted for 13.5 percent of all deaths by suicide among U.S. adults in 2017, despite constituting only 7.9 percent of the adult population. VA also reported that an average of 17 veterans died by suicide each day in 2017, and that an average of six of these veterans (about 35 percent) were recent users of Veterans Health Administration (VHA) health care services.¹

In response, VA identified suicide prevention as its highest clinical priority in its strategic plan for fiscal years 2018 through 2024.² In addition, VA issued a National Strategy for Suicide Prevention in 2018, which identifies four focus areas: (1) healthy and empowered veterans, families, and communities; (2) clinical and community preventative services; (3) treatment and support services; and (4) surveillance, research, and evaluation. Collectively, these four areas encompass VA's 14 goals for preventing veteran suicide, one of which is implementing communication

¹See Department of Veterans Affairs, *2019 VA National Veteran Suicide Prevention Annual Report* (Washington, D.C.: September 2019). According to VA, results from this report should not be directly compared with information presented in its prior reports as it defined "veteran" differently in the 2019 report. Data for the 2019 report is based on 2017 data, the most recent year of data available. Recent users of VHA health care services is defined as those who received VHA care in 2016 or 2017.

²See Department of Veterans Affairs, *Department of Veterans Affairs Fiscal Years 2018-2024 Strategic Plan* (Washington, D.C.: May 31, 2019).

designed to prevent veteran suicide by changing knowledge, attitude, and behaviors.³

According to VA officials, most veteran suicides do not occur on VA campuses, which include VA-owned or leased facilities or property. However, in recent years, there have been media reports of a number of veterans dying by suicide in VHA's medical facilities, parking lots, and on the grounds of VA National Cemetery Administration (NCA) cemeteries.⁴ You asked us to review veteran deaths by suicide on VA campuses. In this report, we examine:

1. VA's process to track the number of veterans that die by suicide on VA campuses; and
2. steps VA has taken to address these types of suicides.

To examine VA's process to track the number of veterans that die by suicide on VA campuses, we interviewed VHA officials responsible for identifying on-campus suicides in VHA's Office of Mental Health and Suicide Prevention (OMHSP) and requested and received a list of on-campus veteran deaths by suicide. This list catalogued instances of veteran suicides and attempts, both on and off campus, beginning in fiscal year 2018. From this list, we selected VHA medical facilities that had experienced multiple on-campus veteran suicides and visited a nongeneralizable sample of three facilities located in North Chicago, Illinois; Milwaukee, Wisconsin; and Seattle, Washington in December 2019 and January 2020.⁵ The three VHA medical facilities are located in

³See Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028* (Washington, D.C.: June 29, 2018).

⁴See, for example, "The Parking Lot Suicides." *The Washington Post*, February 7, 2019, and "V.A. Officials, and the Nation, Battle an Unrelenting Tide of Veteran Suicides." *The New York Times*, April 14, 2019.

⁵We had planned to visit up to four more VHA medical facilities, but were unable to do so because of safety concerns related to Coronavirus Disease 2019 (COVID-19). The VHA medical facility located in Seattle is part of the VA Puget Sound Health Care System along with the VHA medical facility located in American Lake, Washington and shares the same suicide prevention staff. As a result, we collected information about veteran suicides that occurred on both campuses. In addition, the VHA medical facility located in North Chicago is the Captain James A. Lovell Federal Health Care Center, which serves both veterans and active duty members of the military and their dependents and was established in 2010 when the VHA medical facility and the former Naval Health Clinic Great Lakes merged their resources and services.

two different Veterans Integrated Service Networks (VISN).⁶ As part of our visits, we reviewed documents, such as reports about the deaths and interviewed medical facility officials, including suicide prevention coordinators, patient safety managers, and VA Police chiefs, to obtain information about each of the on-campus veteran suicides that occurred at these facilities from fiscal year 2015 through fiscal year 2019.⁷ We determined that the information and communication component of internal control was significant to this objective, along with the underlying principle that management should use quality information to achieve the entity's objectives.⁸

We reviewed and assessed the accuracy of the list VHA provided of on-campus veteran suicides by (1) comparing the cases VHA identified against our reviews of the underlying data sources VHA used to identify these incidents and (2) confirming the VHA-identified cases at the three VHA medical facilities included in our review with officials at those facilities. OMHSP officials told us they used the following data sources to identify on-campus suicides: (1) VHA Issue Briefs—which VHA medical facility staff use to report serious incidents such as unexpected deaths; (2) VA Police incident reports; (3) VHA root cause analyses (RCA)—a specific type of focused review that is used for all patient safety adverse events requiring analysis; (4) NCA first notification of events—which NCA officials use to report serious incidents; and (5) Veterans Benefits

⁶VHA organizes its system of care into regional networks called VISNs. Each VISN is responsible for managing and overseeing VHA medical facilities within a defined geographic area. The VA Puget Sound Health Care System is part of VISN 20 and the Lovell Federal Health Care Center and the VHA medical facility located in Milwaukee are part of VISN 12. VHA provides care through various types of medical facilities, including medical centers and outpatient clinics. In many areas of the country, several medical centers and clinics may work together to offer services to area veterans as a healthcare system in an effort to provide more efficient care. For the purpose of this report we refer to all VA healthcare systems, medical centers, and clinics as VHA medical facilities.

⁷Each VHA medical facility is required to have at least one suicide prevention coordinator, whose responsibilities include: establishing and maintaining a list of veterans assessed to be at high risk for suicide; monitoring these high-risk veterans; responding to referrals from staff and the Veterans Crisis Line; collaborating with community organizations and partners; training staff members who have contact with veterans at the VHA medical facility, community organizations, and partners; and collecting and reporting information on veterans who attempt or die by suicide.

⁸GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

Administration (VBA) situation reports—which VBA officials use to report serious incidents.⁹

We separately reviewed each of these data sets to identify cases of on-campus suicide deaths and then compared the list we compiled from these sources to VHA's list. We identified errors in VHA's list of on-campus veteran suicides and determined that its list is inaccurate, as discussed later in this report. We then compared VHA's process for identifying on-campus veteran suicides to federal internal control standards for use of quality information and relevant control activities.¹⁰ We attempted to compile a list of on-campus veteran suicides for fiscal years 2015 through 2019 to determine trends in these incidents over a 5-year period; however, VHA told us that the data prior to fiscal year 2018 for these sources were either unreliable or unavailable.

To further examine VA's process to track the number of on-campus veteran suicides and steps VA has taken to address these types of suicides, we reviewed relevant regulations, policies, and VA documents, including VA's Fiscal Years 2018–2024 Strategic Plan, its National Strategy for Preventing Veteran Suicide and the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS).¹¹ We also interviewed officials from:

- VA's Office of Operations, Security, and Preparedness—including personnel from the Office of Security and Law Enforcement, and the Integrated Operations Center;
- VHA's OMHSP, National Center for Patient Safety, Center of Excellence for Suicide Prevention, and Office of Field Operations and Support;

⁹An RCA may be required by VHA policy if a VHA facility's initial review of an adverse event finds that there is a risk to the safety of veterans, based on the severity of the event and its likelihood of recurrence. Facility staff are made aware of adverse events through patient safety reports—which are used to report incidents involving patients that resulted or could have resulted in harm to patients, such as falls, medication errors, and suicides or suicide attempts. According to VBA officials, no veteran suicides occurred on VBA properties between fiscal year 2015 and fiscal year 2019.

