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Session: Interactions with VHA care prior to suicide  
Presenter: Steve Dobscha  
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Molly: At this time I would like to introduce our speakers. Speaking first, we have Dr. Steve Dobscha. He is the Director of the HSR&D Center To Improve Veteran Involvement in Care, also known as CIVIC. That is located at the VA Portland Healthcare System in Portland, Oregon.

Joining him today is Dr.Lauren Denneson. She is a Core Investigator at the HSR&D Center to Improve Veteran Involvement in Care, also located at the VA Portland Healthcare system in Portland, Oregon. Once again, we will not be unmuting lines. Please do not use the hand raising icon. We will only be taking questions in writing through the question section. At this time I would like to turn it over to you, Dr. Dobscha.

Steven Dobscha: Thank you very much. I think where I should probably start is with a – green therapy. Okay, sorry, I will come back. First I start with having to control the slides. Basically neither Lauren nor myself have anything relevant to disclose.

Molly: I am sorry for interrupting. Steve, can you pull the speakerphone a little bit closer to you?

Steven Dobscha: How is that?

Molly: That is better, thank you.

Steven Dobscha: Alright. Just to give a rundown on what we hope to accomplish today. First, I am going to be giving a little bit of background information on suicide and suicide as it is relevant to primary care. I am then going to talk a little bit about the overall research project from which these analysis are derived. Then I will be focusing on presenting findings from a quantitative analysis to identify Veteran characteristics associated with suicide.

I will then turn things over to Lauren who is going to be presenting findings from a qualitative content analysis medical record of two subgroups of individuals who died by suicide, mainly a group of OEF/OIF Veterans and a group of women Veterans. Alright, I am having a little trouble. Alright, poll question one; before we get going too far. We are interested in knowing what is your primary role in the VA? That might help us stay with our discussion.

Molly: Thank you. For our attendees, simply click the circle next to the answer that best fits your primary role. We understand that many of you have many roles within the VA. This would be your primary role. The answer options are student, trainee, or fellow, clinician, researcher, manager, or policymaker, or other.

If you are clicking other, please note that at the end of the presentation we will be having a feedback survey with a more extensive list of roles. You might be able to check yours off in detail during the survey. It looks like we have a very responsive group today. Almost 90 percent of our audience has voted. That is great. I think you guys are the winner.

We will go ahead and close the poll now and share those results. It looks like almost half of our audience are clinicians; 21 percent researchers. Fifteen percent identify as other; 8 percent manager, policymakers, and 6 percent student, trainee, and fellows. Thank you for those respondents.

Steven Dobscha: Yes, thank you very much. Alright. Let me give a little bit of background. Some of these things you may be very aware of. First, suicide is the tenth leading cause of death in the United States at this time. Importantly for the age group 25 to 34, it is the second leading cause of death after accidents. This is particularly relevant for our youngest group of Veterans, the Veterans returning from Iraq and Afghanistan. In addition, it is known that about 20 percent of suicide decedents are Veterans and up to 6,500 Veterans die each year.

We know that the rate of suicide among Veterans who receive care in the VA Healthcare setting is greater than the rate of suicide in the general population. Also, worth being aware of is that about one-fourth of Veterans who die by suicide have healthcare contacts with the VA in the year prior to death. We are going to be focusing on the group of Veterans who are getting care in the VA. With respect to primary care, it is fairly well documented that half of suicide victims have contact with primary care clinicians within one month of suicide. That is contrast to about one-fifth who have contact with mental health clinicians in the month prior to suicide.

There is a lot of opportunity or potential opportunity for primary care clinicians to intervene among patients who are at the highest risk. Now, interestingly there is little information describing the characteristics of these patients or the primary care that they received during those last interactions. For example, it is not really clear whether patients are coming to these visits because they are in distress; maybe seeking help. Or, are they really just coming in for routine care or some combination of all of them? These questions led to our VA HSR&D funded project, Veteran interactions with VA Primary Care Prior to suicide.

The overall objectives of the project are to describe characteristics of in VA primary care received by suicide decedents in the year prior to death. Describe and evaluate content of last interactions with VA primary care teams; and to focus on the subgroup of Veterans of Iraq and Afghanistan in terms of what are their characteristics as they present in primary care? What type of care have they received in primary care? The overarching goal is to identify opportunities to identify and intervene with Veterans of highest risk. I have listed our co-investigators and collaborators on the project. I also want to mention that there have been a number of other people who have been extraordinarily helpful as we have worked on this project. To give a little bit of an overview, the study is a retrospective case control study.

