A Next Step in Suicide Prevention

TO THE EDITOR: In recent years, the issue of veteran suicide prevention has risen to that of a major public health challenge. Present estimates find that 20 veterans die by suicide each day (1). In 2014, veterans accounted for 18% of adult suicide deaths, despite constituting only 8.5% of the general adult population (1). After adjustment for age and gender, veterans are considered to be at 21% higher risk of suicide than American civilian adults (1). Responding to this challenge requires adopting innovative supportive options for veterans struggling with suicidality.

The U.S. Department of Veterans Affairs (VA) oversees the largest integrated health care system in the nation. In an effort to further develop its suicide prevention efforts, a memorandum of understanding (MOU) was recently signed between the VA National Office of Suicide Prevention and the VA National Chaplain Center. This MOU formalized an enhanced collaborative relationship between VA clinical providers and VA chaplains aimed at preventing suicide in veteran populations. Both the VA and the military have sought in recent years to enhance the role of chaplains as part of veteran suicide prevention efforts, a strategy that was recently reaffirmed at the Veterans Suicide Prevention Call to Action Conference (February 2, 2016, Washington, D.C.).

We posit that this enhanced relationship will bode favorably in terms of providing an added measure of support and care to veterans at increased risk of suicide. Research finds that VA chaplains regularly deal with suicidality among their service users (2). The MOU lays a foundation for enhancing the mental health competencies of VA chaplains. It also looks to increase sensitivity to the spiritual, pastoral, and existential care needs of veterans on the part of clinical health care providers. For example, problems with forgiveness and maladaptive religious coping strategies have been associated with suicide risk in some veteran groups (3). Spiritual health and well-being is named as one component of a comprehensive suicide prevention strategy (4).

We also posit implications for health services research. The MOU outlines a national and systemic framework for interdisciplinary collaboration, including enhanced communication between professional groups and coordination of care, education, and evidence-based best practice. As established service providers at VA health care facilities, chaplains support their service users through spiritual and pastoral care as well as psychosocial support (including counseling) (5). Future research might consider examining the effects of such interdisciplinary collaboration, especially as related to any measurable changes in suicidal behavior and other health outcomes.

Chaplains offer professional support to at-risk veterans who might otherwise be reluctant to seek mental health care services because of fear of stigma. Where appropriate, chaplains also facilitate access to formal health care providers. Further, they ensure the timely provision of health care services by alerting facility-based clinicians about at-risk veterans so that suicide risk and any underlying health complaints can be clinically addressed. The MOU recently signed between the VA National Office of Suicide Prevention and the VA National Chaplain Center marks an important next step in veteran suicide prevention efforts.

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Prescriptions Filled Following an Opioid-Related Hospitalization

TO THE EDITOR: In a recent study titled "Prescriptions Filled Following an Opioid-Related Hospitalization," Naeger and colleagues (1) analyzed prescription records from 36,719 inpatient hospitalizations related to opioid misuse (defined as opioid abuse, dependence, or overdose) to elucidate gaps in treatment delivery postdischarge. The authors found that in the 30 days after discharge, only 16.7% of patients received any Food and Drug Administration (FDA)–approved opioid use disorder (OUD) medication (methadone, buprenorphine, or naltrexone). In addition, a substantial percentage of patients received prescriptions for medications that increase overdose risk for individuals with OUD, such as benzodiazepines (13.9%) and opioid pain medications (22.4%). These findings highlight that most patients hospitalized for opioid-related conditions do not receive timely FDA-approved pharmacological treatment for OUD postdischarge. As noted by the authors, increased efforts are needed to ensure that patients hospitalized for opioid-related illnesses receive recommended treatment.

Opioid misuse and OUD are a widespread public health crisis currently at epidemic levels, affecting over two million

Americans in 2014 (2). Since 1999, overdose deaths related to prescription opioids have quadrupled in the United States, with over 183,000 total deaths attributed to prescription opioids from 1999 to 2015 (2,3). The Obama administration took substantial steps to ameliorate this crisis (4,5). These measures include the expansion of the U.S. Department of Health and Human Services (HHS) rule to increase from 100 to 275 the number of patients whom qualified physicians prescribing buprenorphine can treat for OUDs, as well as an increase of HHS funding to increase medication-assisted treatment of OUDs with naloxone and buprenorphine in underserved communities, provision of Substance Abuse and Mental Health Services Administration–led buprenorphine training in underserved areas, and implementation of a parity rule to increase access to mental health and substance use disorder treatment for Medicaid patients. These wide-reaching policy changes have the potential to change culture in the medical profession to more proactively screen, diagnose, and treat OUD; however, without adequate procedural and policy changes by health care systems, OUD treatment will remain fragmented, and patients will remain at risk for adverse outcomes.

The San Francisco Veterans Affairs Healthcare System recently launched the Prescription Opioid Safety Team (POST), an innovative consultation team, to screen for, diagnose, and treat OUD. POST is multidisciplinary, comprising addiction and pain specialists, and is available to all departments for inpatient or outpatient consultation. POST evaluates patients who take opioids for OUD status and severity, risk of developing or worsening OUD, risk of opioid-related adverse events, drug-to-drug interactions, and the presence of co-occurring psychiatric and substance use disorders. The team offers individualized recommendations to improve opioid safety, including education on the often iatrogenic nature of OUD; supported opioid and benzodiazepine tapers; transitions to buprenorphine or methadone when indicated; naloxone distribution; and prompt referrals to mental health, addiction, and pain specialty care. Given the increasing prevalence of opioid misuse and OUD, other health care systems may consider implementing similar consultative models to identify and treat OUD at all points of care. We believe that inpatient hospitalization represents a critical opportunity for early intervention to reduce risk of opioid-related adverse events.

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IN REPLY: Herbst and colleagues identify some of the steps taken in the multifaceted approach being pursued to address the opioid epidemic. They note some of the policy responses designed to increase access to treatment for opioid use disorder (OUD) and highlight the Prescription Opioid Safety Team (POST) used by the San Francisco Veterans Affairs Healthcare System to evaluate, educate, and treat individuals with possible OUD.

We agree with their perspective that opioid-related hospitalization represents an opportunity to intervene with patients who have OUD. The Substance Abuse and Mental Health Services Administration (SAMHSA) has supported recent research that has shown that engagement with outpatient substance use disorder treatment after an opioid-related hospitalization is associated with the patient's use of behavioral health services before the hospitalization. Naeger and colleagues (1) found that having a behavioral health outpatient visit prior to an opioid-related hospitalization was associated with higher odds of engagement in substance use disorder treatment after the hospitalization. Consequently, patients who were not connected with the behavioral health treatment system before an opioid-related hospitalization may particularly benefit from services during the hospitalization that will encourage engagement with substance use disorder treatment after their discharge.

SAMHSA also supports research to examine the impact of policies on the opioid epidemic. Ali and colleagues (2) found that prescription drug–monitoring programs (PDMPs) result in an average decrease of 10 days of nonmedical use of prescription pain relievers (NMPRs) a year. Their analysis shows that the reduction in NMPRs with use of PDMPs was achieved by decreased doctor shopping. Although there has been concern that the use of PDMPs to lower NMPRs might have the unintended consequence of encouraging substitution with heroin, Ali and colleagues reported that PDMP implementation was not associated with increases in initiation of heroin use or its abuse or dependence. PDMPs without mandatory access and enrollment, however, were found to result in