GAO@100 Highlights

Highlights of GAO-21-326, a report to congressional committees

April 2021

VA HEALTH CARE

Efforts Needed to Ensure Effective Use and Appropriate Staffing of Suicide Prevention Teams

Why GAO Did This Study

Compared to the general population, veterans suffer a disproportionately higher rate of suicide. VA has stated that suicide prevention is the agency's top clinical priority. At its local medical facilities, VHA employs suicide prevention teams, which include coordinators—staff with a full-time commitment to suicide prevention activities—and case managers.

The Support for Suicide Prevention Coordinators Act included a provision for GAO to review, among other issues, the responsibilities and workload of suicide prevention coordinators. This report examines how VHA (1) uses local suicide prevention teams, and (2) helps determine facilities' suicide prevention staffing needs. To do this work, GAO analyzed team staffing data, reviewed VHA policies, and interviewed OMHSP officials and team staff from five medical facilities. The facilities were selected for variation in composition of suicide prevention teams, geographic location, and total number of patients, among other factors.

What GAO Recommends

GAO is making three recommendations, including that VHA (1) conduct an evaluation of local suicide prevention teams that includes an identification of the effects of program growth on workload, and (2) incorporate key practices for staffing model design into its determination of facilities' suicide prevention staffing needs. VA concurred with GAO's recommendations and identified actions it is taking to address them.

View GAO-21-326. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) uses suicide prevention teams at local facilities to implement its Suicide Prevention Program, which was mandated by law in 2007. As VHA has added new initiatives to the program since its inception—such as Risk ID, a standardized suicide risk identification process that it initiated in 2018—local teams' activities have increased, in particular as more veterans at risk of suicide are identified. This has created challenges, according to the selected teams in GAO's review. For example, team staff at one facility said they have experienced burnout and turnover due to new initiatives and a large caseload of veterans at high risk for suicide. Staff from a team at another facility said they typically manage a caseload of about 150-200 veterans identified as being high risk for suicide. According to VHA guidance, teams are expected to engage in a number of activities related to these veterans, including regular interactions. Team staff at one facility noted the importance of these interactions in building relationships with veterans at risk of suicide, so veterans know they can reach out to their local teams when they need help.

VHA's Office of Mental Health and Suicide Prevention (OMHSP) determines policy for and monitors the program. OMHSP officials said that they have made changes to their guidance and technical assistance, which may help address some of the challenges reported by teams. For example, in January 2021 OMHSP issued new guidance that consolidates information on teams' activities, including those related to recent initiatives. In addition, in June 2020, OMHSP initiated monthly "office hours" calls for teams to answer questions and provide technical assistance beyond what is covered during other regular calls.

However, VHA has not conducted a comprehensive evaluation of local suicide prevention teams, including an assessment of any challenges teams face in implementing VHA policies and the effects of program growth on workload. Without such an evaluation, VHA does not have a good understanding of how its various activities and initiatives are affecting teams, including any effects on the care teams provide veterans who may be at risk for suicide. Such an evaluation would allow OMHSP to refine the guidance and other support it provides to local teams to potentially reduce challenges they face.

OMHSP uses a benchmark to help determine facilities' suicide prevention staffing needs. Although facilities are responsible for making their own staffing decisions, according to the benchmark, each facility should aim to have at least one coordinator or case manager for every 10,000 unique patients the facility serves. However, the benchmark may not accurately reflect facilities' staffing needs because it was not developed according to the key practices for staffing model design previously identified by GAO. For example, the benchmark does not account for the increasing workload of teams, such as the addition of activities related to new initiatives over time. Additionally, it does not account for risk factors, like suicide rates, that may vary among facilities. Because the benchmark was not developed following key practices, VHA may not be able to help facilities to appropriately determine their staffing needs. As a result, suicide prevention teams may be vulnerable to understaffing, which may leave facilities unable to meet veteran needs related to suicide prevention.