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Suicide Prevention in Health Systems – Evidence and Opportunities for Veterans

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE

WORKSHOP ON IDENTIFYING AND MANAGING VETERAN SUICIDE RISK IN NON-VA HEALTHCARE SETTINGS

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Background / Significance

- Suicide is the 10th leading CoD in the US
  - #1 cause of injury-related death
- >48,000 people die of suicide each year
  - Over 6,000 veterans per year.
- 1 million suicide attempts each year
- US suicide rates have not changed over time
  - Rates have risen ~25% since 2000
- Veterans have an elevated risk for suicide.
  - While many veterans receive care in the VHA, many others receive care in health systems across the country
    - 62% have used some VHA care.
  - We think these healthcare systems are an important environment to prevent suicide.

2012 National Strategy for Suicide Prevention:

GOALS AND OBJECTIVES FOR ACTION

A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

GOAL 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

GOAL 8: Promote suicide prevention as a core component of health care services.

GOAL 9: Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors.

For the first time, the National Strategy recognizes the importance of health systems in suicide prevention!!!!

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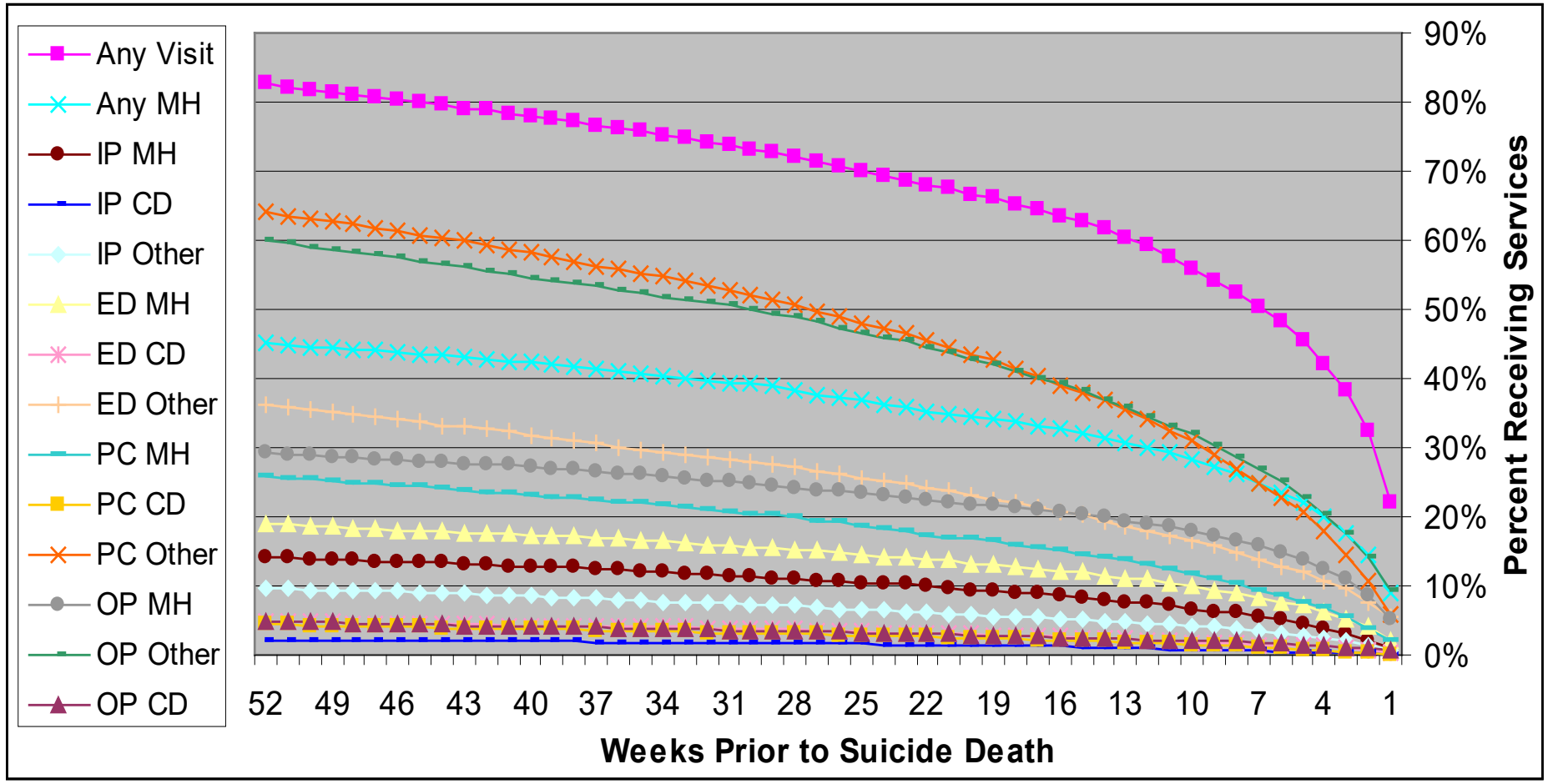
Health Care Visits Prior to Suicide



