U.S. Department of Veterans Affairs

Preventing Veteran Suicide is Everyone's Business

Maximizing the Veteran and Employee Experience through Timely, Quality Mental Health Care

Brief History of VA Suicide Prevention Program

- **2007** - *Department of Veterans Affairs begins an intensive effort to reduce suicide among Veterans due in part to the passage of Public Law No: 110-110 , the Joshua Omvig Veterans Suicide Prevention Act, This effort lead to the creation of the Veterans Crisis Line and the Office of Suicide Prevention. It also established funding for Suicide Prevention Coordinators at every VAMC.*

- **2008 -** *VA's Mental Health Services established a suicide surveillance and clinical support system based on reports of suicide and suicide events submitted by Suicide Prevention Coordinators, established clinical protocols for Veterans identified as high risk for suicide including patient record flags and initiated it's Suicide Prevention gatekeeper training for all staff "Operation SAVE.*

- **2010** - *VA mandates outreach activities for SPC's to better engage community in SP efforts, begins training and focus on lethal means firearms safety through VA Family Firearm Program and implements mandatory Safety Planning for High Risk Veteran and utilization of Standardized Suicide Prevention Nomenclature.*

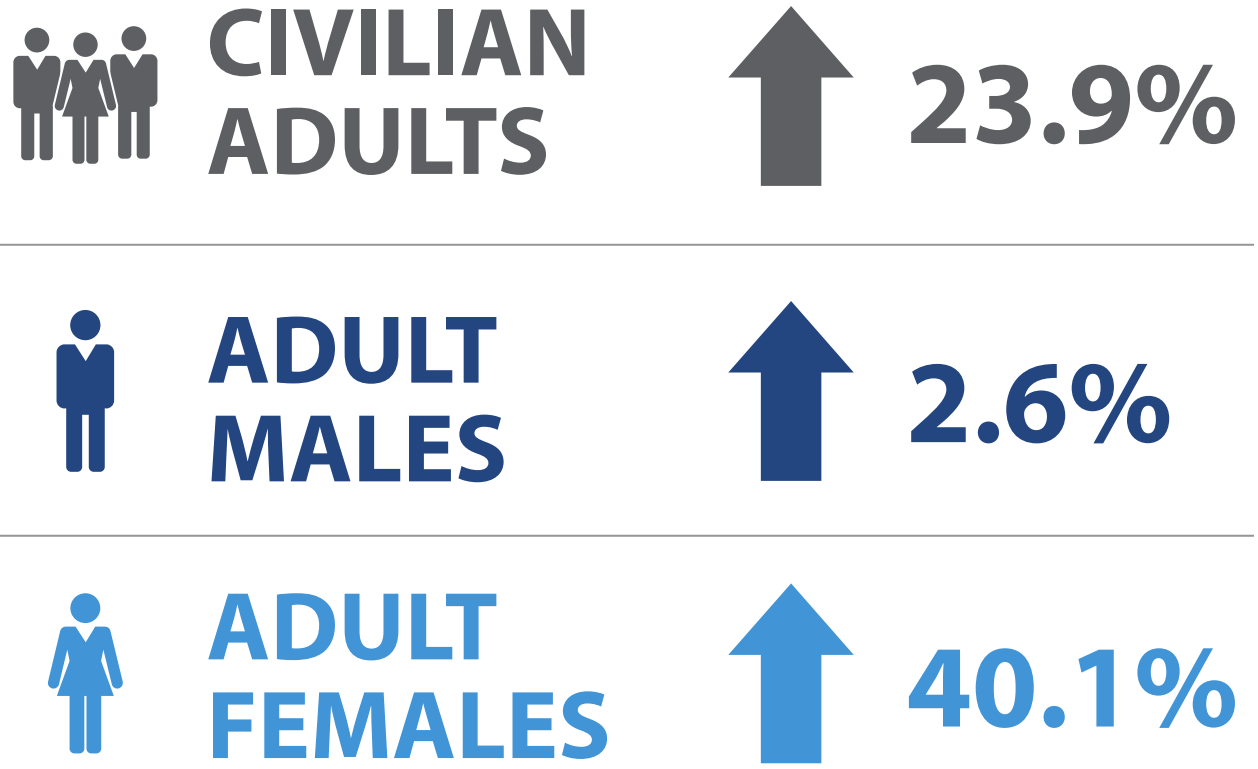
- **2010** - *the VA also began an intensive effort to shorten delays associated with access to National Death Index (NDI) data and increase understanding of suicide among all Veterans by developing data sharing agreements with all 50 U.S. states.*

