

The Suicide Prevention Research Impact NeTwork (SPRINT) and Office of Mental Health and Suicide Prevention present



Suicide Prevention Research in VA: Developing a Continuum of Intervention

July 9th, 2020 | 10:00 am – 1:30 pm (PDT)

Who is in the audience?

- What would you consider your *primary* role:
 - Researcher
 - Clinician
 - Administrator
 - Other

Today's Goals

- Provide a brief review of current state of suicide prevention research evidence and operations and research priorities
- Highlight several active suicide prevention projects, with a focus on intervention research spanning a continuum from clinical care to community.
- Review prior research on mental health impacts (including suicidal self-directed violence) of pandemics and other national crises, and introduce several COVID-19 projects in process.

SPRINT Mission: To accelerate VA suicide prevention (SP) research that will improve care and reduce suicidal thoughts and behaviors among Veterans

SPRINT PIs: Steven Dobscha MD; Mark Ilgen PhD; Teresa Hudson Pharm D, PhD

SPRINT's Goals:

- Serve as an inclusive and collaborative network of VHA and non-VHA researchers and SP Centers of Excellence dedicated to conducting high-quality, high-priority, and high impact SP research.
- Maintain a “state of the science” inventory of information about VHA and non-VHA health services SP research activities, VHA operations-funded SP projects, and the evidence-base for SP interventions.
- In collaboration with stakeholders including operations partners, use the inventory to create a focused SP research agenda; and facilitate development of team-science efforts to address the agenda.
- Support innovation and development of methodological and content expertise, and high impact projects that create, test and implement potential solutions.

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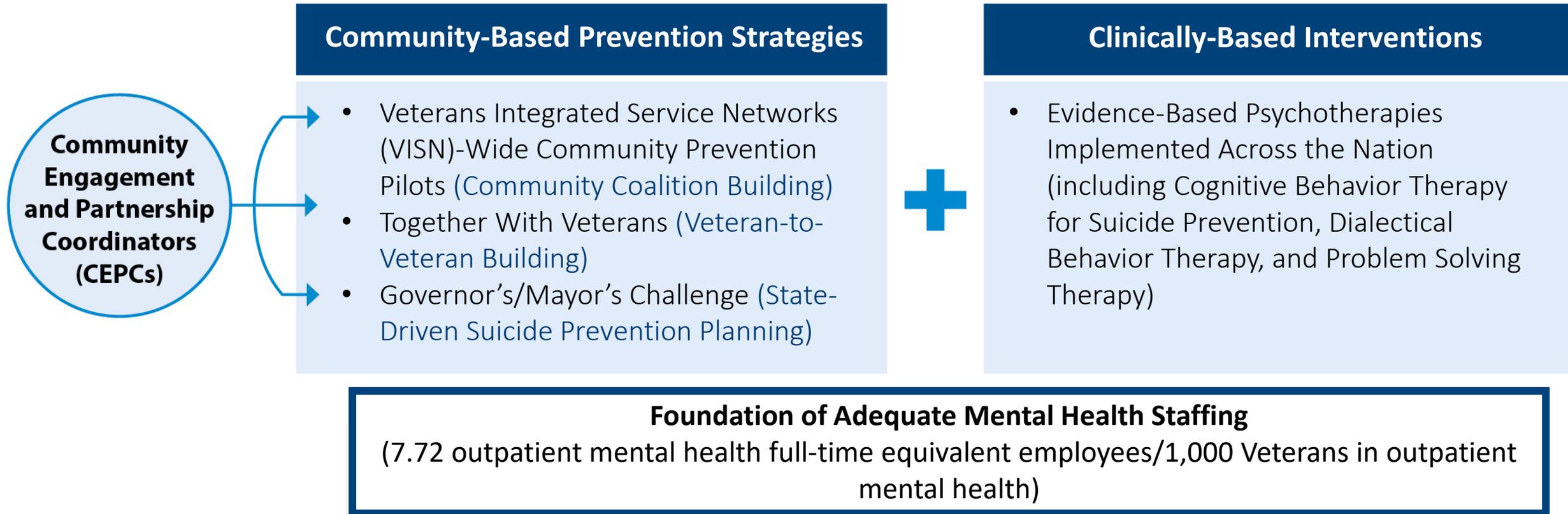
Working Together to Implement the Department of Veterans Affairs' (VA) Public Health Model for Suicide Prevention

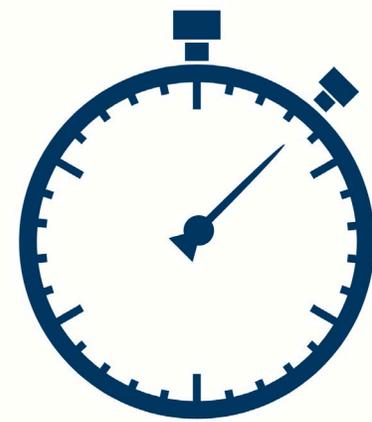
Public Health Strategy



VA's public health strategy combines partnerships with communities to implement tailored, local prevention plans while also focusing on evidence based clinical strategies for intervention. Our approach focuses on both what we can do now, in the short term, and over the long term, to implement VA's [National Strategy for Preventing Veteran Suicide](#).

Suicide Prevention 2.0 Vision for the Distance: Combining Community & Clinical Interventions





The Now Plan

Prevention Strategies to Implement in the Short Term

5 Prevention Strategies for the Short Term

- **Strategy 1:** Lethal Means Safety: Securing Firearms, Medications, and Other Items to Save Lives
- **Strategy 2:** Caring for Veterans in Specific Medical Populations
- **Strategy 3:** Re-Engaging Prior VHA Users: Directly Reaching Veterans
- **Strategy 4:** Suicide Prevention Program Enhancement
- **Strategy 5:** Reaching All Veterans Through Powerful Messages of Hope: Nearly 20 Million Veterans, 2 National Campaigns

Strategy 1: Lethal Means Safety: Securing Firearms, Medications, and Other Items to Save Lives

- **Goal:** Promote the dissemination of lethal means safety materials and training to empower Veterans, community members, providers, and loved ones to store firearms, medications, and other items to save lives
- **Outcome:** Increase education and awareness across healthcare providers within the Veterans Health Administration (VHA) and in communities across the nation on lethal means safety



Strategy 2: Caring for Veterans in Specific Medical Populations

- **Goal:** Promote suicide screening and management of "medical bad news" in specific populations that may be at risk for suicide
- **Outcome:** Increase suicide risk screening, assessment, and follow-up with Veterans



Strategy 3: Re-Engaging Prior VHA Users: Directly Reaching Veterans

- **Goal:** Conduct outreach and encourage prior VHA users to reengage in VHA care
- **Outcome:** Increase contact with Veterans who previously received care from VHA in order to offer additional referrals for VHA care and learn more about their current healthcare access



Strategy 4: Suicide Prevention Program Enhancement

- **Goal:** Establish and improve VHA processes for identifying and intervening with Veterans at increased risk
- **Outcome:** Increase use of clinical resources such as patient record flags, safety planning, Recovery Engagement and Coordination for Health — Veterans Enhanced Treatment (REACH VET), and additional best practices to decrease suicide and engage Veterans at increased risk



Strategy 5: Reaching All Veterans Through Powerful Messages of Hope: Nearly 20 Million Veterans, 2 National Campaigns