¹⁰See [GAO-14-704G](#).

¹¹See *Department of Veterans Affairs Fiscal Years 2018–2024 Strategic Plan*; *National Strategy for Preventing Veteran Suicide 2018–2028*; and *PREVENTS: The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide*, June 17, 2020.

- VBA's Office of Field Operations and Office of Mission Support; and
- NCA's Cemetery Operations.¹²

We reviewed documents and interviewed VA officials regarding their efforts to address and analyze on-campus suicides. We also spoke with officials at the three VHA medical facilities we visited and discussed actions VA and the facilities have taken in response to these suicides, including any efforts to analyze the incidents. We compared VA's efforts to federal standards for internal control for the use of quality information and relevant control activities.¹³ We determined that the information and communication component of internal control was significant to this objective, along with the underlying principle that management should use quality information to achieve the entity's objectives.

We conducted this performance audit from June 2019 to September 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA Organization and Campuses

VA's mission is to serve America's veterans, and to do this it provides benefits to veterans, including health care, various types of financial assistance, and burial services. VA administers its services and programs through three distinct administrations—VHA, VBA, and NCA. In some instances, the VA administrations have facilities or offices that are co-located on the same campus.

¹²To gain additional insights on on-campus veteran suicides, we also interviewed representatives from national veterans service organizations, including The American Legion, Vietnam Veterans of America, Disabled American Veterans, and Iraq and Afghanistan Veterans of America.

¹³See [GAO-14-704G](#).

VHA operates one of the largest health care systems in the country, providing care at 1,240 medical facilities, such as VHA medical centers and community-based outpatient clinics, to more than 9 million veterans enrolled in VA's health care program. In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription drugs, and long-term care services. VHA is responsible for overseeing the delivery of care to enrolled veterans, as well as overseeing the health care professionals and support staff who deliver that care.

Within VHA, the Office of Mental Health and Suicide Prevention (OMHSP) monitors and supports the implementation of mental health policies and the performance of mental health programs in VHA medical facilities and conducts ongoing evaluations of mental health services and policies, according to VHA officials. The office was established in May 2017 with VHA's stated purpose of improving the quality and availability of behavioral and mental health services and reducing illness, death, disability and cost resulting from mental health disorders.¹⁴

In addition to VHA, VA campuses include VBA and NCA properties. Through its 56 regional offices across the nation, VBA provides veterans with a variety of non-medical benefits. For example, VBA pays monthly disability compensation to veterans with service-connected disabilities (injuries or diseases incurred or aggravated while on active military duty or training) according to the severity of the disability. NCA manages 137 VA national cemeteries across the United States. Within its cemeteries, NCA manages about 21,400 acres, of which approximately 57 percent is undeveloped.

VA Suicide Prevention

VA identified suicide prevention as its highest clinical priority in its strategic plan for fiscal years 2018 through 2024.¹⁵ Since 2006, VA has undertaken a number of initiatives to help prevent veteran suicide, including, for example:

¹⁴Before May 2017, suicide prevention and mental health issues were organizationally located under different offices within VHA.

¹⁵See Department of Veterans Affairs, *Department of Veterans Affairs Fiscal Years 2018-2024 Strategic Plan* (Washington, D.C.: May 31, 2019).

- **Center of Excellence and Veterans Crisis Line.** In 2007, VA established the Center of Excellence for Suicide Prevention and the Veterans Crisis Line. The Center of Excellence collects VA suicide prevention program data, which provides information on veteran suicides and suicide attempts for veterans receiving VA care, as well as those veterans not receiving VA care. VA's Veterans Crisis Line provides toll-free, confidential support 24 hours per day for veterans, their families, and their friends through phone, online chat, or text message.¹⁶
- **REACH VET.** In 2016, VA established the Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) initiative, which uses predictive modeling to analyze existing data from veterans' health records to identify veterans at increased risk for adverse outcomes, such as suicide, hospitalization, or illness. REACH VET coordinators staffed at medical centers are responsible for notifying the appropriate VHA mental health provider or primary care provider that a veteran has been identified as being at high risk for suicide, based on a high-risk list of veterans generated monthly by REACH VET's predictive model. After being identified by REACH VET, veterans are to be contacted by VA health care providers to determine whether additional care or services are needed.
- **Standardized suicide risk identification.** In 2018, VHA began implementing a standardized suicide risk identification process for all veterans receiving VHA health care that comprises three components: (1) annual initial screenings, (2) secondary screens for those veterans with positive initial screens and for those receiving mental health care, and (3) comprehensive screening for veterans with positive secondary screens or who demonstrated suicidal behavior. According to VHA, the three components

¹⁶Veterans, as well as their family and friends, can access the Veterans Crisis Line by calling a national toll-free number—1-800-273-8255—and pressing “1” to be connected with a responder, regardless of whether these veterans receive health care through VA. The Veterans Crisis Line can also be reached online at www.VeteransCrisisLine.net, or by sending a text message to 838255. We have previously reported on the Veterans Crisis Line and made recommendations for improving the timeliness and quality of VA's Veterans Crisis Line responses. VA concurred with our recommendations and in July 2016, developed and implemented procedures to regularly test the Veterans Crisis Line system. In addition, in July 2017, VA updated its Veterans Crisis Line quality assurance plan to document measurable targets and time frames for key performance indicators needed to assess the Veterans Crisis Line's performance. See GAO, *Veterans Crisis Line: Additional Testing, Monitoring, and Information Needed to Ensure Better Quality Service*, [GAO-16-373](#) (Washington, D.C.: May 26, 2016).

facilitate a population-based mental health screening for those with unrecognized risk; a screening for those who may be at risk; and screening and evaluation for those at elevated risk. VHA implemented the suicide risk identification process in three phases—one phase for each of the three components. According to VHA, it completed implementation of all three components in October 2019.¹⁷

VA Facility Reporting of On-Campus Veteran Suicides

According to VA policy, VA facilities are required to report information about on-campus veteran suicides to VA's leadership through the following mechanisms among others—each with its own requirements and purpose:¹⁸

- **VHA Issue Briefs:** VHA medical facility staff are to report serious incidents—including on-campus veteran suicides—through VHA Issue Briefs, which are reports provided by VHA medical facilities to VA leadership to notify them of unusual incidents, unexpected deaths such as suicides, disasters, or anything else that might generate media interest or impact care delivery. For an on-campus veteran death by suicide, facility officials are required to report details such as the suspected cause of death, whether the veteran had received VA health care, including any mental health care, and the date and type of the last appointment when this

¹⁷See Department of Veterans Affairs, *VA's Memorandum on Suicide Risk Screening and Assessment Requirements* (Washington, D.C.: May 23, 2018); *VA's Memorandum on Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation* (Washington, D.C.: Nov. 02, 2018); *VA's Memorandum on Eliminating Veteran Suicide: Update on Suicide Risk Screening and Evaluation* (Washington, D.C.: Feb. 22, 2019); and *VA's Memorandum on Eliminating Veteran Suicide: Implementation Updated on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives* (Washington, D.C.: Oct. 17, 2019).