- **2012** - *VA implements its Behavioral Health Autopsy Program and Improving the Culture of Safety in Mental Health Residential Rehabilitation Treatment Program.*

- **2016** – *VA releases most comprehensive study of Veteran suicide ever conducted in its report "Suicide Among Veterans and Other Americans 2001-2014".*

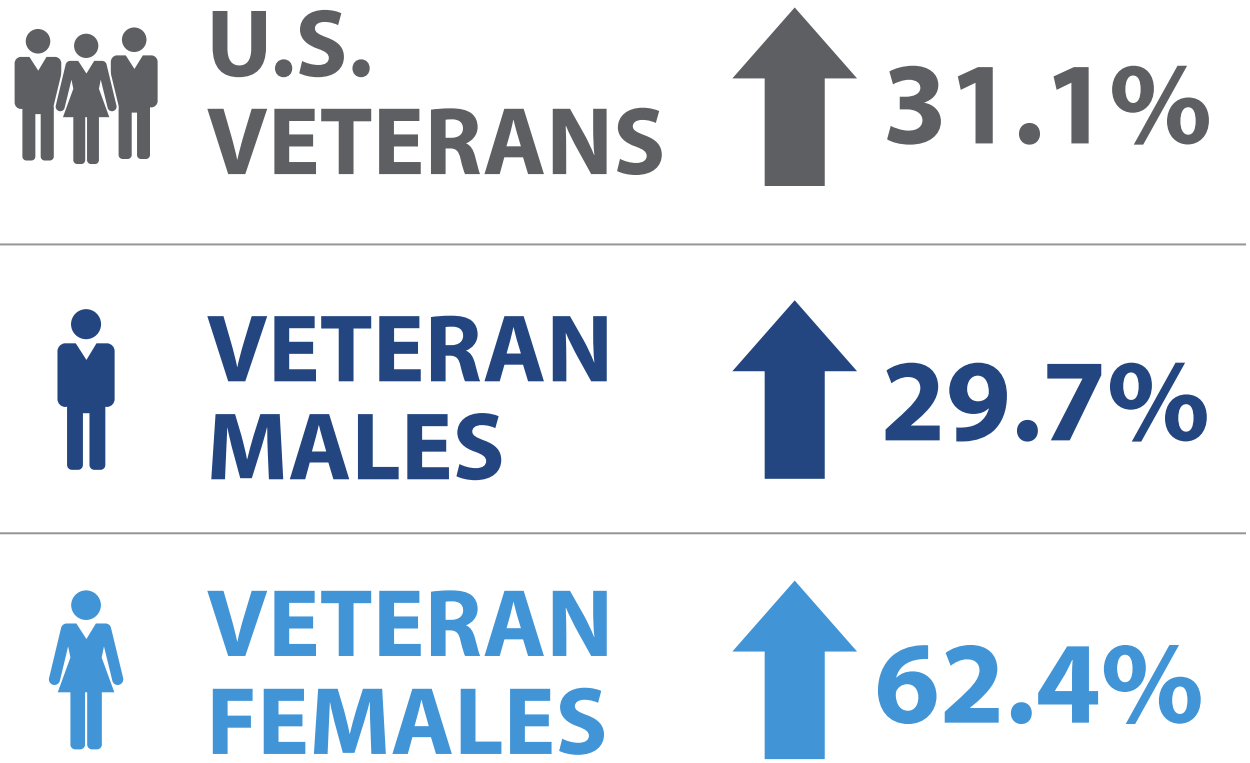
.