- **Goal:** Reach Veterans inside and outside VA to engage them in treatment and access to needed services
- **Outcome:** Implement public health messaging campaign to increase awareness and engagement in Veteran-centric resources across the nation

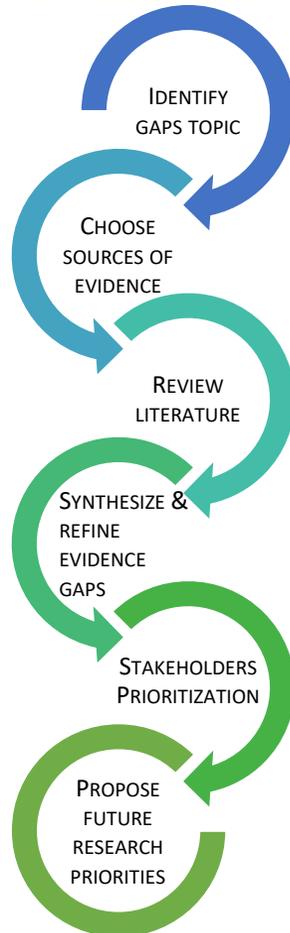


PHCoE 2019 Suicide Research Gaps

Brief Summary



PHCoE Research Gap Identification & Prioritization Process



Prioritized Research Gaps Reports

- Combat & Operational Stress Control (2020, in progress)
- Suicide Prevention (2019, report in progress)
- Adjustment Disorders (2018)
- Selected Substance Use Disorder Topics (2017)
- Post-traumatic Stress Disorder and Depression in the Military (2016)

PHCoE Identification of Research Gaps



- Derived from the *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (2019)*
- Updated literature review and synthesis to identify any new research

- Eight categories, 56 individual gaps
 1. Screening for Suicide Risk
 2. Evaluation, Determining Level of Risk, and Relationship to Treatment
 3. Risk and Protective Factors
 4. Non-pharmacologic Interventions
 5. Pharmacologic Interventions
 6. Post-acute Care Approaches
 7. Community-based Interventions for Reducing Risk of Suicide
 8. Technology-based Modalities

- Consolidated to 6 categories, and 35 individual gaps
 1. Screening, Evaluation, Risk Determination, and Referral to Treatment (Combined two categories from CPG)
 2. Risk and Protective Factors
 3. Non-pharmacologic Interventions
 4. Pharmacologic Interventions
 5. Community-based Interventions
 6. Post-Acute Care Approaches*

*Integrated gaps related to technology-based modalities into other categories

Suicide Gap Prioritization Methods



- Developed and piloted a research gap prioritization form that was sent to selected external SMEs and stakeholders
- Respondents were asked to rate 35 research questions based on perceived priority on a Likert scale
- Q factor analysis to derive a list of the prioritized research gaps and category rankings

External SMEs and Stakeholders



- 19 nationally-recognized suicide experts:
 - VA (47%), DoD (26%), academic (26%) settings
 - 74% with past involvement in DoD/VA suicide research
 - 68% plan to apply for future DoD/VA suicide research funding
 - 16% with prior/current DoD military service

Suicide Gaps Prioritization Results



Highest-rated Research Gaps

(where more research is most needed):

1. **Lethal means safety** as an intervention
2. **Crisis response/safety planning** to prevent suicide
3. Effective **implementation of CBT** across the MHS*
3. **Technology-based BH interventions** (stand-alone) to prevent suicide*
3. **Technology-based adjuncts** (web, phone apps) to prevent suicide*

* Rated equally

Suicide Gaps Prioritization Results



Lowest-rated Research Gaps:

- Effect of **antidepressants** on suicide risk in demographic and geographic subpopulations
- **Naloxone** distribution to prevent suicide
- Effects of **physical health conditions** on suicide risk
- Effects of **psychiatric conditions** on suicide-related outcomes

SPRINT Review of SP Research Landscape

In September 2019, 20 representatives from the SPRINT investigator team, HSRD, CSRD, RRD, VA Operations, DoD, Military Suicide Research Consortium, and others met to 1) Review current evidence on SP interventions, 2) review active SP projects, and 3) learn about OMHSP SP priorities.

Main Data Sources for Landscape Review included:

- *Evidence: Compendium of Systematic Reviews of Suicide Prevention Topics (ESP)*
- Active Projects
 - Prior Office of Research and Development (ORD) Review (9/18/18)
 - List of Mental Health and Suicide Prevention (OMHSP) Operations projects
 - 2019 Partnered Evidence-Based Policy Resource Center (PEPREC) list of ORD projects
 - Clinicaltrials.gov and NIH Reporter
 - Department of Defense (incl. CDMRP; DSPO, MSRC)
- We focused on collected information on active suicide prevention projects in Veteran and military populations that had funding in 2018 and 2019.

Information on Evidence

Compendium: Systematic Reviews of Suicide Prevention Topics

August 2019

Prepared for:

Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service
Washington, DC 20420

Prepared by:

Evidence Synthesis Program (ESP)
Coordinating Center
Portland VA Health Care System
Portland, OR
Mark Helfand, MD, MPH, MS, Director

Authors:

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Nathan Parsons, MS
Kathryn Vela, MLIS
Lauren M. Denneson, PhD
Steven K. Dobscha, MD



VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

Department of Veterans Affairs
Department of Defense

Version 2.0 – 2019

Based on evidence reviewed through April 2018

ESP Compendium: <https://www.hsrd.research.va.gov/centers/core/sprint.cfm>

VA/DoD Guideline: <https://www.healthquality.va.gov/guidelines/MH/srb/>



Research Gaps from ESP 2019 Compendium

Populations	Transitioning/separating Veterans Veterans not connected to/using VA services Biological markers for suicide
Interventions	Multilevel interventions Community interventions Technological interventions Neuro-imaging/Neuro-psychological testing
Comparators	Head-to-Head comparison of interventions Technological interventions
Outcomes	Minimum effective intervention Differential intervention effect due to therapist level of experience Evaluations of sustainability and scalability Treatment variability due to SUD/OD, PTSD
Timing	Short-term vs. Long-term effects of intervention Effect of upstream vs. crisis interventions
Setting	VA Military Urban/rural
Study Design/ Methods	Controlled studies Ecological studies Stepped-wedge design studies Interrupted time-series analysis Standardization of terms, metrics, reporting of results Study replication

High priority research gaps identified in September 2019 meeting

Risk Factors and Assessment, in particular

- Understanding and addressing how risk varies over time; personalized approaches based on risk

Outcomes (and measurement), in particular

- Identification and validation of useful proxy outcomes for suicide behaviors (e.g., all-cause mortality, mental health symptoms, well-being or other quality of life indicators)

Special Populations, in particular

- Includes Veterans not connected to VA; improving engagement of Veterans not connected to VA
- Rural Veterans, Elders, LGBTQ, Women, Homeless Veterans

Community, in particular

- Engaging families and close supports in suicide prevention for Veterans
- Application of promising community and non-VA systems interventions to Veteran population
- Communication/messaging: Understanding public and media impacts; testing messaging to decrease stigma and increase engagement

Other intervention research, in particular

- Studies of application of technology (including telehealth/mobile solutions) to at-risk Veterans
- Effectiveness and implementation of psychotherapies for Veterans at risk
- Lethal Means Safety