The way that this came about is that in 2010, Secretary Shinseki, the Secretary of Veteran Affairs called upon state governors to share death certificate data on Veterans suicides with the VA in order for it to enhance its suicide prevention efforts. Those data were collected by the VA. We ended up partnering with VA Mental Health Suicide Prevention and the VISN 2 Center of Excellence in Canandaigua to gain access to those data.

We worked for this project with data from the first 11 states who contributed data to that database. We identified 269 Veterans from the 11 states who died by suicide in 2009. That is the most recent year in the data set that we have. We matched those Veterans to 538 controls. That is one to two ratio match. They were matched on age, sex, the primary care clinician seen, and when over the course of the year they were seen. As I mentioned, we collect the data death certificate data. But we link that data with the VA corporate data and warehouse data; and also conducted a manual medical record review to do the project.

The focus of where I am going to be going in the next few minutes is really to describe the demographic, clinical, and psychosocial context characteristics of male Veterans who received VA primary care in the six months prior to suicide. We focused on male Veterans for this analysis because 97 percent of the sample were men. There were only 24 women Veterans in this year, 2009; and actually only 11 OEF/OIF Veterans during this year. I will do a little pre-introduction of Lauren's talk. Lauren is going to be focusing on those subgroups looking at several years worth of data, which will help us to learn more about those subgroups.

Now getting back to this analysis, I have listed here the demographic measures that we looked at. We also have a set of clinical measures including an ICD diagnosis given in the six months prior to death; a measure of co-morbidity, and a measure of suicidal ideation and endorsement. Essentially, these variables here – and these variables here were all obtained using manual medical record review. Our team has a fair amount of experience doing manual medical record review. We ended up…

We put together a data collection sheets for this project over several iterations. We tested iterative reliability such that the reliability for every item was considered excellent with a cap \_\_\_\_\_ [00:10:27] 0.75. Over the course of the chart review period, retested interrelated reliability periodically to make sure that reliability remained at least excellent. If you are interested in how we operationalized some of these variables, you can send either one of us an e-mail. There is also a slide at the very end, which gives a little bit more information about this.

This is a picture of the 11 states who were – we collected data for. You can see that they are fairly well distributed geographically. I have included some information here comparing this 11 state sample to the national VA sample. You can see that for the most part our samples are fairly representative of the national VA data. We do have a slightly higher proportion of white as compared to other Veteran subjects. As far as facility characteristics go, comparing the 11 states sample of a national sample, it is also fairly comparable.

This slide here is showing a bivariate of comparison of the cases to the controls. The cases are in this column here. The control is over here. What we find here is actually not very surprising. We find that for example, the number of Veterans in the cases group, the Veterans who died by suicide. They are less likely to be married as compared to the controls. We find that they are more likely to be white compared to the controls. They are less likely to have a VA service connected disability than controlled. These have all been – these findings have been seen in prior studies of suicide, and namely marital status and non-white tend to be protective.

There have been just a few studies looking at VA service connected disability; which does seem to be protective. It is not really clear why that is. One hypothesis is that people who have VA service connected disability ratings have fewer out-of-pocket costs. They may be more likely access services. But it is also possible that people may in general be more engaged with care in that group. Like I said, it is not really that well understood at this time. These are now the clinical variables in the analysis comparing cases to controls. We can see that any psychiatric diagnosis is very common in the – among the group. The Veterans who died by suicide, almost twice as prevalent as among the controlled. The diagnosis significantly is different between the cases and controlled. It included major depression, bipolar disorder, anxiety disorder, which is much more prevalent as well as substance use disorders.

I will mention that traumatic brain injury was too infrequent at least as we obtained the data in this project to really do any substantial analysis with. If you look down at the lower third of this graph, or table, you will see that functional decline and sleep disturbances, anger, as well as endorsement of suicidal ideation or attempt were all more frequent among the cases. There are a few things worth noting that are interesting on this table.

First is that PTSD was not more common among the cases as compared to control. If you look at evidence syntheses on the relationship between PTSD and suicide, the findings are generally fairly mixed with some studies showing that PTSD can be as a higher risk or associated with higher risk of suicide and other studies not finding that. One hypothesis here is that getting treatment for PTSD may be protective. If you have PTSD and are getting treatment, perhaps your risk of suicide is not greater.