¹⁸VHA medical facilities also provide VA leadership, defined in this report as officials in VA Central Office, with additional information about veteran suicides through VHA's Suicide Prevention Application Network and Suicide Behavior and Overdose Reports. Through these mechanisms, VHA medical facilities are to submit additional information to VA leadership on suicides and suicide attempts. VHA medical facilities are also required to complete peer reviews for all in-patient suicides and suicides that occur within 7 days after discharges from in-patient mental health treatment or residential care. Peer review for quality management is used when there is a need to determine whether a provider's actions associated with an adverse event were clinically appropriate—that is, whether another provider with similar expertise would have taken similar action.

information is available—usually within 2 business days from the time of the incident.

- **Root Cause Analyses (RCA):** When a veteran dies by suicide during or soon after receiving care at a VHA medical facility, VHA medical facilities are required by policy to complete an RCA—a process to identify and evaluate systems or processes that caused an adverse event, recommend changes to the systems or processes to prevent the event’s recurrence, and determine whether the recommended changes, when implemented, are effective.¹⁹ According to VHA policy, an RCA must be conducted for: (1) any inpatient suicide, (2) all outpatient suicides within 72 hours of discharge from status as an inpatient, and (3) all outpatient suicides within 7 days of discharge from inpatient psychiatric treatment.²⁰ RCAs are used to identify the factors that contributed to adverse events or close calls, such as suicide attempts, and any steps VHA medical facilities could implement to prevent similar events in the future.²¹ VHA National Center for Patient Safety staff are responsible for categorizing and analyzing RCA data, and the center provides training and education for medical facility staff on the RCA process. According to VHA policy, the National Center for Patient Safety is also responsible for disseminating important information learned from RCAs, to VHA staff.
- **Behavioral Health Autopsy Program (BHAP):** In December 2012, VHA began the BHAP as a national initiative to collect demographic, clinical, and other related information on veteran suicides to improve its suicide prevention efforts by identifying

¹⁹VHA facility staff who complete RCAs are made aware of some veteran suicides through VHA patient safety reports. Specifically, as of July 2020, facility staff are required to complete patient safety reports for inpatient suicides at a VHA facility; suicides within 3 days of discharge from a VHA facility; suicides within 7 days of discharge from a VHA inpatient mental health unit or VHA residential unit, or a suicide death or attempt by a VHA-enrolled veteran on a VHA campus. Facility staff may also complete a patient safety report for any suicide attempt or death where the VHA medical facility patient safety manager feels there were system failures that could/should be addressed by the facility.

²⁰See Department of Veterans Affairs, Veterans Health Administration Handbook 1150.01, *VHA National Patient Safety Improvement Handbook* (Washington, D.C.: Mar. 04, 2011).

²¹A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as “near miss” incidents. See Department of Veterans Affairs, Veterans Health Administration Handbook 1150.01: *VHA National Patient Safety Improvement Handbook* (Washington, D.C.: Mar. 04, 2011).

information that could be used to develop policy and procedures to help prevent future veteran deaths.²² As part of this initiative, VHA medical facility suicide prevention coordinators are required to complete standardized medical chart reviews for all veteran suicides known to facility staff and reported on or after October 1, 2012.²³ As part of the BHAP, VHA collects a veteran's demographic data, such as date of birth, date of death, race, ethnicity, and gender; and also collects clinical data, such as the date of the veteran's final VHA visit, whether that visit was outpatient or inpatient, and the results of any mental health screens, including those for depression. VHA also conducts interviews with family members of those who die by suicide who agree to participate in the BHAP to obtain information on suicide risks, barriers to care, and suggestions for new programs to prevent suicide, according to officials from VHA's Center of Excellence for Suicide Prevention.

In addition, officials from VBA offices, NCA cemeteries, and VA Police are required to complete incident reports following an on-campus suicide. VBA officials, through situation reports, and NCA officials, through first notification of event reports, notify VA leadership of serious incidents—including suicides—that occur on VBA or NCA campuses, respectively. VA Police generate incident reports when they are notified of a death by suicide on a VA campus. According to officials from VA's Office of Operations, Security, and Preparedness, every VHA medical facility that is considered a medical center has a VA Police service, which has sole responsibility for law enforcement functions at each medical center.²⁴

²²See Department of Veterans Affairs, *VA's Memorandum on Behavioral Autopsy Program Implementation* (Washington, D.C.: Dec. 11, 2012).

²³VHA medical facilities are required to submit the BHAP medical chart review to VA's Center of Excellence for Suicide Prevention within 30 days of facility staff becoming aware of a veteran's death by suicide. Medical facilities can also submit reviews for veterans who did not utilize VHA health care services. Veterans not seen by VHA medical staff will not have clinical information available in VHA's medical records, but facilities can report information that is known through other mechanisms, such as a coroner's report or the veteran's family members, if available. According to VA, a comprehensive suicide prevention program requires timely and accurate information beyond that acquired from veterans being seen in VHA. Data on these veterans are needed to, among other things, improve understanding of suicide among all veterans.

²⁴According to VA policy, the Office of Operations, Security, and Preparedness coordinates VA's emergency management, preparedness, personal identity verification, physical security, personnel security and suitability, police services and law enforcement activities to ensure the Department can continue to perform the mission essential functions under all circumstances across the spectrum of threats.

However, unless co-located with a medical center, VA Police jurisdiction does not extend to VBA offices or NCA cemeteries.

VA Began Tracking the Number of On-Campus Veteran Suicides in Fiscal Year 2018, but Weaknesses in Its Process Have Produced Inaccurate Numbers

VA has a process to identify on-campus suicides; however, its numbers are inaccurate. Prior to October 2017, VHA officials told us that there was no systematic process in place to identify the number of veterans who died by suicide on VA campuses. VA officials said that they identified the need to compile information from existing data sources to identify these incidents amidst concerns that there may be an increasing trend.