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Inventory of Current Active Projects

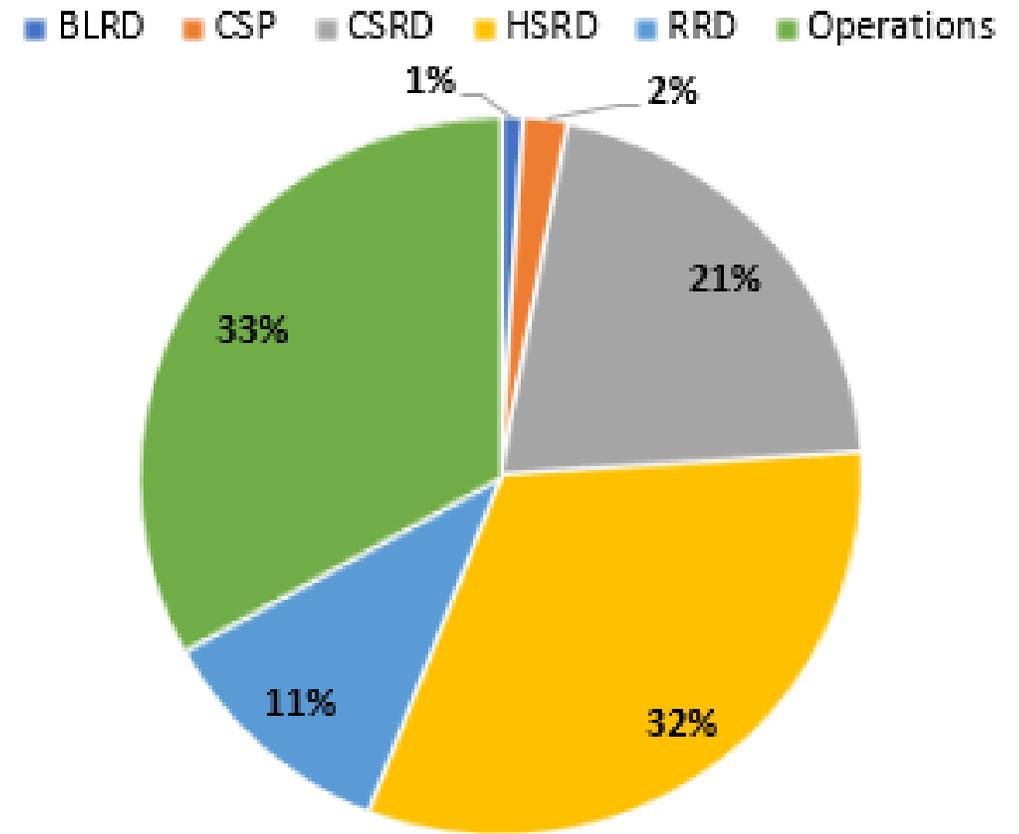
- Included:
 - Active research and operations SP projects in Veteran and military populations
 - Projects with current funding during FY2020 as well as others with pending funding.
 - Projects required at least one aim/goal specifically focusing on suicide prevention
- Databases and data sources:
 - Information from Office of Research and Development (ORD) RAFT Database— includes HSRD, CSRD, RRD, BLRD, Cooperative Studies (CSP) funded projects
 - Office of Mental Health and Suicide Prevention (OMHSP) Operations projects (Contact: Gloria Workman); Rural Health projects
 - Department of Defense [incl. Congressionally Directed Medical Research Programs [CDMRP]; Defense Suicide Prevention Office [DSPO]; Military Suicide Research Consortium [MSRC] (Contact: Kate Nassauer)
 - Non-VA funded projects via searches of *Clinicaltrials.gov* and *NIH Reporter*.

FY2020 Current (or approved for) Funding

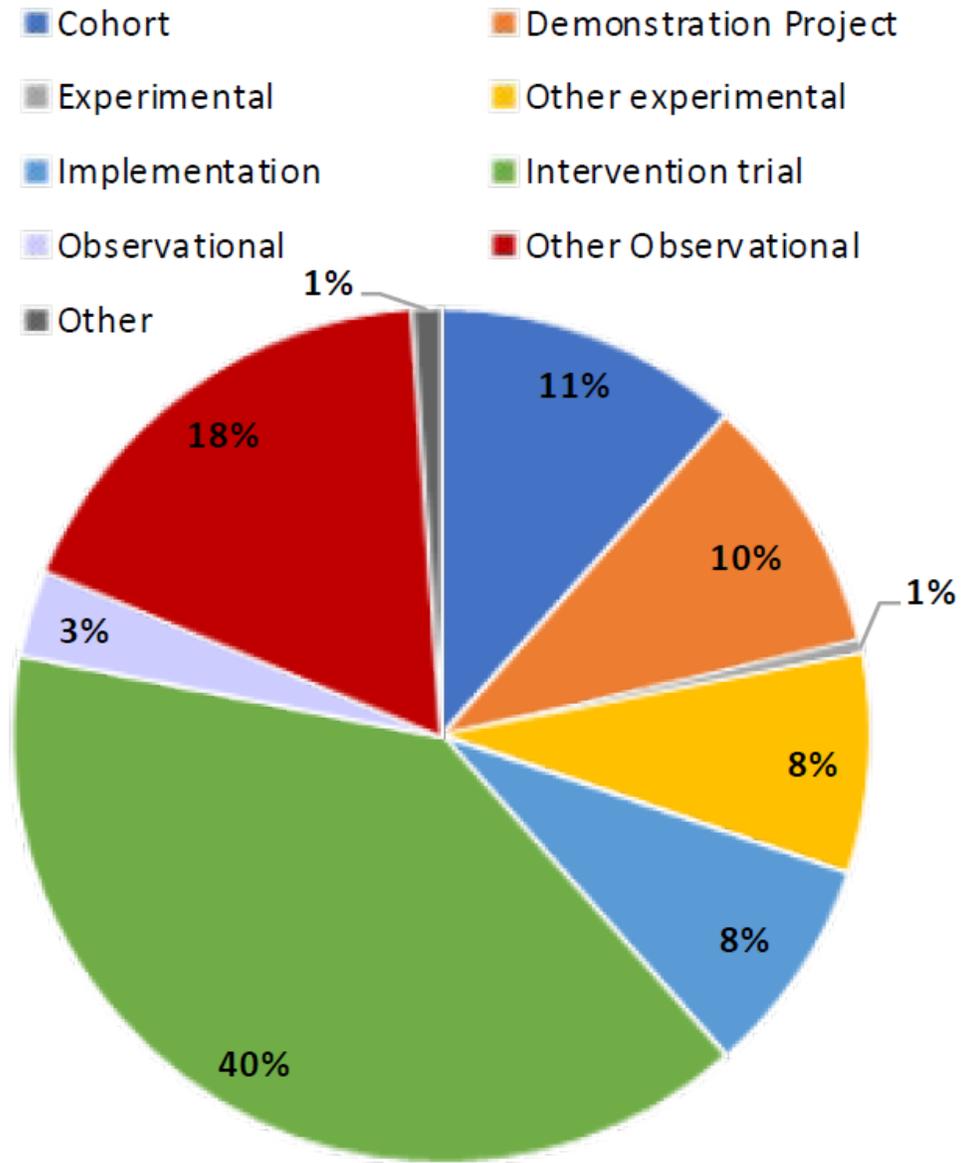
- 203 active projects conducted by 132 unique PIs
 - 106 projects funded by VA
 - 77 projects funded by DoD
 - 15 projects funded by NIH
 - 5 other (from other sources or not able to rate)