Another thing worth noting here is that pain diagnosis were not more common in the case group as compared to the control group. Several studies have shown that pain is associated with increased risk of suicide people in the neighborhood of twice the odds of dying by suicide, if you look across multiple studies. But sometimes that relationship, it may manifest over a number of years. We really just looked at that six months period here. Then this is the comparison of the cases versus controls in terms of our psychosocial context variables. I think what is really striking here is that the prevalence of psychosocial stressors is overall just much higher among the cases as compared to controls. The only area where we did not see a significant difference was in housing and mobility.

Next what we did was a multivariable analysis. This is where we put all of the variables into one model at the same time. What that really allows us to do is to control for possible confounders; and allow us to assess independent affects of the variables when the other variables are present. What you see here is that again, a non-white race is protective. This is really the odds of dying by suicide. Although, it is just marginally so. Service connected disability rating remains protective. Major depression turns out to be a key predictor of suicide in this primary care population as does anxiety disorder and functional decline.

If you look down here into our suicidal ideation variables; also endorsing thoughts of suicide, or an attempt is also associated with dying by suicide. Interestingly, these individual psychosocial stressors at the bottom here were not individually associated with death by suicide; although relationship problems was close to being significant. In a postdoc analysis, we wanted to look at the numbers of psychosocial stressors in order – in other words the burden of psychosocial stressors. When you add that to the model, it is still not significant. But you do see that the number of – as the number of psychosocial factors goes up, you do see a marginally significant relationship between the number and death by suicide. It is certainly moving in the direction that we would expect.

To summarize, this component of the talk. What we found is that mental health conditions including substance abuse disorder, functional declines, and sleep disturbance, anger, suicidal ideation, and psychosocial stressors were all significantly more prevalent in the cases compared to controls. In our multivariable model, the key predictors included anxiety disorder other than PTSD, depression, functional decline, as well as endorsement of suicidal ideation. What does all this mean? Or, what can we really learn that is potentially new here?

I think one of the interesting findings is that the odds of dying by suicide that were associated with anxiety were twice those of the odds associated with depression. A lot of times particularly in primary care, we get very focused on identifying and treatment of depression. I am less sure about how much we focus on anxiety. This result is consistent with another recent study done by Ken Conner as well as other studies. But in Dr. Conner's study, they looked at a national VA sample and similarly found anxiety to be associated with suicide. As far as why this occurs, we are not exactly sure. I mean, it has thought for many years that people who have anxiety may have increased motivation or more drive or activation perhaps that act on suicidal ideation.

But anxiety also may be a strong indicator of additional co-morbidity since a lot of times anxiety disorders are co-morbid with other conditions. In addition, we found that functional decline had a pretty strong association with suicide. This is consistent with prior studies. Although those studies tend to be a little smaller. Because it is very challenging to rate and measure functional decline in larger population based studies. What we think this means is that greater attention may be needed in primary care to improve recognition of anxiety and stress associated with functional decline and to develop interventions that work in primary care for those conditions.

I wanted to say just a couple of things about our other key finding. Suicidal ideation endorsement was associated with increased suicide risk. This is also consistent with another recent study showing an increased risk with positive patient health questionnaire nine item, which asks about the suicide. This was done in a large group health system. That being said, I think it is important to note that there are limitations to screening for suicidal ideation at least by itself when it is not combined with a good clinical assessment.

In general, screens for suicide risk have been shown to have very low predictive ability. That is largely because the rate of suicide is fortunately quite low. This limits the ability of any, pretty much any instrument that we know of to be specific in predicting suicide. You have a large number of false positives. In addition, there are several studies that now show that Veterans frequently do not disclose when asked about suicidal ideation even at their last visit. Eric Smith has a study looking at a large sample of Veterans who had depression diagnosed even within seven days of death.

A minority endorsed suicidal ideation when asked. We similarly have data from the state of Oregon as well as this current study that would suggest that the majority of Veterans do not disclose suicidal ideation even at the last visits prior to death. Then maybe they do not have it yet. But it also may be that they are not comfortable disclosing it. Just all important things to keep in mind with respect to use of suicidal ideation screening or risk assessment instruments. You really want to combine that information with a good clinical assessment.

Then finally, I wanted to mention that – and get back to this issue of our psychosocial context variables dropping out of the final model. I do not think it means that these issues are important. We do see some suggestion that the overall burden of stressors may be important. One of the things that we did not look at or did not do in this analysis was examine interaction effect; which is really combinations of stressors or other predictor variables. That may be something else that would generate some additional information.