Between 2001 and 2014, the age-adjusted rates of suicide in the U.S. civilian population have increased



VA's largest analysis of suicide data informs prevention strategies for high-risk Veterans

Between 2001 and 2014, the age-adjusted rates of suicide have increased.



Data should drive efforts to reduce suicide

65%

of Veteran suicides are among people age 50 or older

67%

of Veteran suicides are a result of firearm injury

A Public Health Approach

- What is the framework?
  - Joiner's Interpersonal-Psychological Theory
  - Ecological Systems Theory
  - IOM Model

- What does a public health model mean?
  - All Veterans, not just those enrolled in VHA care
  - Community and population focused
  - Upstream from point of crisis
  - Communicate clearly to everyone a call to action

Suicide Prevention is Everyone's Business

Shared responsibility for eliminating Veteran suicide through:

- Engagement of staff and leadership across VA
  - Everyone is a steward of suicide prevention everyone can make a difference #BeThere
- Strategic Public Private Partnerships
  - We can't do it alone; motivating private and public sector to offer resources and innovation to increase access to quality care and enhance connectedness to ALL Veterans and their loved ones
  - VA/DoD Partnership is a priority; share data, improve transition and access to resources for all Service members and their families
- Provider training to facilitate risk identification and action
- Engagement in high-quality mental health treatment that is Veteran-centered
- Robust education about safety related to lethal means and how to talk about guns/firearms
- Proactive research and data science

Veteran-specific risks

- Frequent Deployments to hostile environments (though deployment to combat does not necessarily increase risk).
- Exposure to extreme stress
- Physical/sexual assault while in the service (not limited to women)
- Length of deployments
- Service-related injury

Veterans and Homelessness

- Overrepresented among the homeless population[1]
- On a single night in 2016, 39,471 Veterans were experiencing homelessness in the U.S.[2]
  - Just over 9% of all homeless adults
- In a study with older homeless Veterans, self-report of depression was the primary correlate of suicidal behavior.
  - Suicidal behavior before entering a housing program did not predict outcomes, such as program completion, housing outcome, and employment.

(Schinka, Schinka, Casey, Kasprow, & Bossarte, 2012)

Process for learning more and reducing the number of Veteran suicides

Analyze the 20 Per Day		*Identify how to make an impact*		*Implement Strategies*	
• **Develop models** • **Collect required data** to understand the 20 Veteran suicides per day (VBA, Veteran Centers, etc.) • Identify **partnerships** and data resources to support the strategy • Analyses and reporting	**Population**	• **Identify potential settings and contexts for outreach and programming** • **Coordinate with Federal, State, Local governments and external stakeholders** • Develop action plans	**Impact**	• **Partnerships regarding Veteran outreach** (National Violent Death Reporting System, VBA, etc.) • Partnerships regarding gun safety programs • Push intervention (e.g., public service outreach)	**Strategies/Intervention**

Suicide Prevention Priorities

- Improve military to civilian transition
  - Expand pre and post separation services
  - Expedite VA enrollment
- Know all Veterans
  - Comprehensive review of all Veterans who have died
  - Federal, State and local identification of all Veterans
  - Increase use of predictive analytics for suicide risk
- Partner across communities
  - Internal across VA & Public Private Partnerships
  - Clear, consistent communication about suicide prevention
  - S.A.V.E. training available to the public
- Lethal Means Safety
  - Improve risk identification & safety planning
  - Partner with gun shops and partners to spread awareness
  - Naloxone kits widely available
- Improve Access
  - Mental Health Services for Other Than Honorable
  - VA Medical Centers offer open access for Mental Health
  - Expand ‘Press 7’ Option to Veterans Crisis Line
  - Evidenced Based treatment and engagement

Data-Driven Suicide Prevention: Summary of Research Evidence

Strong evidence

- Reducing access to lethal means (#1)
- Proper ID/treatment of mood disorders
- Education of PCPs regarding depression
- Structured follow-up after a suicide attempt

Inconclusive but positive evidence

- Letter programs
- Electroconvulsive therapy (ECT)
- Targeted public health campaigns

Tailor to specific risk groups and focus on quality of mental health services for high-risk patients.