VA Funded Suicide Prevention Studies: N=106

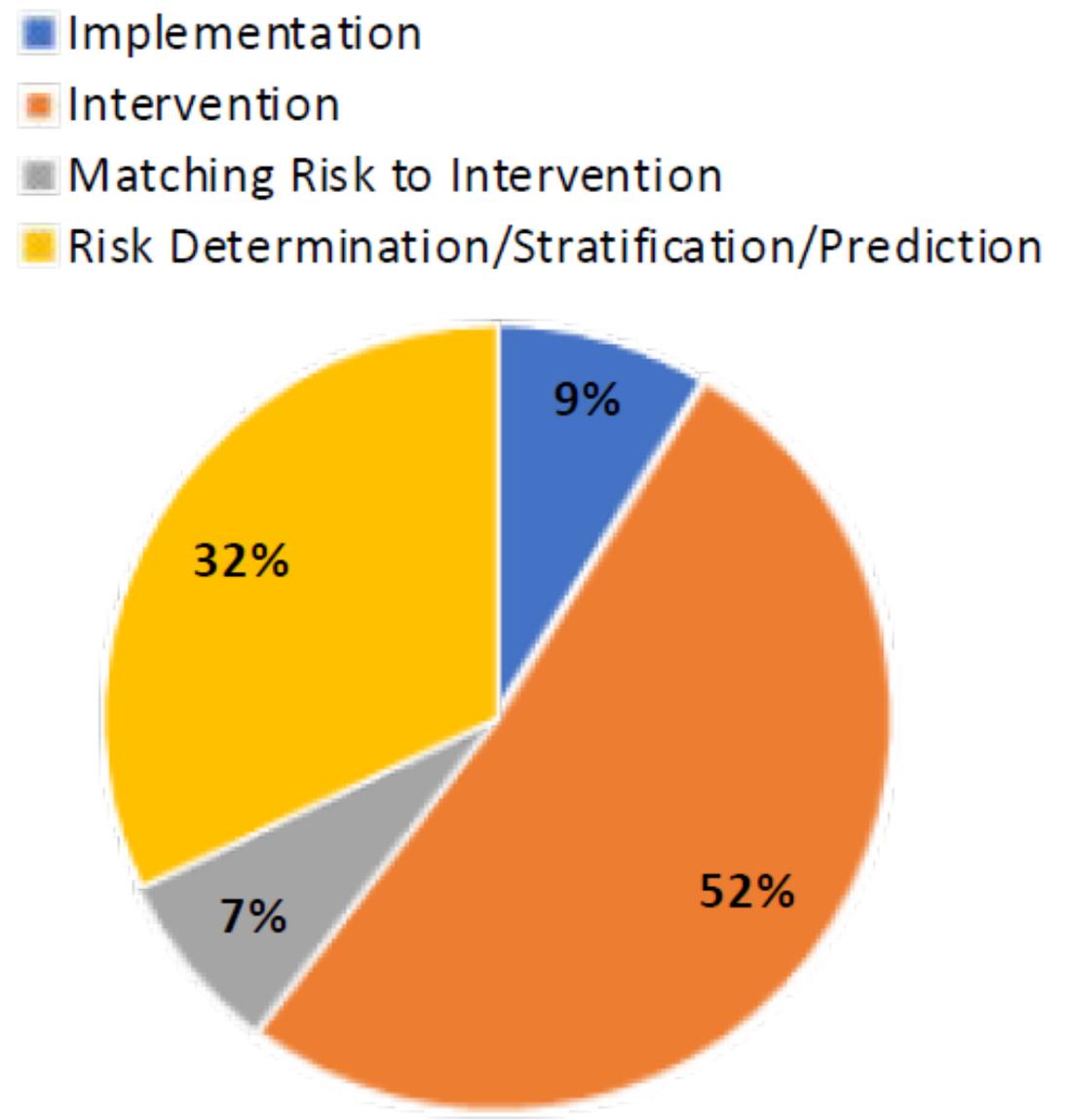
VA Studies	
Funding Department	Study Count
HSRD	32 (30%)
CSRD	21 (20%)
BLRD	1 (1%)
RRD	11 (10%)
Cooperative Studies	2 (2%)
Operations	33 (31%)
Other	6 (6%)
Total	106