I just want to put in a study – or a slide about study limitations. I think our biggest limitation here is that we do not have patient level measures. We relied on chart review, which itself relies on clinician documentation. There is also a potential a misclassifying Veterans status. Sometimes death certificate data are not accurate in terms of being able to identify Veterans accurately. On the other hand, we focused in this analysis specifically on people who had received care in the VA and had information – had actual medical records.

I think that potential is fairly minimal in that case. We did not use a truly national sample. Although, I think our findings are probably fairly representative. We had few women and few Veterans of Iraq and Afghanistan; and few with TBI. We did not explore for interaction effects. Finally, I think there is a limited impact of what we can take away from all of this using a purely quantitative approach. I think that will hopefully lead into what Lauren is going to be speaking about, which uses more of what is called a mixed methods approach. She can explain what that means. Thank you. We are just switching seats now.

Lauren Denneson: Okay, hi, and good afternoon, everyone. My name isLauren Denneson. As Steve mentioned, and Molly has talked about, I am going to be talking about the qualitative analysis that we did as part of this study. We did this for a couple of reasons. We touched on one of them. But we noticed that there is a lot of – or that we did not have a lot of women in our sample. We also did not have a lot of OEF/OIF Veterans in our sample. We very limited in what we could do quantitatively to look at those groups.

We decided that a qualitative approach would be a little bit better. But we also recognized that in the quantitative chart review that we had been doing, the medical records are full of a lot of rich data that we were essentially leaving on the cutting room floor when we were doing our very thematic type of review. We wanted to be able to speak to some of the more nuanced data that we were seeing. This is the sort of expanded qualitative team that worked on the project. We are going to started with our poll, the second poll question trying to get a little bit more information about how experienced you all are and what qualitative methods.

Molly: Thank you. As our attendees can see that second poll question is now up on your screen. Please click the circle next to the response that best describes your experience with qualitative research. Starting at the top, you have limited exposure and knowledge of qualitative research. You have some to substantial knowledge of qualitative research; next, have collaborated on qualitative research; or, finally have led a qualitative research study. Once again, we have a very responsive group. We very much appreciate that. Eighty percent of our audience has already voted. We will give people a few more seconds as the answers are still streaming in. alright, it looks like we have capped off at about 85 percent.

I am going to go ahead and close the poll now, and share those results. It looks like exactly 50 percent of our respondents have limited exposure or knowledge of qualitative research; 27 percent have some to substantial knowledge of qualitative research; 14 percent report having collaborated on qualitative research; and 9 percent have led a study on qualitative research. Thank you to those respondents.

Lauren Denneson: Okay, thank you. I will probably spend a little bit more time describing some of the specifics of our analysis then for those of you who don't have a lot of qualitative experience. The focus of what I am talking about is we are looking again at the OEF/OIF Veterans and the women Veterans who are in our sample. We really wanted to be able to describe the psychosocial and context life experiences. That is the support and stressors that they were experiencing in sequence prior to death; describe the primary health concerns that they are bringing to the VA. Then better understand the type of VA care that they were getting before they died.

We are doing all of this in hopes that we could somehow highlight some of the more important treatment needs of these subpopulations that we often do not have a large enough sample size to really get at. We approached this like a content analysis. What we did is we took the medical records out of the national electronic medical record. We exported it using their report function. We put them literally right into a Word document for each case. As Steve mentioned before, we had data from 11 states. This spanned 41 different VA facilities.

We selected suicide decedents from the date range of 2009, or 2007 to 2009. That gave us like just under and around 30 Veterans for group. We did not want to spread too much to get more in our samples. Because then we were starting to maybe wonder if the VA policies and procedures, and treatment had changed too much over that time period. We kind of landed on that sweet spot of those three years. We were looking at the six months prior to suicide for all of the care that we were looking at. Then we wanted to take a more rapid turnaround approach.

If you have seen or listened to Alison Hamilton's wonderful Cyberseminar on the topic, she really put the bug in our ear about using this approach. We thought it would be great to try in this project to try to do it a little bit more quickly. We also had a very, more deductive approach to our project. We were not doing a very intensive inductive, in depth review. We had some very definite things that we wanted to look for. We engaged three non-clinician reviewers to look more at the demographic, psychosocial, and health kinds of aspects of these individual's lives. Then we brought in two clinician reviewers. Steve was actually one of them – to do a more targeted clinical review looking at things like \_\_\_\_\_ [00:30:54] social psychologists. We also had anthropologists and public health experts in the mix. But we do not.