Ahmedani, B.K., et al. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870-877. doi:10.1007/s11606-014-2767-3. PMID: 24567199.

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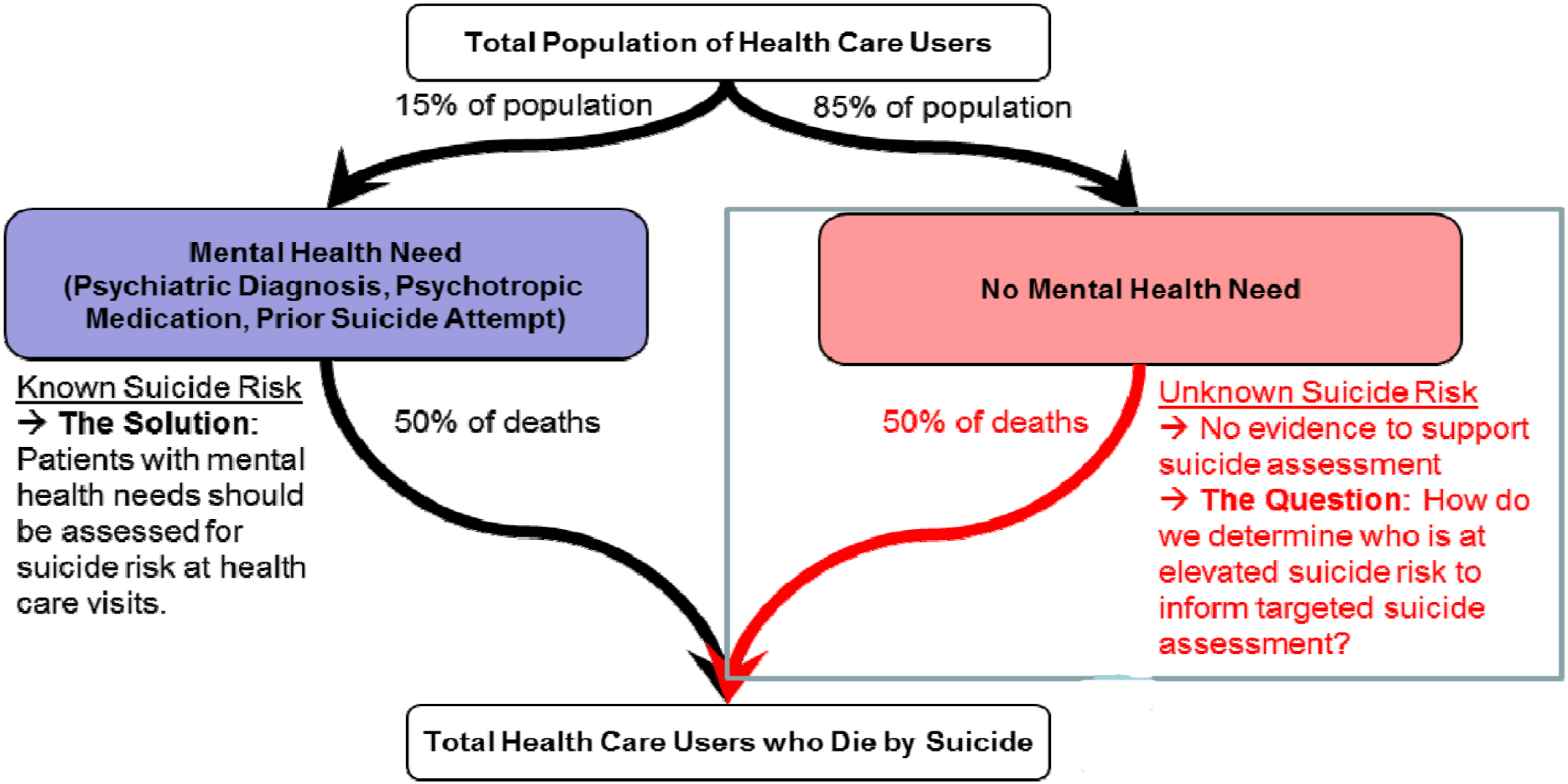
MHRN Mental Health Research Network