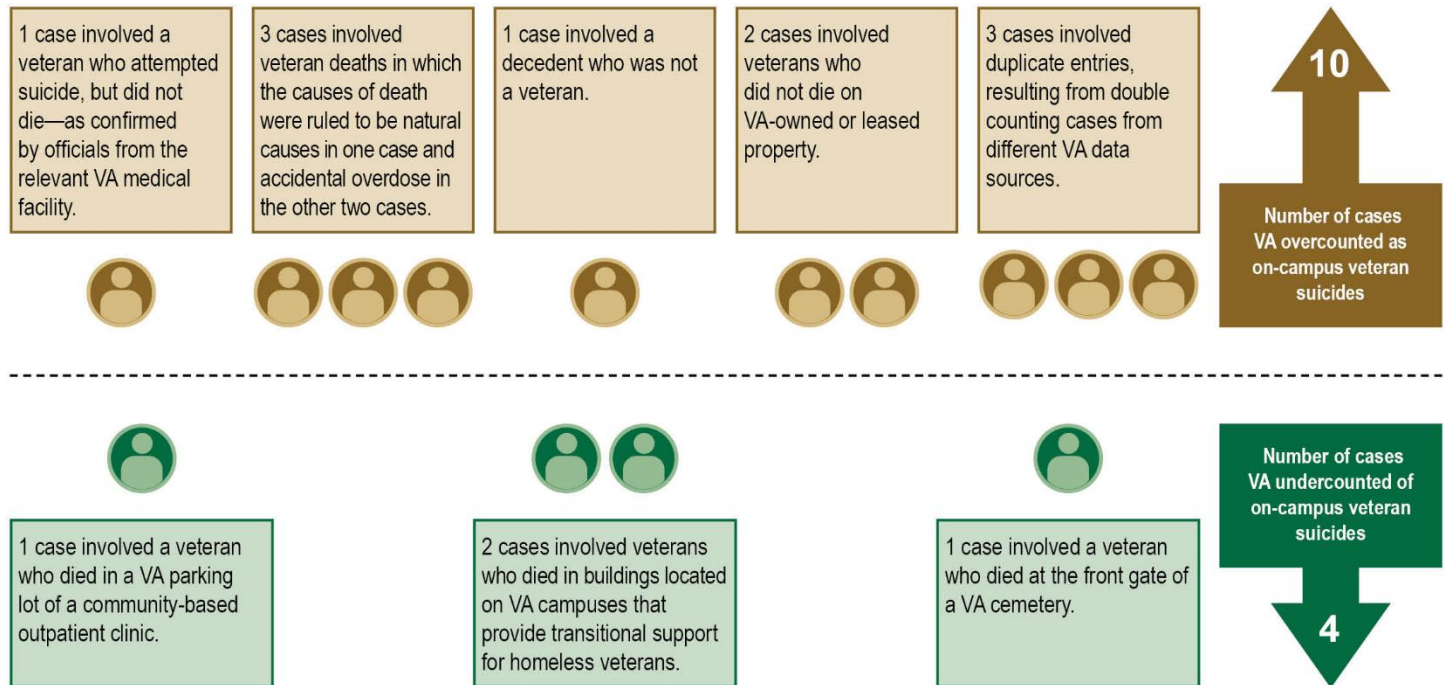
In October 2017, VHA's Office of Mental Health and Suicide Prevention (OMHSP) established a process for obtaining information on the number of on-campus veteran suicides from a variety of VA data sources because, according to VHA officials, no single source of VA data provides a comprehensive count of these incidents. Specifically, they began reviewing and cataloging VHA Issue Briefs. In addition, OMHSP officials told us that they coordinate with VHA's National Center for Patient Safety, NCA, and VA Police quarterly to identify potential gaps in VHA Issue Brief reporting of on-campus suicides. On a monthly basis, according to VHA officials, VHA reports to VA leadership information on the number of suicide attempts and deaths that occurred on VA campuses; the number of associated root cause analyses (RCA); and a count of the veterans who were receiving mental health care from VHA at the time of their attempts or deaths by suicide. OMHSP officials told us that the results of VHA's process is also used to inform Congress about on-campus suicides, which they began doing in April 2019.

VHA's list, which OMHSP officials told us they used to inform Congress and was reportedly up-to-date through the end of fiscal year 2019, showed that 55 veterans died by suicide on VA campuses during fiscal years 2018 and 2019, with 31 suicides occurring in fiscal year 2018 and 24 suicides occurring in fiscal year 2019. Although VHA officials told us that they conduct periodic spot checks of the data they compile to ensure the correct use of the underlying data to identify cases of on-campus veteran suicides, we found errors in VHA's list. Specifically, we identified

four cases of undercounting (deaths that should have been reported as an on-campus veteran suicide but were not) and 10 cases of overcounting (deaths that were reported as on-campus veteran suicides but should not have been).²⁵ For example, VHA's list did not include a suicide that occurred in a VA parking lot of a community-based outpatient clinic despite the death being reported in a VHA Issue Brief and VA Police data. In contrast, VHA's list also included one case as a suicide, in which the veteran was alive. Our review of the VHA Issue Brief indicated that the veteran attempted suicide, but had not died, and thus should not have been included in VHA's count of deaths by suicide; officials at the relevant medical facility confirmed that the veteran was alive (see fig. 1).

²⁵There may be more cases of undercounts and overcounts that we were unable to identify. It was our intention to administer a data collection instrument to all VHA medical facilities to obtain an accurate count of on-campus veteran suicides between fiscal years 2015 and 2019. However, due to VHA's need to prioritize its staff's efforts to respond to Coronavirus Disease 2019 (COVID-19), in April 2020 VHA officials asked us to postpone administering the data collection instrument and we decided to forgo using the data collection instrument as part of this review due to the uncertainty around the length of the delay. The examples described here provide an illustration of the inaccuracies found.

Figure 1: Examples of Errors on the Department of Veterans Affairs' (VA) List of 55 On-Campus Veteran Suicides for Fiscal Years 2018 and 2019 (as of September 2019)



Source: GAO analysis of VA data. | GAO-20-664

We determined that VHA's list of on-campus veteran suicides is inaccurate because VHA's process for identifying such suicides is not robust. Specifically, as it develops its list, VHA does not obtain complete information or corroborate the information it obtains with other sources. OMHSP officials told us they review VHA Issue Briefs and subsequent updates to identify on-campus suicides. However, these officials also told us they did not obtain the VHA Issue Briefs in two cases, which we found resulted in at least two of the undercounts of on-campus suicides, and subsequent updates to VHA Issue Briefs, which we found resulted in at least three of the overcounts. For example, at one VHA facility included in our review, the facility updated the Issue Briefs to reflect that two suicides included on VHA's list were determined to be an accidental overdose and a death by natural causes, but these updates, which were made in July and August of 2018, were not reflected on VHA's list—which VHA officials told us was up-to-date through the end of September 2019.

These updates are important because it is not always immediately clear whether a death was a suicide or whether there was another cause (e.g.,

accidental, natural), and it may take a coroner or medical examiner's review to determine the official cause of death. Furthermore, VHA is not corroborating the information on its list with other sources, including VHA medical facilities. Although OMHSP officials told us they coordinate with other VA offices on a quarterly basis to identify any potential gaps in VHA Issue Brief reporting, all four of the undercounts that we identified were captured in VA Police data. Additionally, officials at two VHA medical facilities we visited based on VHA's information that indicated they had multiple on-campus suicides, told us that the information was incorrect. Officials from these facilities provided us with the most up-to-date information at the time of our visits, which showed the deaths were not suicides.