Study Design

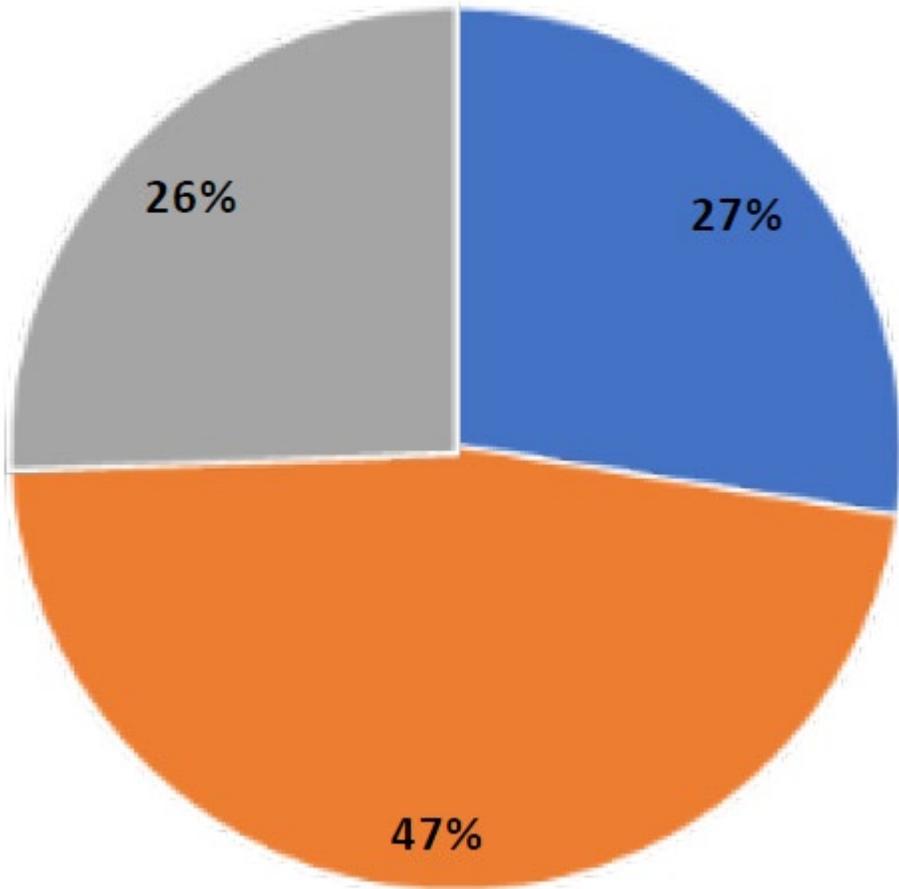


Primary Focus



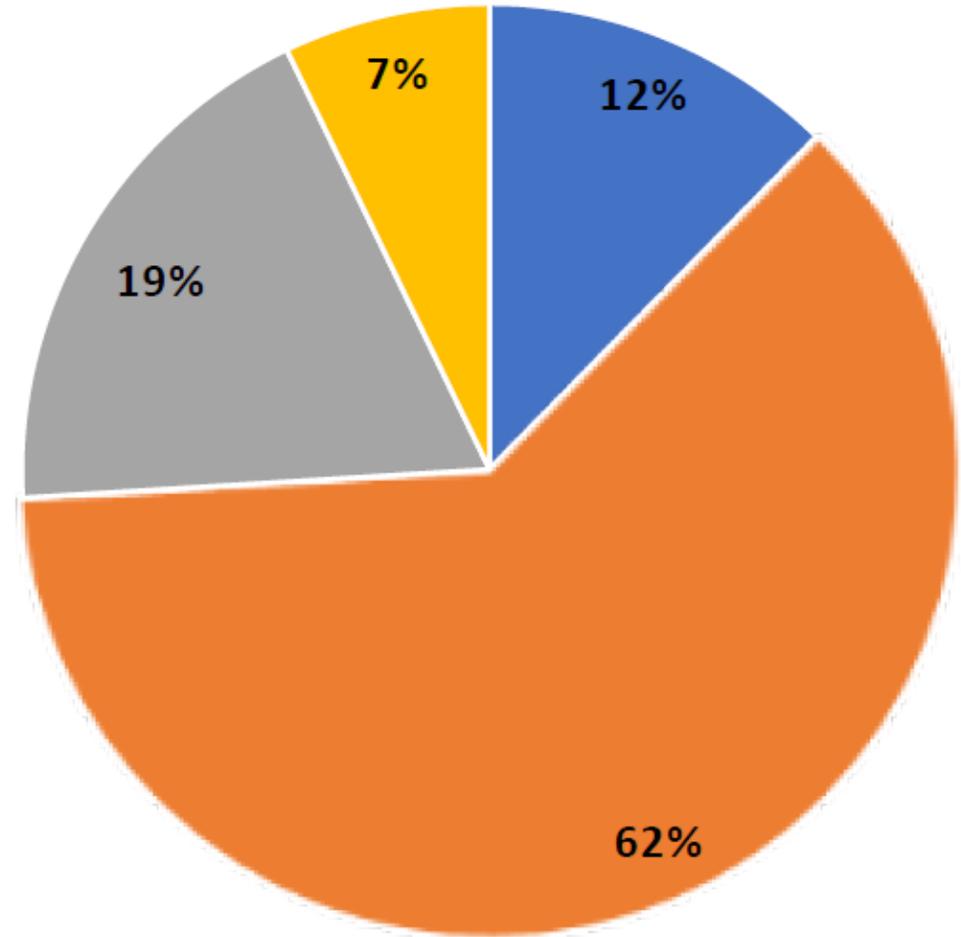
Public Health Approach

■ Indicated ■ Selective ■ Universal



Socio-ecological level

■ Community ■ Individual ■ Relationship ■ Societal



High priority research gaps

% of VA projects

<p>Risk Factors and Assessment, in particular</p> <ul style="list-style-type: none"> • Understanding and addressing how risk varies over time; personalized approaches based on risk 	<p>21%</p>
<p>Outcomes (and measurement), in particular</p> <ul style="list-style-type: none"> • Identification and validation of useful proxy outcomes for suicide behaviors (e.g., all-cause mortality, mental health symptoms, well-being or other quality of life indicators) 	<p>2%</p>
<p>Special Populations, in particular</p> <ul style="list-style-type: none"> • Includes Veterans not connected to VA; improving engagement of Veterans not connected to VA • Rural Veterans, elders, LGBTQ, Women, Homeless Veterans (COVID-19) 	<p>16%</p>
<p>Community, in particular</p> <ul style="list-style-type: none"> • Engaging families and close supports in suicide prevention for Veterans • Application of promising community and non-VA systems interventions to Veteran population • Communication/messaging: Understanding public and media impacts; testing messaging to decrease stigma and increase engagement 	<p>16%</p>
<p>Other intervention research, in particular</p> <ul style="list-style-type: none"> • Studies of application of technology (including telehealth/mobile solutions) to at-risk Veterans • Effectiveness and implementation of psychotherapies for Veterans at risk • Lethal Means Safety 	<p>32%</p>

Active projects—observations

- A substantial proportion of effort is being devoted to:
 - Intervention development or testing
 - Focus on individual and selected (at-risk population) levels.
 - Examining various psychotherapeutic approaches in various pops. to suicide prevention.
- Although there are studies examining risk factors/assessment, few are examining how risk changes over time or how to (personalize) match intervention to level of risk.
- No large scale hybrid-type study of CBT intervention
- Compared to this time last year:
 - Overall number of VA-funded research and operations projects related to suicide prevention has increased substantially (from 63 to 106)*
 - Proportions of study design type and socio-ecological level have not changed appreciably, but the proportion of projects employing a universal public health approach has grown slightly

Suicide Prevention Research in Progress



Reactions from Panelists



Research Project Presenters

Jennifer Funderburk PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse VA Medical Center

RCT of behavioral activation for depression and suicidality in primary care

Marianne Goodman MD, Director, JJPVA Suicide Prevention Research and Care Center, VISN 2 MIRECC

Multi-site suicide safety planning group intervention for high-risk suicidal Veterans

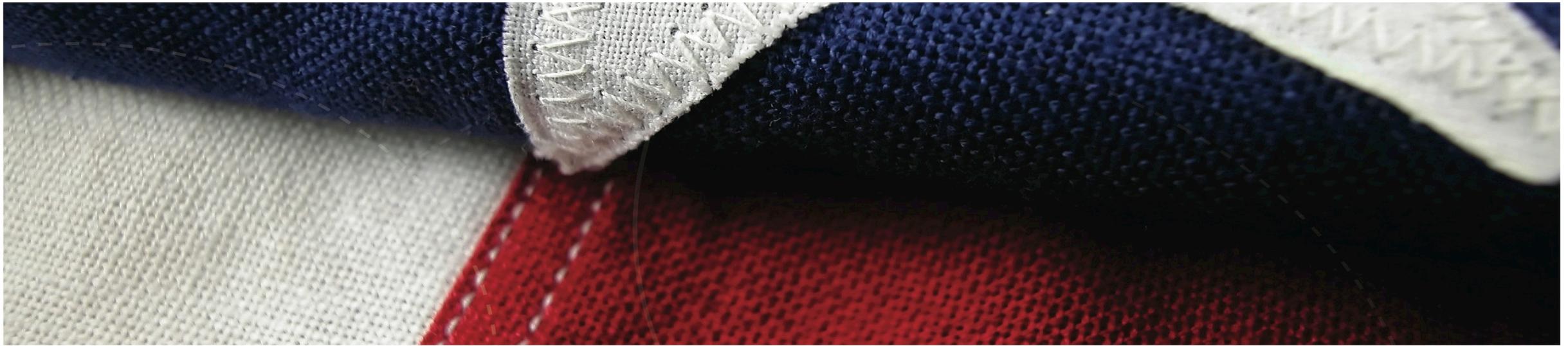
Gala True PhD, Investigator, South Central MIRECC Southeast Louisiana Veterans Health Care System