We are less able to look at the treatments and the clinical implications of the cases. That was really helpful to have them doing the clinical review. Each case got reviewed by two non-clinicians and both of our clinicians. We had a good overlap there. Then we pulled in some demographics and military service data from the VA admin data in our OEF/OIF \_\_\_\_\_ [00:31:29]. For those of you who are not familiar with the more – the rapid review qualitative approach, we started off with having sort of data categories that you want to find information about. When we got together and we were trying to figure out what we wanted to know about these cases, we approached it with the social ecological model where we were looking at all of the different factors that \_\_\_\_\_ [00:32:03] lives. They were going on and seeing what – we wanted to know what we could glean from the medical records about the various aspects that you see on your screen right now.

We started calling them our case narratives. For the social category, we were asking questions of what were there? Was there evidence of what their family was like growing up? What kind of friends did they have, dependents, intimate relationships, et cetera, and so on down the line? We started out very, and like I said more top down with these questions and these categories that we wanted to get more information about. But then we tested it out. We just – an iterative process to bring in some additional things that we were finding in the charts. But realized it would be really important and helpful to look at.

Then some of the specific questions that we were asking within each category were informed a lot by prior research and prior work \_\_\_\_\_ [00:33:06] intervention. Like I mentioned before, we had two clinicians doing a more targeted clinical review. They were looking primarily at mental health conditions and the type of psychotherapy and medications that the cases were receiving. The adequacy and extensive suicide risk assessment; and really, did the risk assessments affect this trajectory of care, and things like that? The under treatment or care needs that were under addressed; overall impressions of the diagnosis, and overall impressions of the adequacy and appropriateness of the treatment.

Then they had another category where they could write in things that they were noticing. We took these categories to do some analysis with them. We created these \_\_\_\_\_ [00:34:05] matrices. Or some people call it charting where you have the case along the left-hand side. Then across the top, we had all of our categories. Or, we would limit some of our charts to a couple of categories. We specifically looked at supports and stressors in one of our charting procedures. Another one, we looked a lot more in depth at the clinical \_\_\_\_\_ [00:24:27].

That helped us come out with some of the themes that I am going to talk about here in a minute. For our OEF/OIF samples, we ended up with 38 OEF/OIF Veterans. Ten percent of those were female. We had a little bit of overlap between our OEF/OIF sample and the women's sample that I am going to talk about. That ended up being four women. The average age was 34. They are pretty young, and mostly white, and non-Hispanic. Two-thirds were not married. But we noted that five of those 25 were in a committed relationship. That was important enough to come out in the chart. Primarily the method of suicide in this group was firearms.

You can see \_\_\_\_\_ [00:35:16] left area. For the OEF/OIF Veterans, we generally did see a lot of chaos going on in the lives. One of the primary things that we noticed was that there was a lot of intimate relationship concerns. Within intimate relationships there was violence and trauma, which is also tied to the next theme, which was anger and aggression. You could see like we start to see there is a lot of interconnectedness. It seems that we are noticing across and what ended up being in both of these groups that we looked at. But then, in the relationship group, there were some recent breakups \_\_\_\_\_ [00:35:57] relationships where they were fearful of their partner leaving them.

As I mentioned, the anger and aggression was very much tied in with those problems. Then financial strain, which is also tied a little bit into the anger and aggression; and some inability to work due to some physical injury or medical issues. Then obviously with this younger group and the more recent deployments, there is more combat and service related issues. We were observing nightmares and PTSD. They were very common. But overall, we noticed that the medical issues were less stressful for the men in this group than for the women.

But there was some, for the women – and I will get more into this when I talk about the larger female groups. There were some ambiguous and stressful medical concerns that they were dealing with. In general, we are seeing that it may be important to address some of the combat and service related issues among OEF/OIF Veterans. Pay a little bit more particular attention to anger and aggression, and some of these things that were tied to financial and relationship issues. In the OEF/OIF Veterans for the medical care, we saw that most of them were receiving mental health treatment.