VA's inaccurate information is at odds with VHA's own goals. Specifically, in its National Strategy for Preventing Veteran Suicides, VHA identified the need for quality veteran suicide-related data to better understand the scope of the problem. The inaccurate information is also inconsistent with federal internal control standards, which state that management should use quality information that is complete and accurate to achieve the entity's objectives—in this case, the collecting of quality data on suicides that occur on VA-campuses.²⁶ Without a robust process that accurately identifies all on-campus veteran deaths by suicide, VHA risks continuing to report incorrect information about these incidents to the public and Congress, as well as preventing VA from understanding the extent of the issue.

VA Has Taken Steps to Address On-Campus Veteran Deaths by Suicide, but Analyses Informing VA's Response Are Limited

VA Has Issued Guidance and Taken Other Actions in Response to On-Campus Deaths by Suicide

VA and VHA have undertaken several efforts to address the issue of veteran suicides occurring on VA campuses. These efforts include:

- **Guidance for VHA medical facilities.** In June 2019, VHA issued guidance to medical facility staff on actions to take following an

²⁶See [GAO-14-704G](#).

on-campus suicide, including reporting the incident to VA leadership, reaching out to the deceased veteran's family to offer support, and offering support to employees affected by the death.²⁷ For example, immediately following an on-campus suicide, the guidance directs facility staff to alert emergency services (medical response teams and VA Police) and notify facility leadership. The guidance also directs facility staff to mobilize facility support, which includes activating a crisis response directed at employees and other individuals who were involved with the veteran's care or affected by the death. In addition, the guidance outlines the notification of the deceased veteran's family or next of kin of the death. One of the three selected VHA medical facilities included in our review experienced an on-campus veteran suicide following the issuance of this guidance. According to that facility's suicide prevention coordinators, the facility followed this guidance.

- **Improvements in VA Police patrolling.** According to officials from VA's Office of Operations, Security, and Preparedness, VA has taken steps to improve VA Police patrol activity on VA campuses in an effort to prevent future on-campus veteran deaths by suicide. Through its VA Police Infrastructure Protection, Intelligence, and Crimes Analysis Division, VA's Office of Operations, Security, and Preparedness conducts analyses of VA Police data of on-campus suicides dating back to calendar year 2015, and suicide attempts that were averted by VA police intervention. According to officials, the results of these analyses are provided to VA Police chiefs twice a year to inform police patrol activity that could serve as preventative actions, such as regularly checking parking lots, and increased questioning of those who seem like they might need help.
- **Expanded suicide prevention training for VHA staff.** According to officials from OMHSP, VHA expanded its suicide prevention training requirements for clinical and non-clinical staff at VHA medical facilities in response to on-campus suicides. Officials told us VHA's suicide prevention training emphasizes the ability to both identify and respond when a veteran is at risk of suicide. As

²⁷The guidance was initially issued to VHA staff in June 2019 and was updated in November 2019 to include information on available supports for facility staff affected by the incident and the family of the veteran involved in the incident. See Department of Veterans Affairs, *VA's Memorandum on Guidance for Action Following a Suicide on a Department of Veterans Affairs (VA) Campus* dated Nov. 13, 2019.

of December 2017, VHA staff must complete the required suicide risk and intervention training module and pass a course test within 90 days of entering their position.²⁸

- **VHA medical facility safety improvements.** According to OMHSP officials, VHA has taken steps to improve the safety of locations in VHA facilities that care for veterans at risk of suicide, including mental health units and emergency departments. For example, VHA developed its Mental Health Environment of Care Checklist and, in May 2017, directed all VHA medical facilities to use this checklist in the treatment of suicidal patients, and in the design of space for the treatment of veterans with mental health conditions in emergency departments and urgent care.²⁹ The checklist was designed, according to VHA policy, to help facilities identify and address environmental risks for suicide and suicide attempts while veterans are being treated on acute inpatient mental health units and other areas. According to officials from VHA's National Center for Patient Safety, facility staff are required to use the checklist every 6 months to identify facility features that may increase the risk for suicide, such as items that may be used for strangulation or suffocation; and develop a plan to correct any identified deficiencies.

As another example of facility safety improvements, in May 2019, VHA directed all of its medical facilities with an acute mental health unit to install door top alarms on swinging corridor doors of patient rooms by February 1, 2020.³⁰ According to officials from one of the VHA medical facilities we visited, the purpose of a door top alarm is to alert facility staff to intervene if a patient is attempting to use the door as a ligature point to hang themselves. Patient safety managers at some of the selected VHA medical facilities included in our review told us their facilities are using the

²⁸Veterans Health Administration Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees* (Dec. 22, 2017). Clinical staff are required to complete annual clinical training on suicide prevention and intervention and all non-clinical staff are required to take annual "Signs," "Ask," "Validate," and "Encourage" and "Expedite" or S.A.V.E. refresher training. Before the training expansion in December 2017, clinical staff were required to receive suicide risk training every 3 years and non-clinical staff were required to receive S.A.V.E. training every 2 years. According to VHA officials, VHA tracks compliance with these training requirements on a monthly basis through its Talent Management System training portal.

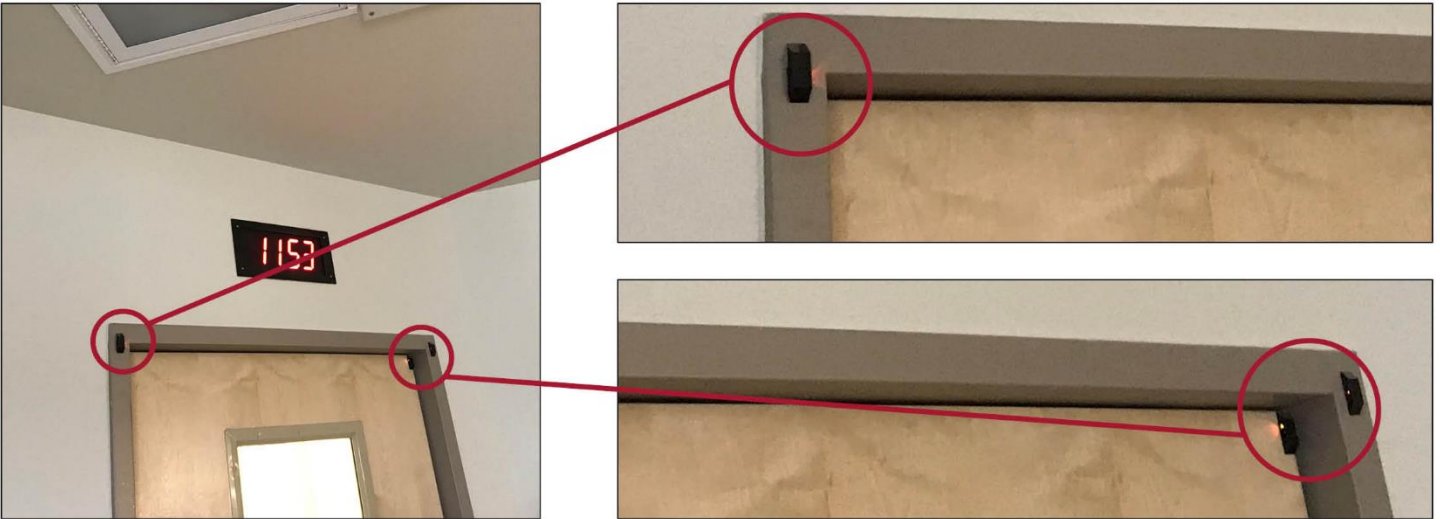
²⁹Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients* (May 12, 2017).