Veteran-Informed Safety Intervention and Outreach Network

Elizabeth Karras PhD, Investigator, VA Center of Excellence for Suicide Prevention

The use of public messaging strategies to facilitate help seeking among Veterans at risk for suicide





RCT of Behavioral Activation for Depression and Suicidality in Primary Care

Jennifer S. Funderburk, PhD,

VA Center for Integrated Healthcare

Wilfred Pigeon, PhD

VA Center of Excellence for Suicide Prevention

SPRINT Conference June 2020



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Conflicts of Interests & Acknowledgements

- No conflicts of interests
- The views in this article are those of the authors and do not reflect the views or official policy of the Department of Veterans Affairs or other departments of the U.S. government.
- This work supported a Health Services Research and Development Service grant (IIR 14-047-1) to Drs. Funderburk and Pigeon (multi-PIs) as well as a VA Center of Excellence for Suicide Prevention pilot grant and resources of the VA Center for Integrated Healthcare and the VA Center of Excellence for Suicide Prevention.

Acknowledge Research Team

- **Co-Investigators:** Stephen A. Maisto, Michael Wade, Laura Wray
- **BA-PC Manual Development:** Derek Hopko
- **Project Coordinator:** John Acker
- **Significant contribution to the completion of this research:** Robyn Shepardson, Jennie Tapio, Brielle Mather, Lee Bernstein, Kimberly Barrie, Dezarie Moskal, Sarah LaFont, Jacklyn Babowitch, April Eaker, Hayley Fivecoat, Jesse Kosiba, Martin DeVita, Luke Mitzel, Michael Paladino, Garry Spink, Suzanne Spinola, Stephanie Cristiano, Kelsey Krueger, Jessica Blayney, Julie Gass, Jen Wray, Sharon Radomski, Dev Crasta, Stephanie Cristiano, Mariam Parekh



VA Center for Integrated Healthcare & Center of Excellence for Suicide Prevention

- **VA Center for Integrated Healthcare**

- Mission: To improve the quality of Veterans health care by enhancing the integration of mental health services into primary care
- Research, education, clinical and implementation initiatives to enhance integration
- <http://www.mirecc.va.gov/cih-visn2/> -



- **Center of Excellence for Suicide Prevention**

- Mission—To integrate surveillance with intervention development through research to inform the implementation of effective Veteran suicide prevention strategies
- <https://www.mirecc.va.gov/suicideprevention/index.asp>



Presentation Overview



Depressive Symptoms in Primary Care

- Depressive symptoms are associated with:
 - Mortality,^a Morbidity,^a Quality of Life Decrements,^a Lost Work Days,^b Healthcare Utilization^c
 - Suicidal thoughts and behaviors, including completed suicides^e
- Where do Patients Seek Help? **PRIMARY CARE**^d

^a(Ferrari et al., 2013; Mack et al., 2015; World Health Organization, 2017)

^b(Agency for Healthcare Research and Quality, 2002)

^c(Bhattarai, Charlton, Rudisill & Gulliford, 2012)

^d(Olson, Kroenke, Wang, & Blanco, 2014)

^eIlgen, M.A., Bohnert, A.S., Ignacio, R.V., et al. (2010)



HSRD funded Multi-Site RCT (IIR 14-047) Brief Behavioral Activation for Primary Care



Eligibility Criteria

INCLUSION

PHQ \geq 10

No anti-depressants or on stable dose for \geq 6 weeks

Stable therapy for anx or SUD (3+ months)

No more than one session with an integrated MHP*

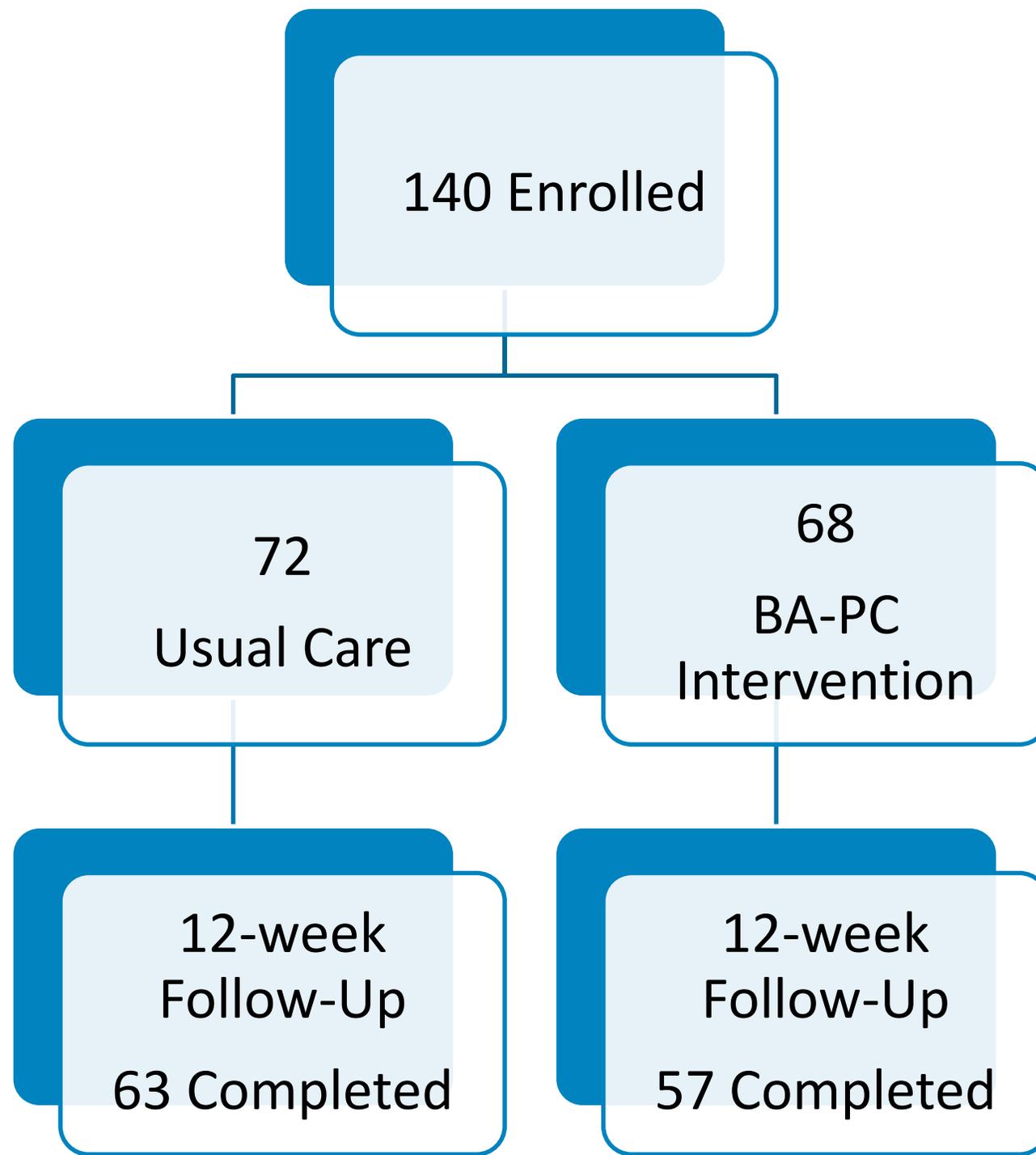
EXCLUSION

Imminent suicide risk

Unstable psychiatric condition or history of Bipolar Disorder

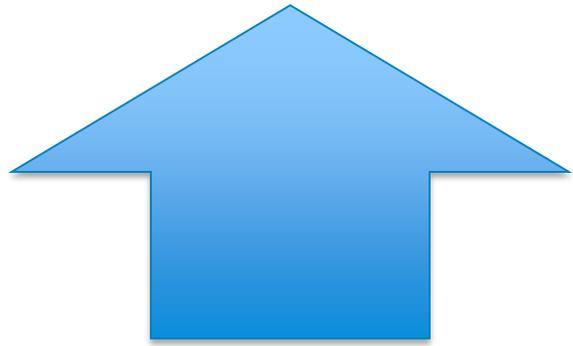
Recently started antidepressants or had dosage change