Some evidence

- Gatekeeper trainings
- CBT, CAMS, DBT
- Family-based interventions post-suicide attempt

Insufficient, weak, or absent evidence

- Screening in primary care populations
- Telephone/internet services, mobile applications
- Skills development
- “Reasons to live” lists

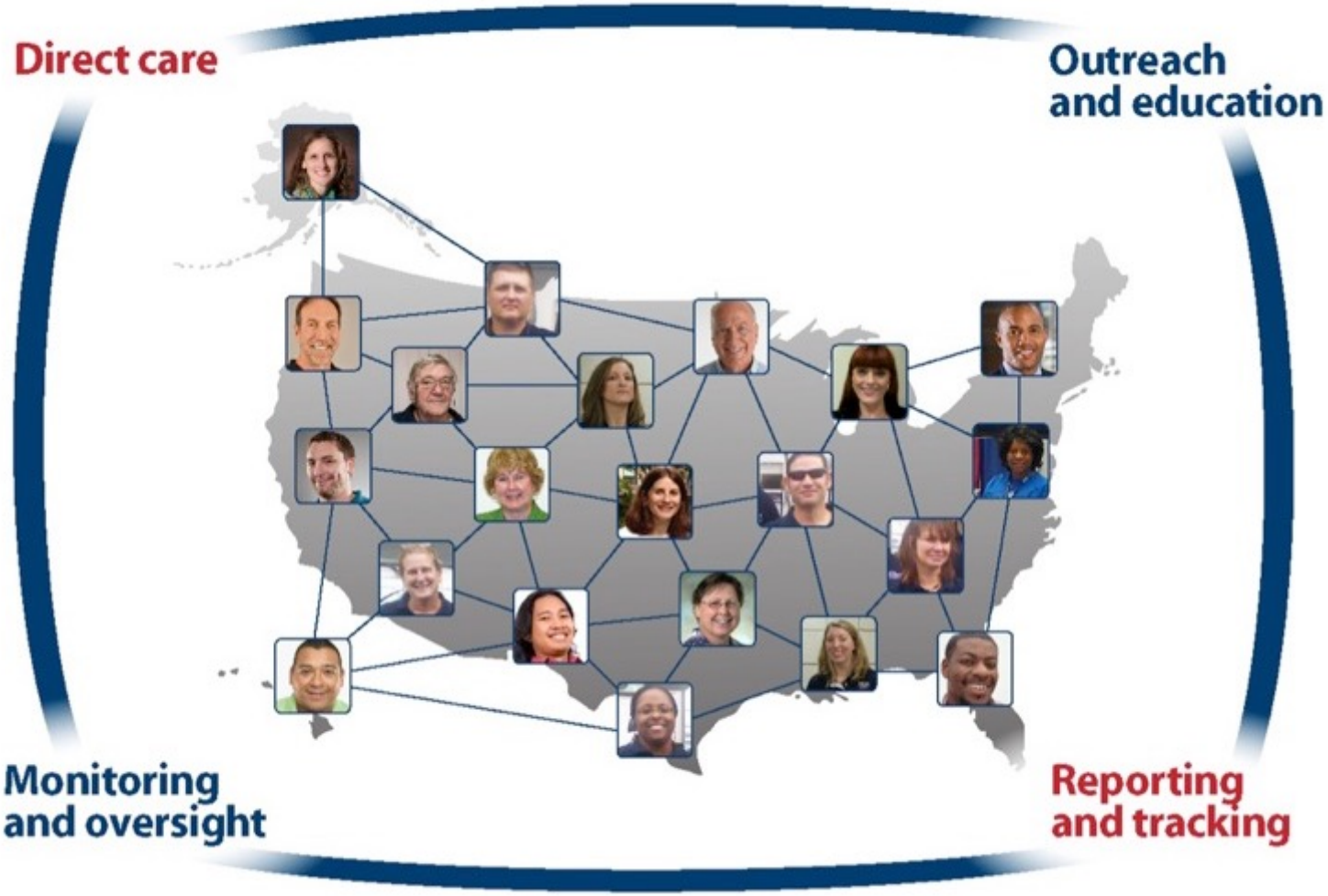
Free, Confidential Support 24/7/365

- Veterans
- Family members
- Friends
- Servicemembers

• • • • Confidential chat at **VeteransCrisisLine.net** or text to **838255** • • • •

Suicide Prevention Coordinators

More than 400 SPCs nationwide



Operation S.A.V.E.