³⁰See Department of Veterans Affairs *Memorandum on Use of Over-the-Door Alarms for Corridor Doors in Acute Mental Health Units Treating Suicidal Patients*, May 10, 2019.

**Appendix I: Comments from the Department of
Veterans Affairs**

Mental Health Environment of Care Checklist and their facilities have installed door top alarms or are in the process of doing so. Officials from these facilities also told us about other safety improvements these facilities made to prevent on-campus suicides, such as installing heightened barriers to prevent individuals from jumping from elevated locations (see fig. 2).

Figure 2: Examples of Safety Improvements Made by Selected Department of Veterans Affairs Medical Centers to Prevent On-Campus Suicides (December 2019 and January 2020)



Over-the-door alarm installed at an inpatient mental health unit.



Heightened barriers added at a medical center to prevent attempts to jump into the open atrium.

Source: GAO. | GAO-20-664



Heightened barriers at a parking garage to prevent efforts to jump off the structure.

VHA's Analyses Informing VA's Response to On-Campus Veteran Suicides Are Limited

VHA has taken steps to analyze on-campus veteran suicides to inform its efforts to prevent future incidents from occurring. Specifically, VHA policy directs facilities to conduct root cause analyses (RCA)—focused reviews that assess what happened, why it happened, and what can be done to prevent it from happening again—for some on-campus veteran suicides. In addition, according to VHA officials, the Office of Mental Health and Suicide Prevention (OMHSP) analyzes information it collects through its efforts to identify on-campus suicides. However, we found that these efforts are limited because RCAs are not conducted for most on-campus veteran suicides and OMHSP does not make use of all the relevant information VA collects about the veterans involved in these incidents for its analyses.

RCAs. According to VHA officials, RCAs provide information on opportunities to improve patient safety with the goal of preventing recurrences of adverse events. However, we found that RCAs are not conducted for most on-campus veteran deaths by suicide. According to National Center for Patient Safety officials, RCAs were not conducted for 27 of the 36 on-campus veteran suicides that VHA identified between October 1, 2017 and April 1, 2019. Moreover, at the three VHA medical facilities included in our review, we found that RCAs were not conducted for four of the five on-campus veteran deaths by suicide that occurred between fiscal years 2015 and 2019.

Through discussions with National Center for Patient Safety officials, we found that VHA facilities do not conduct RCAs for all on-campus veteran suicides because VHA policy does not require them to do so. Specifically, VHA policy only requires RCAs for: (1) any inpatient suicide, (2) all outpatient suicides within 72 hours of discharge from status as an inpatient, and (3) all outpatient suicides within 7 days of discharge from inpatient psychiatric treatment.³¹ In contrast, National Center for Patient Safety officials told us facilities are not required to conduct RCAs for other on-campus suicides that do not meet this criteria, such as those in which the veteran was never an inpatient, because there is no potential for

³¹Department of Veterans Affairs, Veterans Health Administration Handbook 1150.01, *VHA National Patient Safety Improvement Handbook* (Washington, D.C.: Mar. 04, 2011).

system or process improvements for an RCA to identify for these incidents.

However, limiting RCAs and their potential links to improvements only to veterans who are or have been recent inpatients may fail to identify other at-risk veterans. For example, we found that an on-campus veteran suicide at one of the medical facilities included in our review occurred 22 days following discharge from inpatient psychiatric treatment—15 days beyond the criteria for an RCA—and 11 days following an outpatient mental health appointment at the facility. Consequently, an RCA was not conducted for this incident, even though the veteran had recently received inpatient and outpatient mental health care at the facility.

OMHSP Analyses. According to VHA officials, in addition to RCAs, OMHSP analyzes information it collects as part of its effort to identify on-campus veteran suicides and, on a monthly basis, reports to VA leadership information on the number of suicide attempts and deaths by suicide that occurred on VA campuses; the number of associated RCAs; and a count of the veterans who were receiving mental health care from VHA at the time of their attempts or deaths by suicide. OMHSP officials told us the purpose of these analyses is to determine areas of opportunity for policy changes and care enhancement to prevent future incidents.³²

OMHSP's analysis of on-campus veteran suicides is based on VHA Issue Briefs, which we found includes relevant information for analyzing this issue, such as information about the location and method of suicide and some of the veteran's clinical information (e.g., dates of any recent VHA care). However, OMHSP does not use other sources of relevant information VA collects about the veterans involved in these incidents that could strengthen its analysis, such as information from RCAs or information collected through the Behavioral Health Autopsy Program (BHAP)—a quality improvement initiative by VHA to improve its suicide

³²We reviewed the July 2019 monthly report OMHSP provided to VHA leadership and it included information on the number of on-campus veteran deaths by suicide and suicide attempts for July 2019 and the 4 months prior, and whether the veterans involved in these incidents: were currently receiving mental health care, had a "high risk for suicide" flag in place (an indicator placed on a veteran's medical record when that veteran is deemed high-risk for suicide), or missed a recent appointment. In addition, the reports also included information on whether an RCA was conducted for each case, but did not provide any information from the RCAs. OMHSP officials told us they are working on a summary-level report on on-campus veteran suicides using the data from its tracking of these incidents to inform suicide prevention activities and help inform VA leadership, but were unable to provide us with an estimated completion date for the report.

prevention efforts—among others.³³ For example, we found that through its BHAP medical chart reviews, VHA collects detailed information about veterans and their clinical histories that is not routinely collected through VHA Issue Briefs, and which could help inform OMHSP's analyses, such as information on veterans':

- **sociodemographic characteristics**—veterans' marital status, primary source of income, sexual orientation, educational level, race, and ethnicity.
- **military histories**—whether veterans served in a military conflict or combat zone and the era when the veteran served (e.g., World War II, Vietnam).
- **clinical histories**—whether the veteran used non-VA care, and the number of prior suicide attempts and whether the veteran had a family history of suicide.