Current or recent partial hospitalization***

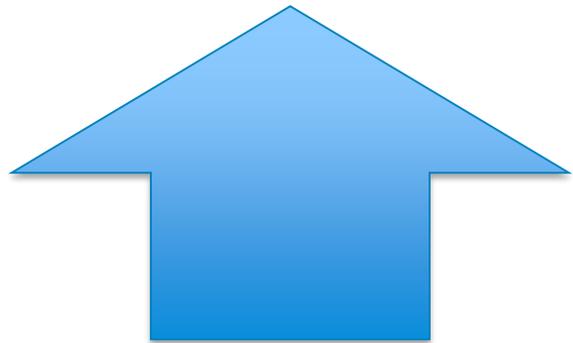


Results

BA-PC Compared to TAU

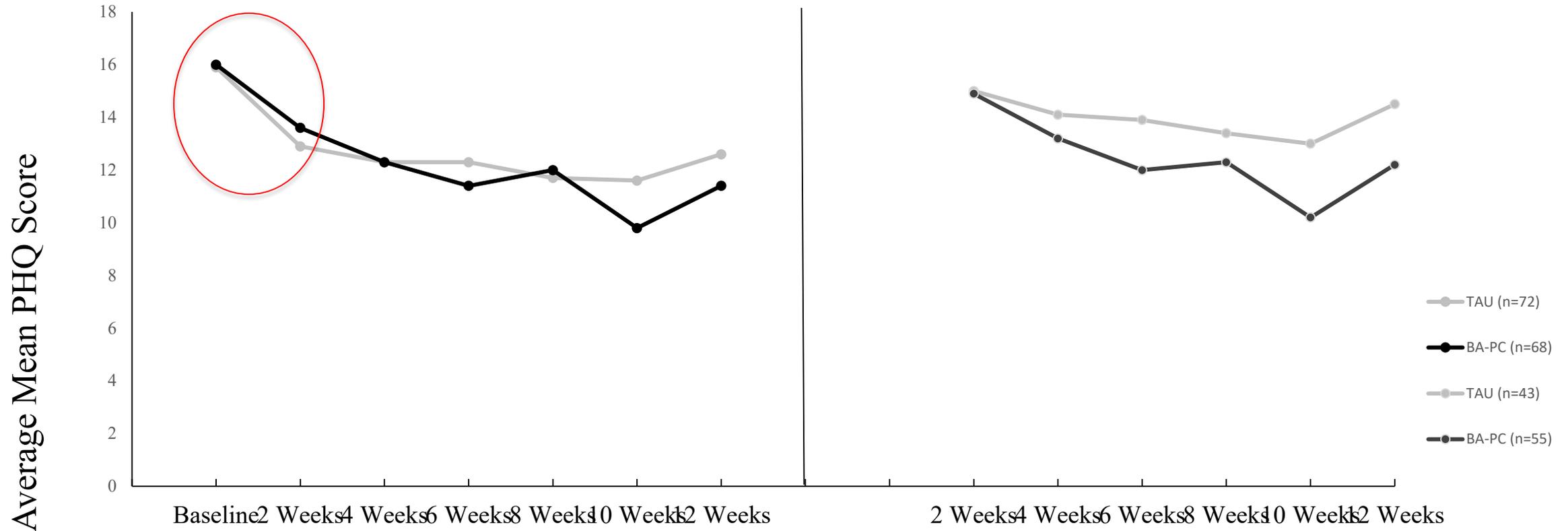


Quality of Life

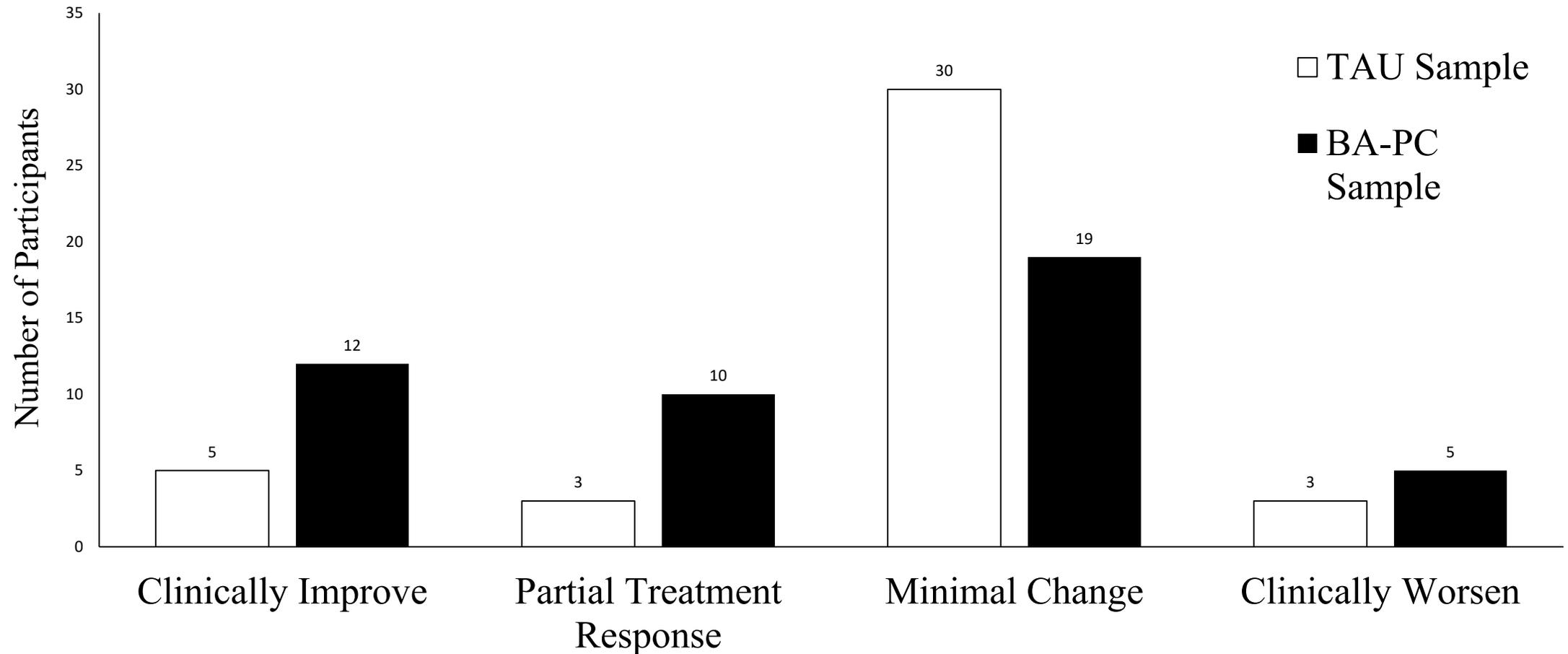


Mental Health Functioning

Observed Average Depressive Symptoms Across the 12 Weeks Among the Full (left) and Secondary Analysis (right) Samples



12-Week Change in Depressive Symptoms Among the Sample of Patients Who Continued to Report Symptoms of Depression After 2 Weeks



Does BA-PC Work Better for Certain Subgroups?

