Workshop on Identifying and Managing Veteran Suicide Risk in Non-VA Healthcare Settings

Best Practices, Gaps, & Challenges—Setting the Context

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Language of Prevention: Suicide, Attempted Suicide, Adverse Health Behaviors

Intervention terminology	Approach	Target	Objectives	Examples of prevention efforts
Universal Prevention Interventions ("Distal" Prevention Efforts)	Population	Implement sweeping, broadly directed initiatives in entire populations, not based upon individual risk. Develop programs that reach asymptomatic individuals. Change health and social systems to enhance prevention, early intervention, and health/mental health promotion efforts.	Prevent disease through reducing risk and enhancing protective or mitigating factors across broad groups of people.	1) Create a seamless health-transition system between DOD and VA. 2) Enhance contacts with 'emerging' vets shortly after discharge and at repeated intervals. 3) Continuously disseminate information regarding 24-Hour Veteran Crisis Line & 988. 4) Assure rapid implementation of new health initiatives across all VISNs. 5) Reduce barriers to access to care across all service elements—including VHA facilities and local health providers as needed. 6) Implement service plans with collaborating state agencies. 7) 'Family detector system' for early warning of health needs.
Selective Prevention Interventions	High Risk	Identify groups bearing a significantly higher-than-average risk of developing mental disorders, "life-mess," or fatal outcomes. *Prevention of 'becoming suicidal.'*	Prevent disease through addressing population-specific characteristics that place individuals at higher-than-average risk.	1) *Homeless vets*—sustained engagement efforts, based on organized tracking systems; behavior management programs. 2) *Med-assisted SUD treatment* is suicide prevention. 3) *Pain treatment* is suicide prevention. 4) Community and faith-based programs to contact *isolated older vets*. 5) Collaborative intervention programs for intimate partner violence. 6) Vet Courts; training for CJ personnel. 6) Incarcerated vet engagement programs.
Indicated Preventive Interventions ("Proximal" Prevention Efforts)	Higher Risk	Identify higher risk individuals with detectable symptoms.	Treat individuals with precursor & prodromal signs and symptoms to prevent emergence of full- blown disorder.	1) Screening and treatment for depressed vets in primary care settings. 2) Vigorously treat elders with chronic pain syndromes. 3) Enhance lithium maintenance for persons with recurrent bipolar disorder. 4) Enhanced case management of therapeutic non-adherence, and unstable SMI vets. 5) Closely track suicide attempters for months after discharge from inpatient care. 5) Rigorous follow-up of Crisis Line callers: satisfaction survey system to drive CQI processes, as well as patient engagement. 6) CQI/case reviews to enhance skills and duties of SPCs. 7) Peer support programs for attempters.

Sites and Vet Populations (social geography) – Opportunities for Engagement

Sites	Populations (e.g.) potentially engaged	Populations likely missed	Comments
Universities and colleges	Vets with emerging or recurrent mental disorders – distinctive programs for full time v. part-time (CC) students, graduate v. undergraduate students	Young adult vets not pursuing further education; employed and unemployed vets	Potential for use of Internet and other computer assisted interactive tools
Organized Work Sites	Employed in larger organizations – requires employer 'buy in'	Workers in small businesses, union/hiring halls, day labor, unemployed & underground workers	Potentially suitable for prevention-oriented EAPs, organized at business-community level with local VA facilities and VSOs
Medical Settings	Those using VHA facilities or others with health insurance; those that are willing to access traditional medical settings	Un/under insured; low "utilizers" of health care (men); utilizers of nontraditional health care	Screening of disability, pain, depression, SI; dependent on health providers asking specific questions about FMS status & VA eligibility
Community NGOs/VSOs	Those targeted for service by the NGO funding source; e.g., transient occupants in private homeless shelters	Anyone outside perceived scope of agency	Educating local NGOs about common risk factors for diverse adverse outcomes; need to create vet programs in non-VSO NGO agencies
Religious/Faith Organizations	Those who attend on a regular basis; targeted outreach and community activities	Non-participants or outside of program scope	Often an untapped resource
Courts/Criminal Justice (CJ)/Jails	Perpetrators/victims of domestic violence, probationers, prisoners; both Vet Courts and general courts	Failure to gain access for mental health and chemical dependency services for those identified through CJ settings	Integrating mental health and CJ services in a prevention web
Local Government Agencies (social service and health departments; law enforcement)	Homeless vets; occupants of county supported housing	Vets who do not access local Health Dept clinics or Social Services	Potential for integrating into a comprehensive community system tuned to higher risk service recipients
State Government Agencies	Patients with SMI in supported housing; state operated mental health centers and clinics	Persistently avoidant; non-residents not eligible for services	Potential for integration into a comprehensive system tuned to high-risk service recipients
Non-VA Federal Agencies, CMS, Social Security Offices	Elders; disabled vets	Broad swaths of the general population	Must provide galvanizing leadership and expertise

Higher risk Vets and Sites to Contact Them (social ecology)

High-risk groups	Sites	Potential interventions	Comments
Patients with severe, persisting mental disorders	Mental health treatment settings; jails; homeless shelters	Fostering of early interventions; assertive community treatments; linkages to courts and other agencies; CQI processes following readmission to acute services	Available medication interventions must be embedded into comprehensive systems of care and assertive community follow-up; "forensic" ACT services—coordination of housing, courts, and mental health settings critical to success
Men and women with alcohol and substance disorders; perpetrators of domestic violence; victims of DV	SUD & MH treatment settings; courts; jails; homeless shelters	Integration of mental health and prevention services into SUD treatment programs & vice versa; *court integrated mental health services*	Dependent on development of integrated MICA services; rapid access to care for those in need crucial—engagement challenging and central to success
Depressed Women and Men	Primary care settings; work settings; family referral; Crisis Line	Enhanced detection, treatment, and follow up of emerging symptoms	Requires education of care providers re recognition and treatment; subsyndromal conditions important; family education programs – *driven by culture change programs*
Elders with Pain, Disability, Depression	Primary care offices, residential settings; Agency on Aging outreach programs settings; Behavioral Health Lab consultation processes	Pre-emptive treatment of pain and increasing medically related disability; VA-community initiatives for aging cohorts	Can miss socially isolated elders and elders who do not express their needs openly – *driven by culture change programs*
Suicide attempters—may be counted as well among other groups, but also include patients with personality d/o, varying mood disturbances, and CD problems	ERs, ICUs, inpatient psych. and medical services – *need for novel approaches to case identification, engagement, and follow-up*; Crisis Line follow-up: both community and central VA f/u programs – CQI central to longer term success	Community outreach for contacting "no-shows," reminder cards, assertive case management; surveillance as case identification	Those high in ideation and attempts in the context of personality disorders often are 'frequent fliers' to ERs who fail to use standard systems of care; *major ethical questions* regarding the 'activeness' of follow-up and surveillance