- Operation S.A.V.E. will help you act with care and compassion if you encounter a Veteran who is suicidal. The acronym “SAVE” summarizes the steps needed to take an active and valuable role in suicide prevention.

- Signs of suicidal thinking
- Ask questions
- Validate the person’s experience
- Encourage treatment and Expedite getting help

Signs of suicidal thinking

- Threatening to hurt or kill self
- Looking for ways to kill self
- Seeking access to pills, weapons, or other means
- Talking or writing about death, dying, or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities
- Feeling trapped—like there's no way out
- Increasing drug/alcohol use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep, or sleeping all the time
- Dramatic changes in mood
- Perceiving no reason for living, no sense of purpose in life.

Ask the questions:

- **Are you feeling hopeless about the present/future?**
- If yes, ask….
- **Have you had thoughts about taking your life?**
- If yes, ask…
- **When did you have these thoughts, and do you have a plan to take your life?**
- **Have you ever had a suicide attempt?**

Validate the Veteran's experience

- Talk openly about suicide. Be willing to listen and allow the Veteran to express his or her feelings.
- Recognize that the situation is serious
- Do not pass judgment
- Reassure that help is available

Encourage treatment and Expedite getting help

- **What should I do if I think someone is suicidal?**
  - Don’t keep the Veteran’s suicidal behavior a secret
  - Do not leave him or her alone
  - Try to get the person to seek immediate help from his or her doctor or the nearest hospital emergency room, or
  - Call 911
- **Reassure the Veteran that help is available**
- **Call the Veterans Crisis Line at 1-800-273-8255, Press 1**

The REACH VET Program Enhances Veteran Care

- Uses data to identify Veterans at high risk for suicide
- Notifies VA providers of the risk assessment
- Allows providers to re-evaluate and enhance the Veteran's care

Started nationwide in **fall 2016**

Predictive Modeling

Predictive modeling is a research tool used by the VHA which analyzes medical record data to help confirm or alert Providers to those who are at higher statistical risk for adverse outcomes.

Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs

John F. McCarthy, PhD, Robert M. Bossarte, PhD, Ira R. Katz, MD, PhD, Caitlin Thompson, PhD, Janet Kemp, PhD, Claire M. Hannemann, MPH, Christopher Nielson, MD, and Michael Schoenbaum, PhD

Objectives. The Veterans Health Administration (VHA) evaluated the use of predictive modeling to identify patients at risk for suicide and to supplement ongoing care with risk-stratified interventions.

Methods. Suicide data came from the National Death Index. Predictors were measures from VHA clinical records incorporating patient-months from October 1, 2008, to September 30, 2011, for all suicide decedents and 1% of living patients, divided randomly into development and validation samples. We used data on all patients alive on September 30, 2010, to evaluate predictions of suicide risk over 1 year.

Results. Modeling demonstrated that suicide rates were 82 and 60 times greater than the rate in the overall sample in the highest 0.01% stratum for calculated risk for the development and validation samples, respectively; 39 and 30 times greater in the highest 0.10%; 14 and 12 times greater in the highest 1.00%; and 6.3 and 5.7 times greater in the highest 5.00%.

Conclusions. Predictive modeling can identify high-risk patients who were not identified on clinical grounds. VHA is developing modeling to enhance clinical care and to guide the delivery of preventive interventions. (*Am J Public Health.* 2015;105: 1935–1942. doi:10.2105/AJPH.2015.302737)

Over the past 8 years, the Veterans Health Administration (VHA), the health system of the Department of Veterans Affairs, strengthened its mental health services and supplemented them with specific programs for suicide prevention.[1,2] However, suicide rates in VHA have been stable, without decreases that can be attributed to these enhancements.[3] The stable rates stand in contrast to increased rates in other US populations, especially middle-aged men,[4,5] and in veterans who do not use VHA[3,6]; VHA programs may have mitigated population-wide increases. Nevertheless, the finding that suicide rates in VHA remain high represents a strong call for action.