Interestingly enough, a lot of them were actually in \_\_\_\_\_ [00:37:29] care during this six months. We got to see them have like an intake assessment. Some of them were having an intake assessment and maybe one more mental health visit. Then they were not in mental health treatment anymore. That was kind of – that seemed to stand out to us a little bit. They had multiple clinical diagnosis. There was some transitioning between care settings that seemed problematic. Then the clinicians identified some particular care problems in this group, namely under recognizing or under treating substance abuse disorders; receiving sedative and hypnotic, which may or may not have been appropriate at times.

Then sometimes the treatment intensity and outreach could have been a little bit stronger. In this group we saw suicidal ideation assessments a lot. It was quite common. Most people who were being asked about it were actually endorsing it. We thought that this sort of lent some evidence towards increasing outreach treatment intensity, and encouraging stronger Veteran engagement in their care.

Although, we recognized that of course, this data comes from 2007 to 2009. There has been a lot of changes in especially outreach and treatment intensity in the VA. Our female sample ended up being 27 women. They were a little older than the OEF/OIF group. They were averaged in age of 44. They were mostly white and non-Hispanic. A vast majority were not married. We noted within this group that of those who were not married, were living with their significant other. Women were split pretty well between poisoning and firearms as their method of suicide. Poisoning was slightly more common.

Molly: I am sorry to interrupt Lauren. Could I get you to speak up just a little bit?

Lauren Denneson: Okay.

Molly: Thank you.

Lauren Denneson: Okay. In the women group, it was very pronounced as I kind of alluded to earlier. The psychosocial or the supports and stressors that we were examining were very intimately tied up with their health issues and concerns. Particularly common in this group was an experience of trauma. Probably the most commonly experienced health concern in this group was some form of trauma, either childhood sexual abuse, or a neglect, or some issues there – or adult sexual abuse, intimate partner violence.

One of the things that we found a little… There seemed to be fewer PTSD diagnoses among of this group of women who had trauma. But then they were really more likely to be diagnosed with borderline personality disorder or determined to have histrionic traits, or some such. We thought that there may be more attention that should be paid to addressing PTSD among women who have experience some trauma whether it be childhood trauma or adult. We also noticed that there was quite a bit of substance abuse.

This was tied up with a lot of relationship conflict. Sometimes like work relationships and sometimes family, and friends, and significant others. We saw a lot of drug seeking behavior, alcohol abuse. Patients were concerned about how their substance abuse was impacting their relationships at work and with their family. Then there was a lot of substance abuse happening in the context of family stress or prior abuse.

We did notice as I said before, this is a little bit older population. Especially among the older women there was limited functioning, and some poor physical health, and declining health. Women with a lot of multiple chronic health issues that they were struggling with especially pain, and some ambiguous concerning and worsening health concerns; they were kind of coming up closer up to a time of death. They were having – like this one woman was having seizures. They were going unexplained and things like that.

The women that we were looking at were really primarily very complex cases, a lot of visits and a lot of chart notes. There were a handful who seemed to be very reluctant to come to care who were lacking engagement. But there were quite a few who had some very complex health interactions and ambiguous concerns like pain and fibromyalgia. Among this group we saw a lot of what we would call typical risk factors in this suicide field. But when asked about suicidal ideation, most of them were very consistently denying thoughts of suicide every single time they were asked about it.

We did see this odd pattern that we cannot quite categorize or yet, or define yet. What I am kind of calling unmet needs in the days before suicide where women were coming in for – wanting a very specific thing, and the system responding to them like a one woman who had called desperate for detox, and was scheduled for an appointment the very next day. Her clinician said that she was going to evaluate her and probably recommend her for a detox treatment – ended up killing herself between that day and her appointment the next day.

One woman who was coming in and asking for inpatient treatment. There were not inpatient beds available; but was referred to another hospital. She declined. A transitioning Veteran who is unable to receive her medication. There was a survivor of \_\_\_\_\_ [00:44:09] sexual abuse who was experiencing what she termed frightening and mildly romantic feelings towards someone \_\_\_\_\_ [00:44:14] power.

These are all sort of things that were happening close to the days before suicide that seemed to be appropriately addressed but maybe they were looking something else that they needed. It seems like there could have been some.… We may be needing to see if there can be better system responses to cases such as this.

What we have been kind of coming to a conclusion here is that there seems to be more attention that should be paid to non-military related trauma especially in women who have experienced sexual abuse with consideration of having a PTSD diagnosis in the appropriate treatment. An additional attention is warranted to the quality of social relationships overall and the capacity for these Veterans to development meaningful and supportive relationships. Then weighing the risks and benefits of prescribing benzodiazepines instead of hypnotic is also an important. Looking at the treatment intensity that we are providing for substance abuse; and trying to engage Veterans more in terms of abuse treatment. In general, like I said before, improving outreach engagement and continuity in care.