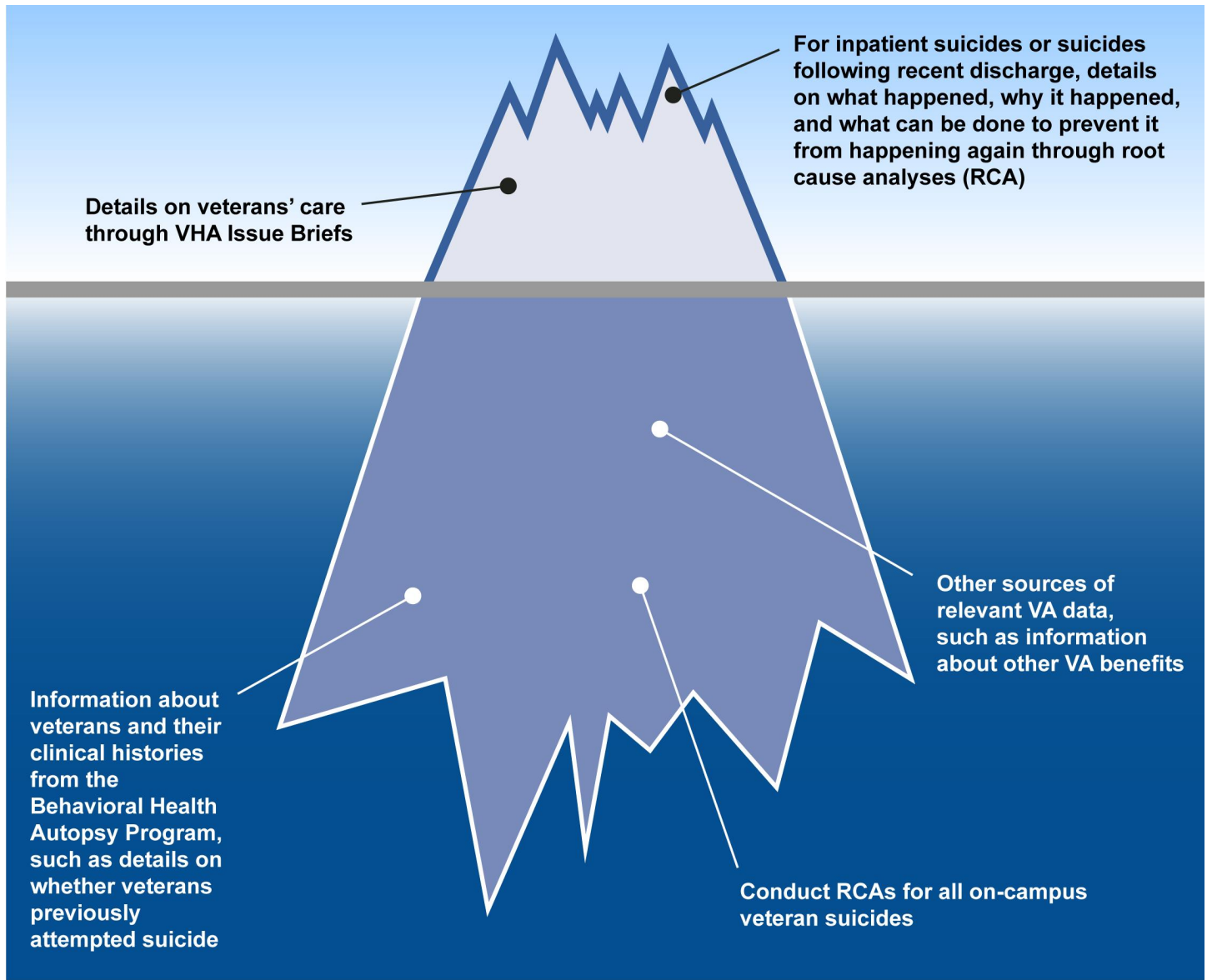
According to VHA policy, a facility's suicide prevention coordinator is required, as part of the BHAP, to collect this and other information through a standardized medical chart review within 30 days of the facility becoming aware of a veteran suicide.

OMHSP officials told us they do not use any of the other sources of relevant information VA collects about the veterans and incidents in their analyses because they are unable to link these other sources of information to the VHA Issue Briefs, which is OMHSP's primary source for identifying these incidents. Specifically, OMHSP officials told us VHA Issue Briefs do not include any personally identifiable information (e.g., social security number, names) that could be used to link VHA Issue Briefs to any other VHA documents, such as RCAs or BHAP medical chart reviews. However, even though Issue Briefs do not include any personally identifiable information, VHA facility staff must collect specific details about the veteran from sources that include personally identifiable information—such as medical records—in order to create the Issue Brief and, as a result, should be able to link the Issue Briefs to other sources of information. For example, during our interviews with officials from the three VHA medical facilities included in our review, we found that medical facility staff were able to link the VHA Issue Briefs for these incidents to other sources of information VHA collects about these veterans, including

³³In addition to suicide-related data, VA collects information about veterans that could be useful in understanding these deaths. For example, VBA provided us with an overview of the benefit history for one of the veterans who died by suicide on a VA-campus.

available VHA medical records and RCAs and BHAP medical chart reviews (see fig. 3).

Figure 3: Information the Veterans Health Administration (VHA) Uses and Could Use to Analyze On-Campus Veteran Suicides



- Information VHA uses to analyze on-campus veteran suicides
- Additional Information VHA could use to analyze on-campus veteran suicides

Source: GAO analysis of Department of Veterans Affairs' (VA) data. | GAO-20-664

VHA has taken steps to analyze on-campus veteran suicides in an effort to determine areas of care enhancement and opportunities for policy changes to prevent future incidents. According to its National Strategy for Preventing Veteran Suicides, VA and its stakeholders must reduce the burden of suicide among all veterans, whether or not they are receiving benefits or services from VA to eliminate veteran suicide and, to reach this goal, VA is committed to furthering research, gathering quality data, identifying and sharing best practices, and transforming the delivery of care and support to veterans. Additionally, as stated in PREVENTS, high-quality data plays a critical role in furthering the understanding of suicide and suicidal behaviors, as well as aiding in developing strategies to ensure that a veteran is provided with interventions tailored to their risk profile. Despite VA's commitment to furthering research and the gathering of quality data, we found that VHA's efforts to analyze these incidents are limited. Specifically, we found that an RCA is not conducted for most on-campus veteran suicides, including cases where the veteran was not enrolled in VHA. Further, OMHSP uses only some of the relevant information VA collects about the veterans involved in these incidents to inform its analyses. Federal standards for internal control state that management should use quality information to achieve the entity's objectives—in this case, the prevention of on-campus suicides.³⁴ By relying on limited information, VHA has limited the quality of its analyses, which impedes its ability to determine whether specific actions could be taken to reduce on-campus veteran suicides, or to make other improvements.

Conclusions

VA has stated that preventing veteran suicide is its top clinical priority; yet it does not have accurate information on how many veterans have died by suicide on its own campuses. Its analyses are limited because of the information used, hindering its ability to make informed strategic decisions about efforts aimed at preventing future on-campus suicides. VHA first began tracking these incidents in October 2017, yet, the process it developed to identify these incidents is weak, resulting in inaccurate information for VA leadership and Congress and a lack of understanding of the extent of the issue. VHA's efforts to prevent future on-campus suicides are further limited by its decision not to comprehensively analyze the issue. Without accurate information on the number of suicides and

³⁴See [GAO-14-704G](#).

comprehensive analyses of the information available, VA does not have a full understanding of the prevalence and nature of on-campus suicides, hindering its ability to address them.