Although epidemiological research has identified an array of risk factors for suicide, effect sizes are, in general, small to moderate.[7,8] Despite considerable research on how risk factors combine or interact to affect risk, few reports offer information from multivariate models that clinicians could use in decision-making.[9–11] Two recent reports demonstrated that predictive modeling that uses information from medical and administrative records can identify patients at risk for suicide,[12,13] and predictive modeling may be more accurate than clinical evaluations.[13]

There is general agreement about domains that clinicians should consider in evaluating patients' risk of suicide.[14,15] However, obtaining the information needed requires high levels of clinical skill, including the ability to instill a sense of trust.[16] Accordingly, additional training has been recommended to ensure that a broad range of clinicians can conduct accurate assessments,[2] and research is needed to enhance the sensitivity of evaluations, improve clinical assessments, and develop psychological and biological markers.[17–20] Improvements in assessments are necessary, for example, to enable accurate identification of patients at imminent risk in the emergency department. However, improvements are not necessary prerequisites for use of predictive modeling to target preventive interventions.

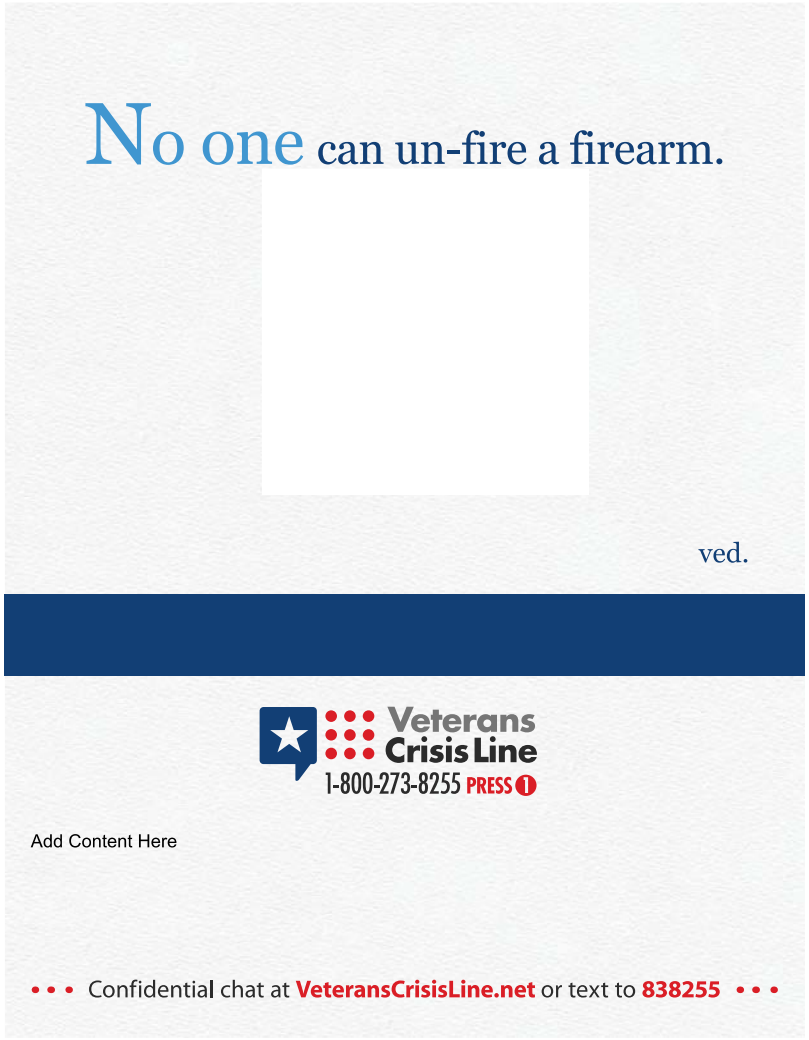
In general, discussions of prevention in the field of mental health,[21] including the *2012 National Strategy for Suicide Prevention*,[2] consider 3 levels of intervention: indicated clinical services for those with symptoms or warning signs associated with high risk, selective clinical and community preventive services for groups of individuals at increased risk, and universal public health strategies directed toward entire populations. The Department of Veterans Affairs' suicide prevention strategy has focused on indicated strategies, for example, facilitating access to mental health services and related services, such as pain management, and on providing resources specifically for suicide prevention, including a crisis line integrated with clinical services.