Many People Who Die by Suicide Don't have Known Risk – We Can't Limit to Behavioral Health



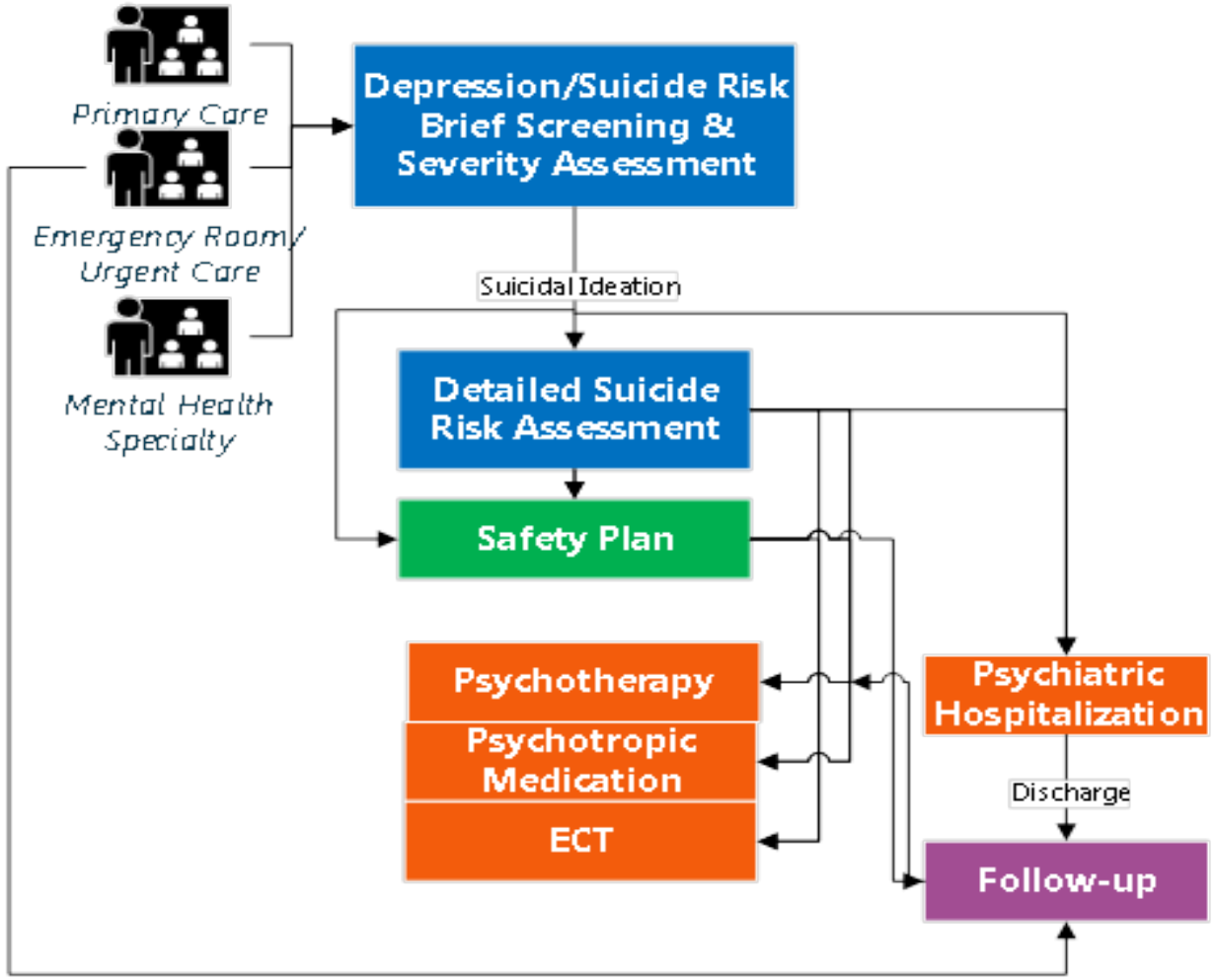
The Evolution of Zero Suicide

- Originally began at Henry Ford (Perfect Depression Care) in 2001.
- The research evolved throughout the 2000s.
- National Action Alliance formed to create a new National Strategy (2012) and implementation call to action (2021).
  - Focus on Zero Suicide.
- Zero Suicide adopted by SAMHSA launching US initiative. (2014).
- International Zero Suicide movement begins (2014).
- Versions of the Zero Suicide Model have now been implemented in >20 countries around the world and in hundreds of US health systems, including in the VHA and in many of the active-duty branches of the military.