Recommendations for Executive Action

We are making the following three recommendations to VA:

The Under Secretary for Health should, in collaboration with relevant VBA and NCA officials, improve its process to accurately identify all on-campus veteran deaths by suicide by ensuring that it uses updated information and corroborates information with VA facility officials. (Recommendation 1)

The Under Secretary for Health should expand the policy requirement for a root cause analysis to include all cases of on-campus veteran death by suicide, regardless of whether the veterans involved were enrolled in VHA health care services at the time of their death. (Recommendation 2)

The Under Secretary for Health should direct the Office of Mental Health and Suicide Prevention to expand its analyses of on-campus veteran deaths by suicide to include all relevant information VA collects for these incidents, such as data from root causes analyses and information collected through the Behavioral Health Autopsy Program. (Recommendation 3)

Agency Comments and Our Evaluation

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix I, VA concurred with recommendations 1 and 3. VA stated that VHA's OMHSP would establish a standing committee to evaluate the issues we identified in each of our recommendations. VA gave a target date of July 2021 for completion of the committee's review.

VA did not concur with recommendation 2 to expand the policy requirement for an RCA to be conducted on all cases of on-campus veteran deaths by suicide. VA stated that while it agreed with our points regarding the importance of suicide surveillance, it did not agree that the RCA is always the appropriate tool. As stated in this report, RCAs are an existing and established process for analyzing adverse events that VA

used to evaluate 25 percent of on-campus suicides from October 2017 to April 2019—those suicides that met VA's criteria requiring an RCA. Our concern, however, is for the 75 percent of on-campus suicides that do not meet the criteria.

To address this concern, VA stated that the OMHSP standing committee it plans to establish would identify opportunities to expand the reporting of serious incidents by VA administrations, other than VHA, and further develop reporting methods, with a target date of July 2021 for completion. The reporting methods VA plans, according to VA, should include optional data surveillance elements, as well as identifying methods for enhancing approaches to extract core and optional data elements for trend analysis and ongoing process improvement.

Rather than creating a new process, we continue to believe that VA should utilize its existing process and perform RCAs for every on-campus suicide in order to understand what happened, why it happened, and if it could be prevented in the future. RCAs provide a mechanism to better ensure the consistent collection and analysis of information—in this case, for on-campus suicides. Moreover, the resultant analyses should provide critical information about potential system-wide weaknesses, creating important opportunities for improvement, which is an important purpose of an RCA.

VA provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or DraperD@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Sincerely yours,

Appendix I: Comments from the Department of
Veterans Affairs

A handwritten signature in black ink, appearing to read 'DA Draper', written in a cursive style.

Debra A. Draper
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs

Appendix I: Comments from the Department of
Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

August 20, 2020

Ms. Debra Draper
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VETERAN SUICIDE: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*** (GAO-20-664).

The enclosure contains technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in blue ink that reads "Brooks D. Tucker".

Brooks D. Tucker
Acting Chief of Staff

Enclosure

**Appendix I: Comments from the Department of
Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***VETERAN SUICIDE: VA Needs Accurate Data and Comprehensive Analyses to
Better Understand On-Campus Suicides***
(GAO-20-664)

Recommendation 1. The Under Secretary for Health should, in collaboration with relevant VBA and NCA officials, improve its process to accurately identify all on-campus Veteran deaths by suicide by ensuring that it uses updated information and corroborates information with VA facility officials.

VA Response: Concur. The Veterans Health Administration (VHA) Office of Mental Health and Suicide Prevention will establish a standing committee that includes relevant representation from VHA, the Veterans Benefits Administration, the National Cemetery Administration and the Office of Human Resources and Administration/Office of Operations, Security and Preparedness (HRA/OSP). HRA/OSP is an essential member of this committee because this office has information about on-campus suicides that may not be available through other avenues. This committee will provide the Under Secretary for Health with actionable recommendations to improve processes for accurately identifying on-campus Veteran deaths by suicide. In addition to reviewing current processes, the committee will work with the VHA Office of Regulatory and Administrative Affairs to review and make recommendations for revisions to relevant policies, and as applicable, VA's Office of Enterprise Integration to review and make recommendations on data collection, management and analytics.
Target Completion Date: July 2021.

Recommendation 2. The Under Secretary for Health should expand the policy requirement for a root cause analysis to include all cases of on-campus Veteran death by suicide, regardless of whether the Veterans involved were enrolled in VHA health care services at the time of their death.

VA Response: Non-concur. VA agrees with GAO's points regarding the importance of suicide surveillance but does not agree that Root Cause Analysis is the appropriate tool for conducting suicide surveillance for all cases.

Consistent with the Centers for Disease Control and Prevention and World Health Organization (WHO) guidelines and recommendations, VHA requires issue briefs for all suicide attempts and deaths that occur at VA Medical Centers. VHA issue brief requirements do not, however, extend to other VA Administrations. The committee cited in Recommendation 1 will identify opportunities to expand issue brief reporting to other VA Administrations and further develop reporting methods, which will expand inclusion of WHO core and optional data surveillance elements. The committee will also identify methods for enhancing approaches to extract core and optional data elements for trend analysis and ongoing process improvement.

Page 1 of 4

**Appendix I: Comments from the Department of
Veterans Affairs**

Enclosure

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Government Accountability Office (GAO) Draft Report
***VETERAN SUICIDE: VA Needs Accurate Data and Comprehensive Analyses to
Better Understand On-Campus Suicides***
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Recommendation 3. The Under Secretary for Health should direct the Office of Mental Health and Suicide Prevention to expand its analyses of on-campus Veteran deaths by suicide to include all relevant information VA collects for these incidents, such as data from root causes analyses and information collected through the Behavioral Health Autopsy Program.

VA Response: Concur. As part of actions undertaken within Recommendation 1, recommendations will be made to the Under Secretary for Health to update processes and policies around coordination and data sharing associated with on-campus suicide death information. As a result, it is anticipated that the Under Secretary for Health shall direct the Office of Mental Health and Suicide Prevention in collaboration with other offices to further formalize processes for timely analyses of on-campus Veteran deaths by suicide to include all relevant information VA collects for these incidents including, but not limited to, Behavioral Health Autopsy Program data, Root Cause Analysis data, police reports, incident reports and information from facilities.
Target Completion Date: July 2021.

Page 2 of 4

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann (Assistant Director), Jim Melton (Analyst-in-Charge), Brittaini Maul, and Matt Nattinger made key contributions to this report. Also contributing were Jennie Apter, Sonia Chakrabarty, Julianne Flowers, Dhara Patel, and Vikki Porter.

Appendix III: Accessible Data

Agency Comment Letter

Accessible Text for Appendix I Comments from the
Department of Veterans Affairs

Page 1

August 20, 2020

Ms. Debra Draper Director

Health Care

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

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Acting Chief of Staff

Enclosure

Page 2

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Target Completion Date: July 2021.

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Page 3

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Target Completion Date: July 2021.

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