To extend its indicated strategies, the Department of Veterans Affairs is implementing a *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*.[22] In addition, it is working to develop selective strategies. Consistent with recent calls for research to develop a taxonomy of high-risk subgroups,[23] VHA's initial approach used decision-tree analyses, considering categories derived from the electronic medical record for demographics, mental health and medical diagnoses, and service utilization. Although it was possible to identify classes of patients at specific levels of increased risk, these were distributed across many small and complex subgroups. Findings did not support use of decision-tree analyses to guide system-wide policies. Accordingly, the focus shifted to evaluating predictive modeling of clinical and administrative data from the electronic medical record for estimating levels of risk for individual patients. If this proved feasible, the next steps would be for the health care system to develop methods for informing providers about which of their patients are at high risk and for enhancing care.

Statistical Risk & Clinical Risk

- REACH VET is a way to “double-check” that patients are receiving the best care possible
- The REACH VET model can be a clinical tool to alert Providers as to which Veterans may need further clinical assessment, resources, and support or outreach
- By **engaging Veterans early**, REACH VET may decrease the likelihood that more serious conditions develop, improving Veterans’ overall health and well-being
- Data is frequently used to support a providers’ clinical assessment (e.g., using validated tools to assess for suicide risk, depression, etc.)

VCL Gun Safety Video: Simple actions help keep individuals and families safe



Suicide Prevention Coordinators at local VA Medical Centers can provide gun locks to secure firearms in the home.

MAKE THE CONNECTION

- Is relevant to all Veterans and their families**, regardless of eligibility for VA care** or the range of mental health issues they may be experiencing
- Informs Veterans, their families and friends, and members of their communities about **resources designed to help Veterans live well**
- **Reaches Veterans where they are** — online and through trusted media and influencers — when they need support
- Features **true stories** from real Veterans, which serve as a powerful tool in breaking down barriers and can **help Veterans realize they are not alone**

VHA Office of Mental Health and Suicide Prevention (OMHSP)
Building a National Strategic Partnerships Network (NSPN) of Public Private Partnerships

Walgreens

Unwavering Support

For Uncommon Heroes

Coping and Symptom Management Apps

https://mobile.va.gov/appstore

www.t2health.dcoe.mil/products/mobile-apps

Problem-solving skills for stress

Manage physical & emotional stress

Safety plan & support during crisis

Monitor & manage PTSD symptoms

Tools for coping, relaxation, distraction & positive thinking

Enhance sleep quality & duration

Additional Resources

VA's center of excellence for research and education on the prevention, understanding, and treatment of PTSD.
Phone: **1-802-296-6300**
www.ptsd.va.gov

Information on VA services and resources, understanding military culture and experience, and tools for working with a variety of mental health conditions.
www.mentalhealth.va.gov/communityproviders/

One-on-one consultation at no charge for VA providers with general or specific questions about suicide risk management.
Phone: **1-866-948-7880**
https://www.mirecc.va.gov/visn19/consult/index.asp

References

[1]Libby Perl, *Veterans and Homelessness*, Congressional Research Service, November 2015, https://fas.org/sgp/crs/misc/RL34024.pdf.

[2]U.S. Department of Housing and Urban Development (2016). The 2016 Annual Homeless Assessment Report (AHAR) to Congress. Washington, DC: Office of Community Planning and Development. https://www.va.gov/homeless/docs/2016-AHAR-Part-1.pdf