Steven mentioned this earlier, but it cannot be said enough. The data that we were looking at are all from medical records which varies of course, over time as standards change. It varies by author, discipline. We all know that it is not capturing the entire interaction that happens between a patient and their provider. We noticed that in particular and as we were doing a qualitative approach that there really is little information about reports and positive aspects of Veterans' lives. We cannot determine if that is because they were not talked about, or addressed? Or the clinician did not find it important to document? Or, the positives and supports were not actually present in their lives. It is a huge limitation. I will open it up to questions.

Molly: Thank you both very much. We do have some pending questions. For those of you that joined us after the top of the hour, to submit your question or a comment use the question section on the right-hand side of your screen. Simply click the plus sign next to the word question. That will expand the dialogue box. Then type your question or a comment in. We will get to it in the order that it is received.

The first question that we have. Steve, this came in while you were speaking. I am just curious if they looked at MST positive or negative screen. That is Military Sexual Trauma.

Steven Dobscha: Right. We did not do that. MST is actually pretty challenging. When people have a screen, it is typically done one time. I mean, it may have changed in the last couple of years. But at the time we were reviewing these data, it was generally done one time in a Veterans life in the VA. We did not really have the ability to go back and see what that was without looking at multiple years of data.

Lauren Denneson: From what we know, they are not in \_\_\_\_\_ [00:48:09] chart.

Steven Dobscha: We would have to do it through a chart review.

Lauren Denneson: A chart, yeah….

Molly: Thank you for that reply. This one, Lauren, it came in while you were speaking. Lauren found that treatment outreach and intensity could have been improved. Just wondering, if you noted if safety plans were in the charts or not?

Lauren Denneson: We did find a few safety plans, but not a lot, like one or two.

Steven Dobscha: Yes. Again, this was 2007 to 2009. I think the safety plan initiative probably started maybe in 2007. I think the update, it took – it takes a while.

Molly: Thank you. The next question, could you describe your rationale for selecting the states and the sites that you sampled from?

Steven Dobscha: Yes. It is pretty straightforward. We essentially took the 11 states that were available to us when we started the project. Now since then, the VISN 2 Center has collected state…. I think almost all states have now contributed data. Obviously there is more recent data than 2009. But at the time we started, it was purely driven by what state data was available.

Molly: Thank you. Are there any secondary analyses you hope to do with this data?

Steven Dobscha: One of the questions would be to do more quantitative analyses with multiple years of data. We focused in on 2009, mainly because we wanted the most recent data. We thought that would be a large enough sample; which turned out to be the case for most cases. But, for example, TBI, there really were not enough cases to do that.

I think we would like to do a little bit more work examining the burden of psychosocial stressors. We thought about taking a look more closely at certain clinical subpopulations; for example, of the pain and PTSD. But we are also open to other ideas, if anybody wants to send us some. Those are the one that are off the top of my head.

Molly: Thank you. The next question; what are the areas where clinicians could improve in their approach to detect the suicidality in your sample?

Steven Dobscha: Okay. That is a tough question. I mean, I think that. Let me just take a step back here. I mean, I think I talked a little bit about the role of screening. That is somewhat limited. I think engaging…. Well, from some of the qualitative work we have done on a previous project, it is very clear that Veterans are often uncomfortable disclosing suicidal ideation.

The factors that seem most important are having a trusting relationship with a provider in which there is continuity of care. Sometimes a lot of that is out of our control. But I think embedding discussions about suicide in a patient centered conversation is probably the most likely way to find out if it is present. The other thing I think I would suggest is I think especially for primary care clinicians. I am not sure how good of a job that we do as a system in helping primary care clinicians understand what options are available when someone does have suicidal thoughts. It seems from some of our prior work, often it comes down to is this patient safe enough to go home? Or, do they need to be in the hospital?

I think developing more resources, including education supports for primary care survivors to either fast track people into mental health, and warm hand-offs; perhaps intermediate types of care, intensive outpatient or partial hospitalization. I mean, I think being aware of those options and making sure that the primary care providers are aware of those would also be quite helpful. I do not know, Lauren, do you want to add anything else?

Lauren Denneson: It is pretty comprehensive to me.