Zero Suicide Model

- A menu of evidence-based approaches and interventions along a continuum of care bundled to establish a care pathway for suicide prevention.
  - Screening and Assessment (PHQ-9, C-SSRS, other).
  - Brief Intervention (Safety Plan, Caring Contacts).
  - Care Coordination to Support Access and Engagement in Care.
  - Suicide-Specific Psychotherapy and Treatment (CBT-SP, DBT).

Suicide Prevention Care Pathway



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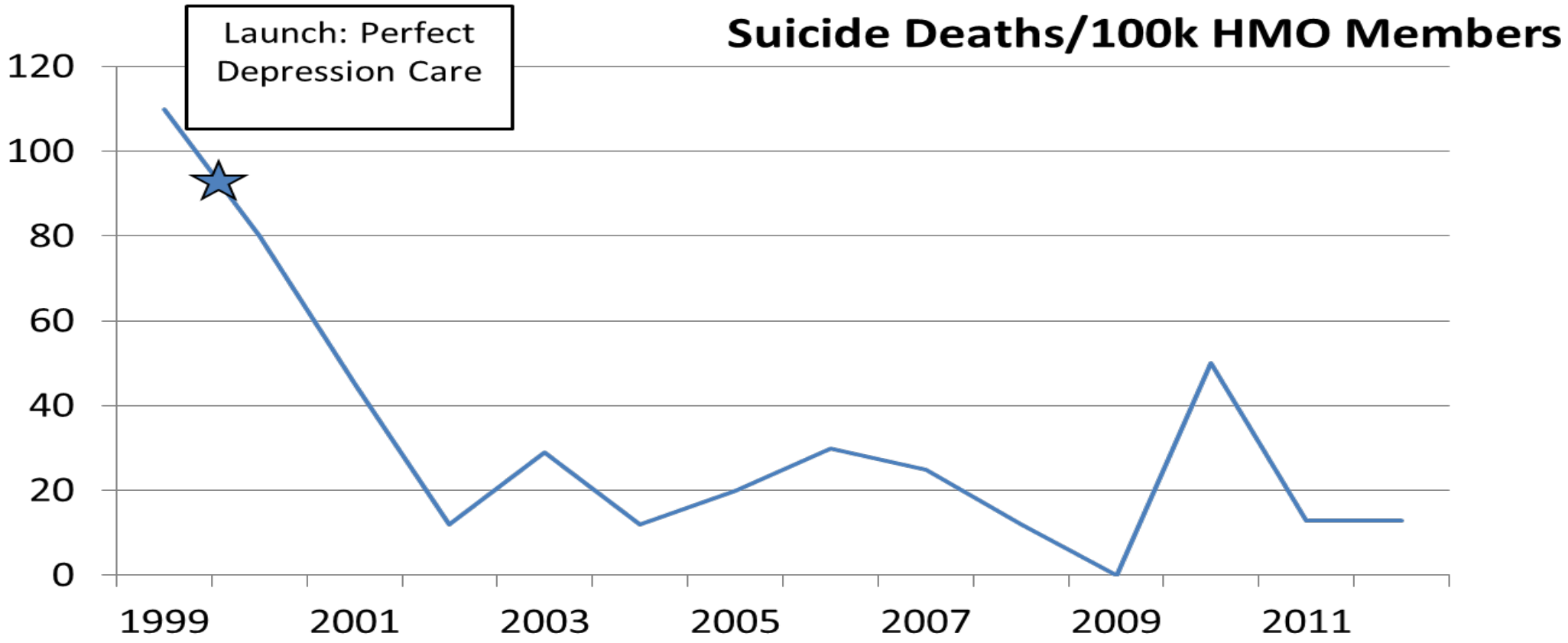
Richards, et al. An Implementation Evaluation of 'Zero Suicide' Using Normalization Process Theory to Support High-Quality Care for Patients at Risk of Suicide. *Implementation Research and Practice*, 2, 1-14.

