

The publication of their report arrives on the heels of our own description of suicide among all members of a large health maintenance organization (HMO)—a study that was the first to include nonpatient members, that is, members of the HMO who did not access any of the HMO services during the membership year of death (2). Together, these two studies provide a heretofore unavailable baseline for health care systems that are engaged in important efforts to prevent suicide.

Juxtaposition of these two studies highlights important findings. Both reports come from health care systems identified as global leaders in suicide prevention. The veteran sample was observed from 2000 to 2010, and our HMO sample was observed from 1999 to 2010. The veteran sample was large enough to allow for adjustment of suicide rates for age, gender, and suicide risk, whereas similar adjustments were not feasible in our smaller HMO population. Hoffmire and colleagues found that among veterans who used VHA services, suicide rates declined during the ten-year study period, whereas suicide rates among veterans who did not use VHA services actually increased. In our HMO network population, suicide rates of HMO members did not change over time, regardless of HMO service utilization.

It is important to note that in both studies a decrease in suicide rates was observed among active patients who accessed health care services during a time when suicide prevention efforts were under way within the health care system. (The HFHS' Perfect Depression Care Initiative was launched in 2001, and the VA's Mental Health Enhancement Initiative and Suicide Prevention Program were implemented in 2005.) In the HMO sample, however, the decrease in suicide was observed only among patients who accessed the HMO network's specialty mental health services, which is where the suicide prevention effort took place. In fact, suicide rates actually increased among HMO patients who accessed general medical services—but not specialty mental health services. Hoffmire and colleagues did not describe this type of subgroup analysis of their sample. Given the clinical, scientific, and strategic importance of the VA's Suicide Prevention Program, it is crucial to understand what impact this initiative may have had on veterans who actually accessed VHA mental health care services, especially because, as the authors point out, veterans with mental illness are one of the populations most vulnerable to suicide.

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## Suicide Prevention in Patient and Nonpatient Populations: In Reply

**IN REPLY:** We thank Dr. Coffey and colleagues for their commentary on our recent study comparing suicide risk for veterans who did and did not use VHA services. Comparing this study with their recent analysis of suicides among Henry Ford Health System members highlights the importance of continued evaluation of suicide prevention activities.

The main findings from our analysis were that veterans, particularly female veterans, were at higher and increasing risk of suicide, compared with their nonveteran peers and that use of VHA services mitigated some of this risk. By compiling death certificate records for all known suicide decedents, the Department of Veterans Affairs (VA) archive of state suicide data made direct comparisons between VHA and non-VHA veterans possible for the first time (1–3). Veteran status in this database is carefully validated by using VA and Department of Defense records (2). Validation of veteran status was shown to have an impact on effect estimates in a study evaluating the relationship between veteran status and firearm suicide (3). Death certificate indication of military history is particularly problematic for female and younger veterans (2)—two of the fastest-growing veteran subgroups for which there is an immediate need to better understand suicide risk and trends.

The VA has, however, been evaluating suicide risk among VHA-utilizing veterans since implementing the Suicide Prevention Program in 2007 (1). As summarized in our report, VA's Suicide Prevention Program is poised to reach the broad population of VHA users and provide access to an integrated network of services aimed at reducing risk. Initiatives include awareness and education campaigns such as “The Power of 1,” a 24-hour Veterans Crisis Line, universal training in risk recognition and management for VHA employees, and the placement of suicide prevention coordinators in each VA medical center to support high-risk patients. Recent efforts also include the development of predictive modeling strategies to identify VHA patients at high risk of suicide (4).

This strong, multifaceted, and continually evolving program makes the VA a clear leader in suicide prevention. As such, we are pleased that our recent publication shed light on the pressing need to increase awareness of risk among female veterans. Response efforts will include continued research and program evaluation activities conducted collaboratively across the VA Suicide Prevention Program and VA's Women Veterans Health Care. Comprehensive, high-quality women's health care is already a top priority within the VA. Every medical center has a women veterans program manager to serve as an administrative leader for women's health programs and an advocate for women veterans, and a Women Veterans Call Center has been established as a resource for women veterans seeking information on VA benefits and services.

Similarly, we recommend that efforts to evaluate gender and age differences in the HFHS population are undertaken.

The effectiveness of intervention programs is likely to vary considerably by these factors, and identifying such differences is a key step toward targeting and tailoring programs to prevent additional loss of life.

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## Were Concerns With Misidentification in Special Education Overlooked?

TO THE EDITOR: In a report in the June issue, Pastor and Reuben (1) described trends in emotional and behavioral problems among children who used special education services. In identifying the limitations of the data, Pastor and Reuben may have passed over a pivotal issue that has troubled the field of special education for nearly half a century—the misidentification of culturally diverse children as persons with disabilities. The issue of misidentification surfaced in a recent task force report submitted to President Obama recommending that the Department of Education implement models “to ensure children are not misdiagnosed and inappropriately placed” in special education (2).

Because most items in the National Health Interview Survey that address emotional and behavioral problems are based on the use of special education services, one unidentified shortcoming of the Pastor and Reuben’s study may be that some parents who responded to the survey had children who were unknowingly misdiagnosed as having a disability, such as autism or attention-deficit hyperactivity disorder. This issue may be further complicated by findings about the state-to-state variations in autism criteria within the field of special education (3), which could further limit the reporting of any national trend analyses.

The language contained in the National Health Interview Survey could lead policy makers to assume the validity of any claims made to parents about the presence of a childhood emotional or behavioral problem. The survey developers may not have fully appreciated the possibility of error when a person makes a judgment about another individual (4). The survey does not take into account the wide range of training requirements among practitioners who might make claims

about childhood mental disorders, such as school psychologists, school counselors, and school administrators. Not all practitioners who make claims about childhood disorders have postgraduate clinical training and supervision, and not all are licensed by a behavioral science board to provide mental health care.

The need for adequate clinical training is highlighted in a detailed case study showing how a series of diagnostic errors made during the problem-solving process of one psycho-educational assessment led a team of practitioners to misidentify a bilingual child with mild hearing loss as a person with autism (5). The larger issue of misdiagnosis in special education may not necessarily be a shortcoming of the study by Pastor and Reuben. However, misdiagnosis may be an issue that should have been discussed when presenting findings based on the reflections by parents about claims expressed to them about childhood emotional and behavioral problems.

Household surveys may indeed be a valuable source of information. However, data from the National Health Interview Survey may not have provided a complete picture of the causes of limitations described by Pastor and Reuben. Discussions about trends in childhood emotional and behavioral problems may not be complete without acknowledging that racial-ethnic misidentification continues to be a problem in special education.

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## Were Concerns With Misidentification in Special Education Overlooked? In Reply

IN REPLY: We agree with Mr. Lee that misidentification of students as having disabilities requiring special education is an important issue. Although data from national surveys may not always fully describe the health conditions of particular children in special education, these data can provide useful information for assessing trends over time on health conditions that limit activity among children who receive special education services. The aim of our study was to examine