Molly: Thank you. This morning, I started reading a book titled What They Do Not Tell You. I do not quite remember the authors names – or name. Do you read books written by Veterans about their Veterans?

Steven Dobscha: I have read books written by Veterans. But I am not familiar with that book.

Molly: Thank you. Was there any data on the number of completers who used the hotline prior to suicide?

Lauren Denneson: Do we have that? We do have that. But I cannot. We have not looked at it extensively. I cannot remember how frequent it was. I think it was pretty rare.

Steven Dobscha: Yeah. That would be a good…. That is a great question. Again, I think that we are going back kind of far in time from the present. But I think that is a really good question. We could certainly look at that.

Lauren Denneson: Well, one of the issues \_\_\_\_\_ [00:53:58] that they – it is only noted in the medical record, if the Veteran calling the hotline says that it is okay that it is documented, and to look them up. There may be – there have been a lot of Veterans in our samples who did contract the hotline that we never knew about. Because they did not okay having that documented.

Steven Dobscha: Right. I believe the minority of people who call the hotline give their information at least currently. They give their information.

Molly: Thank you. There was a question to the last comment. The submitter meant to write do you read books written by Veterans about their Veteran friends? Thank you for that correction.

The next comment, specialty staff, not just primary care also needs support; and how to get patients into mental health. I am in neurology. We frequently have patients who have expressed suicidal ideation. It is very hard to be confident their needs are addressed.

Steven Dobscha: Yeah, absolutely, I am not sure I can add to that comment.

Lauren Denneson: Yes.

Steven Dobscha: Actually, I will say something. In the clinical reviews that we have done for the – as part of the content analysis, these transitions in care are actually fascinating. I mean, there are a number of VAs where – and I think a number of scenarios that we reviewed in which a Veteran is hospitalized at one hospital. They go to a follow-up at one clinic. Then they are referred to a different clinic, and perhaps even it belongs to a different facility.

I mean, it certainly gives me an appreciation for what the staff must have to go through in trying to coordinate care. But it also seems extraordinarily relevant, these hand-offs that we are constantly doing. It really does make a good question, if there are ways to somehow limit the number of continual hand-offs.

Molly: Thank you. The next question, although we obviously should do everything possible to mitigate any possible suicide, you've found that many quote consistently denied any suicide ideations. Can one area of research look at how quote, motivate, the patient is to work on their suicidality given that in at least some cases, no matter how much treatment is offered, some people may still to choose to suicide?

Steven Dobscha: Right.

Lauren Denneson: I mean, I think that is a huge issue and something that we have wrestled with before when we have looked at that \_\_\_\_\_ [00:56:46] findings where we see that a lot of people do not endorse SI. But I do not know if there is any work that is being done on it.

Steven Dobscha: Well, I mean, I think certainly we encourage looking for warning signs. I would encourage people to look at VA Suicide Prevention guidelines that are available online. But sometimes if someone is not disclosing, there still may be warning signs. But I think sometimes this is part of sitting down with the Veteran in a patient centered conversation. Perhaps sometimes coming back to it when there are warning signs, if someone feels a little bit more comfortable in an effort to try to engage them.

The other thing is sometimes even if a Veteran is not willing to disclose actual suicidal ideation, you may still be able to help with motivation to engage in care, treatment, and imparting hope. I mean, all of those things are likely to be protective even if they do not get suicidal ideation out on the table.

Molly: Thank you both for those replies. That is the last pending question at this time. But I would like to give either of you a chance to make any concluding comments, if you would like to.

Steven Dobscha: No. But again, I think we are open. If anybody has other ideas or suggestions on how we might use these data or other questions, feel free to send them to me.

Molly: Excellent. Well, I would like to thank you both for lending your expertise to the field. Of course, thank you to our audience members for joining us. As I mentioned, at the end of this presentation, your feedback survey will pop up on your screen.

As you exit out of the session, please wait just a moment while that screen does populate. It takes just a second to load those few questions. We do look closely at your responses. It helps us to decide which topics and Cyberseminars to support and get out to the field. Also, as I mentioned, this is the first in a new series on suicide prevention.

Please keep an eye on your e-mails and in our registration catalogues for the future presentations that will be coming up. Once again, thank you very much to Drs. Dobscha and Denneson for presenting, and to our attendees for joining us. This does conclude today's HSR&D Cyberseminar. Have a great day, everybody.

[END OF TAPE]