Suicide Death Rates in BHS at Henry Ford



Coffey, M.J., Coffey, C.E., & Ahmedani, B.K. (2015). Suicide in a Health Maintenance Organization population. *JAMA Psychiatry, 72*(3):294-296. doi:10.1001/jamapsychiatry.2014.2440. PMID: 25607598.

Hampton, T. (2010). Depression care effort brings dramatic drop in large HMO population's suicide rate. *JAMA, 303*(19), 1903-1905.

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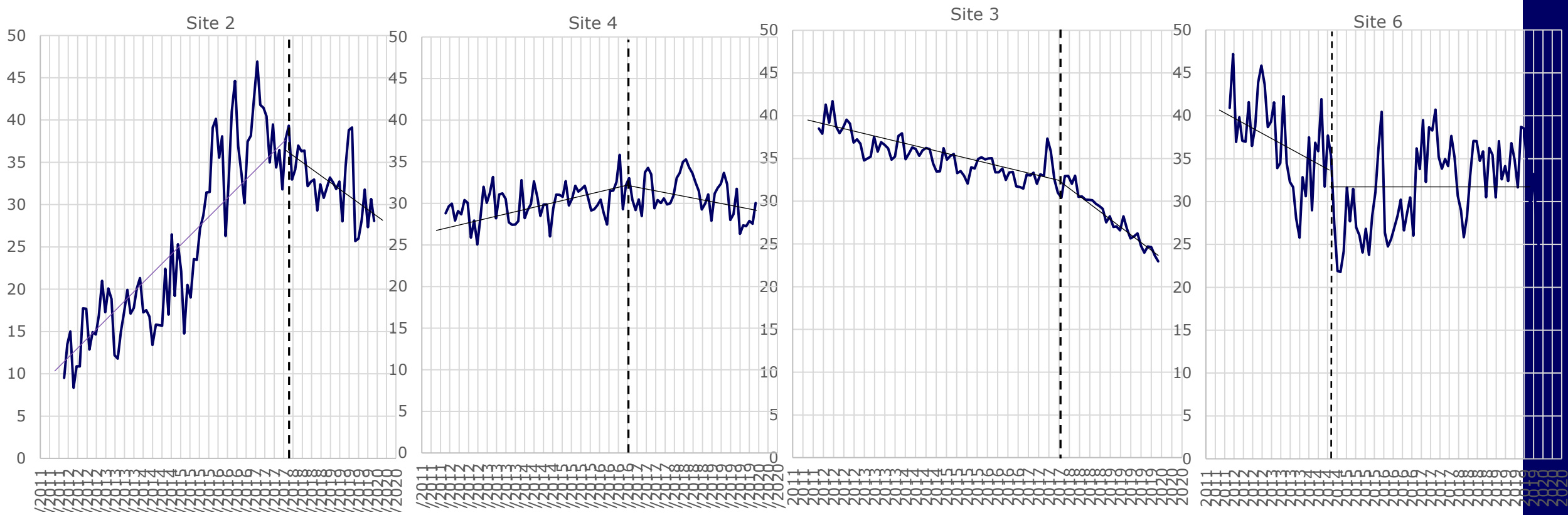
Suicide Attempt Rates in MH Specialty Care



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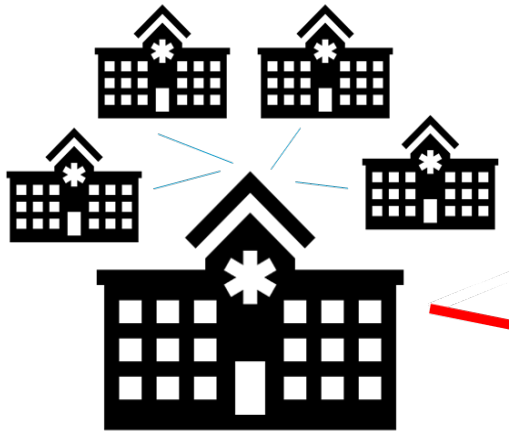
Broad Implementation Across Health Systems

Substance Abuse and Mental Health Services Administration SAMHSA

MIMiND



Inpatient Psychiatric Hospital

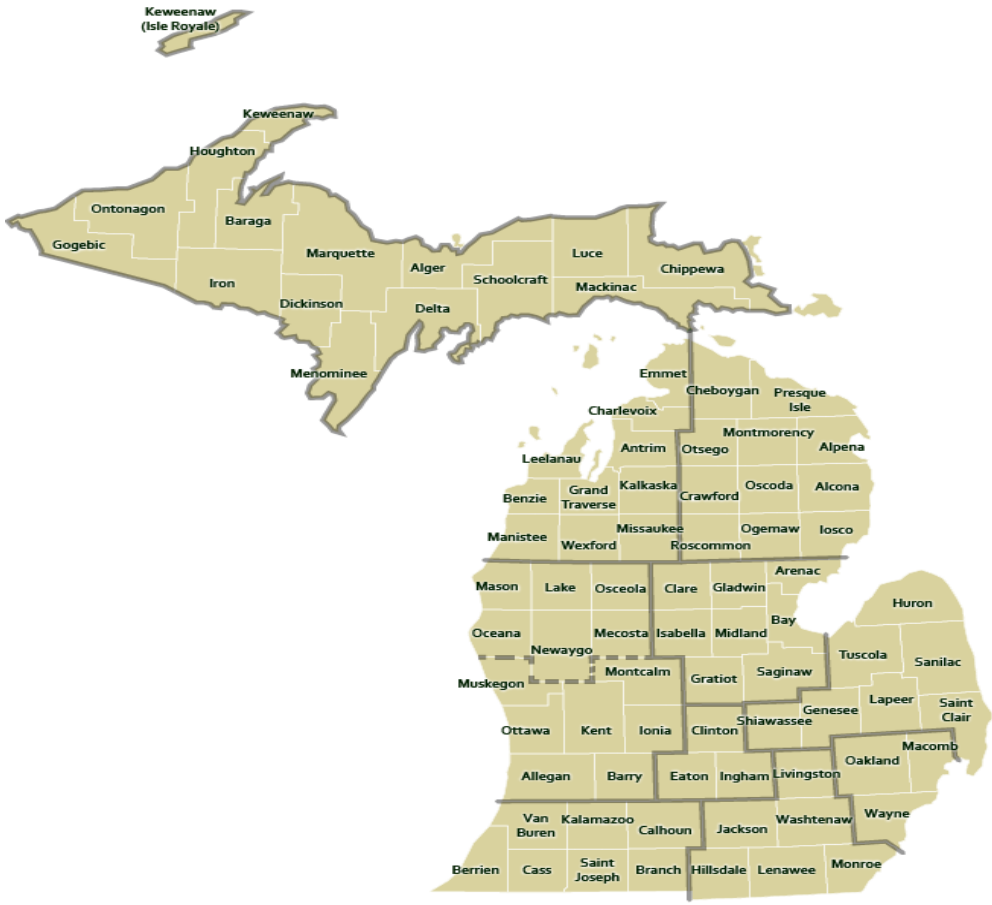
Specialty Behavioral Health Services
If needed.
1. Within BHS
2. External BHS provider

Emergency Department

1. Universal Suicide Risk Screening via PSS-3.
2. Behavioral Health Consultation (in-person at HFH or via telemedicine at partner EDs) for positive suicide risk screens (positive question #2 or 3) – *Proposed Pathway*.
   - 2a. Suicide Risk Assessment
   - 2b. Safety Plan
   - 2c. Means Counseling
   - 2d. Family/Support Involvement
   - 2e. Treatment Planning
   - 2.f. Discharge to Inpatient Hospital or Behavioral Health Integration ED

Behavioral Health Integration "ED Bridge" Expansion
Proposed Pathway

1. Contact within 48 hours post-discharge (Virtual, phone, preferred contact method).
   - 1a. Caring Contact (**Care Coordinator**)
   - 1b. Suicide Risk Re-Assessment. (**Care Coordinator and/or BHI / BHS**)
   - 1c. Care Coordination (**Care Coordinator**)
   - 1d. Safety Plan Review (**BHI / BHS**)
   - 1e. Means Counseling Review (**BHI / BHS**)
   - 1f. Family/Support Review (**BHI / BHS**)
   - 1g. Community and Self-Help Resources (**BHI / BHS**)
   - 1h. Virtual Bridge Psychotherapy (**BHI**)



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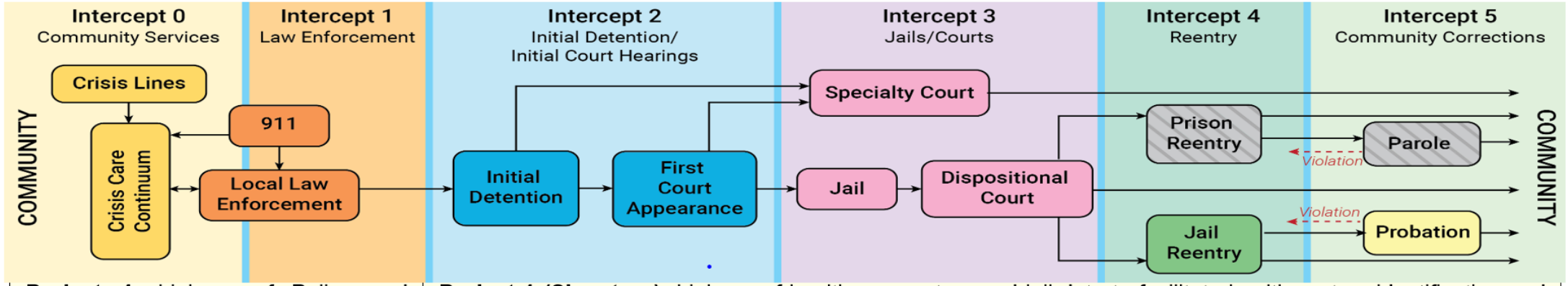
What's Next – New Community Partnerships?

Figure 1: The Sequential Intercept Model Illustrates the Full Range of Justice Involvement



Project 4: Linkage of Police and emergency department (ED) data to facilitate partnership for identification and action (police and ED coordination for action)	**Project 1 (Signature):** Linkage of healthcare system and jail data to facilitate health system identification and community outreach for targeted suicide prevention (health system is notified and acts)
	Project 2: Linkage of managed care organization (MCO) payor and jail data to facilitate community universal suicide prevention for those with justice involvement (MCO is notified and acts)
	Project 3: Linkage of Medicaid data with jail data to facilitate identification of risk at initial entry or re-entry into jail detention (jail is notified of previous community risk and acts)

NCHATS
NATIONAL CENTER FOR HEALTH AND JUSTICE INTEGRATION FOR SUICIDE PREVENTION

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Applications for Veterans - Tailoring Care

- Should we tailor the health system clinical care experience and our suicide care pathways for veterans?
  - Most US health systems do not ask about, or document, veteran or military status in health records.
    - Ask about for Military and Veteran status, just like we ask about race/ethnicity and date of birth.
    - Screening for suicide risk at all visits.
  - Veterans may struggle to engage in care.
    - Enhanced care coordination services.
  - Veterans may be more likely to use firearms as a means of suicide.
    - Emphasis on means safety.

Applications for Veterans – Creative Care Models

- Should we extend care for veterans?
  - Veterans may be less likely to seek care.
    - Add active systematic outreach for veterans, especially those at high risk.
      - VHA already has a model for this activity.
    - Add alternative care support.
      - Peer support.
      - Community health workers.
    - Offer mobile health or virtual care options.
      - Man Therapy.
      - Tele-mental health services.

Applications for Veterans – Partnerships

- Should we create new community partnerships between the VHA and health systems?
  - Partnerships between these entities are less common, and veterans may receive care across systems.
    - Informatics to connect patient records.
    - Established care relationships between entities.
- Should we create new community partnerships between health systems and other community sectors commonly used by veterans?
  - Purposeful relationships to support veterans.
    - Employers.
    - Recreation organizations.
    - Others.

Questions?