- Participants reporting severe depressive symptoms at baseline (PHQ total > 19) who received BA-PC had a greater reduction in reported symptoms at the 12- and 24-week follow ups

	TAU		BA-PC	
	M (SD)	n (%)	M (SD)	n (%)
Baseline	22.29 (1.90)	17 (100)	22.20 (2.51)	15 (100)
6 weeks	15.36 (6.57)	14 (82.4)	15.69 (4.91)	13 (86.7)
12 weeks*	16.13 (5.46)	15 (88.2)	12.17 (5.39)	12 (80.0)
24 weeks*	14.54 (5.30)	13 (76.5)	8.44 (4.56)	9 (60.0)

Suicidal Ideation

- 28% of those screened over the phone and 32% of those at baseline endorsed PHQ-9 item #9
- No differences in those assigned to BA-PC versus TAU based on presence of endorsing PHQ-9 item #9
- Both participants assigned to TAU and BA-PC showed a decline in suicidal ideation as assessed by Beck's Scale for Suicidal Ideation, with those participants in BA-PC showing a greater decline at every time point although not statistically significant

what
does
it all
mean?

Key References

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Resources

- **VA Center for Integrated Healthcare**

- <http://www.mirecc.va.gov/cih-visn2/> -



- **VA Center for Integrated Healthcare Evidence-Informed Interventions for PCMH Clinicians**

- <http://vhasyrapp6.v02.med.va.gov/mrIWeb/mrIWeb.dll?I.Project=EII>

Center of Excellence for Suicide Prevention

- <https://www.mirecc.va.gov/suicideprevention/index.asp>



Feel Free to Contact Us

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PROJECT LIFE FORCE:

Keeping High-Risk Veterans Alive Through a
Group Safety Planning Intervention

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ORIGINS OF PLF- DBT NEGATIVE RCT

Dialectical Behavior Therapy (DBT) Trial in Suicidal Veterans

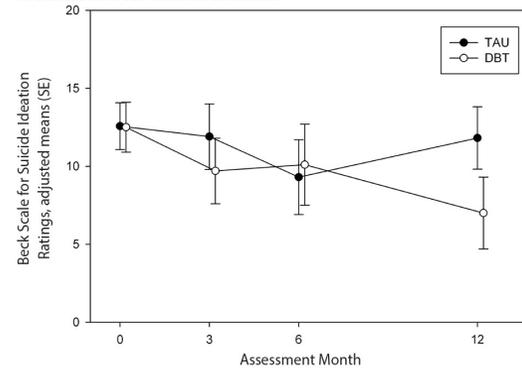
(Goodman et. al, 2016)

RCT:
6-month
DBT vs. TAU
in 93 high-risk
suicidal Veterans:

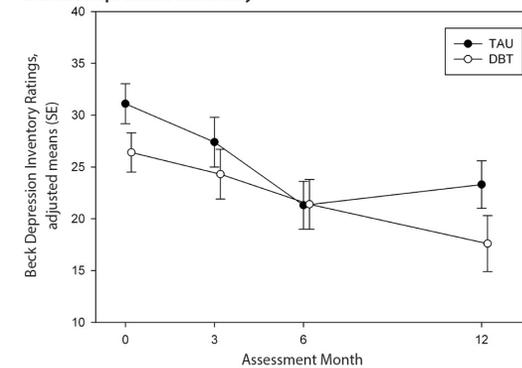
Negative study:
Both groups
improved in all
outcome
measures

Figure 4. Clinical Outcomes Among Veterans at High Risk for Suicide, Receiving Either Treatment as Usual (TAU) or Dialectical Behavior Therapy (DBT)^a

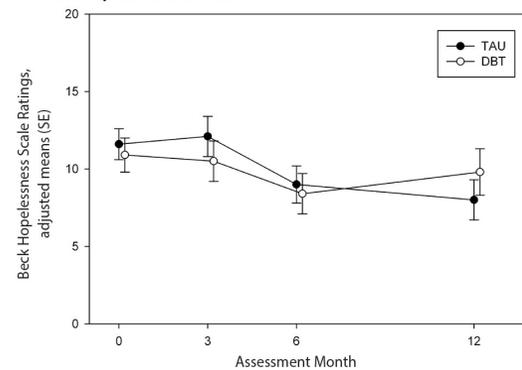
A. Beck Scale for Suicide Ideation



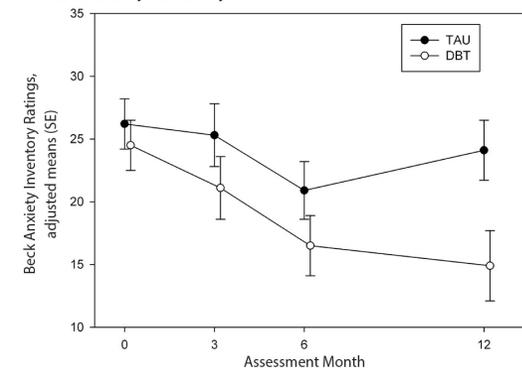
B. Beck Depression Inventory



C. Beck Hopelessness Scale



D. Beck Anxiety Inventory^b



^aMeans are adjusted for the following covariates: age, sex, education, and previous hospitalizations.

^bPost hoc analysis for Beck Anxiety Inventory ($F_{1,37} = 4.52, P = .04$).

Personal Anecdote with Suicidal Veteran



SAFETY PLAN: VA VERSION	
Step 1: Warning signs:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Place _____
4.	Place _____
Step 4: People whom I can ask for help:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Name _____ Phone _____
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Local Urgent Care Services _____ Urgent Care Services Address _____ Urgent Care Services Phone _____
4.	VA Suicide Prevention Resource Coordinator Name _____ VA Suicide Prevention Resource Coordinator Phone _____
5.	VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician
Step 6: Making the environment safe:	
1.	_____
2.	_____
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).	

Qualitative Study of Suicide Safety Plan (SSP) Use (Kayman et al., 2015)

20 Veterans interviewed after SSP construction and 1 month later

Findings notable for:

- Wide range of use (none to several times daily)
- Importance of clinician collaboration
- Barriers/obstacles to use

PLF aims to address these concerns

Problems/obstacles:

- Lack of social network
- Social withdrawal/depression
- Avoidant style of coping
- Burden too great to carry out plan alone

Facilitators of use of the plan:

- Sharing of plan with significant others
- Mobile formats of the plan
- Individualized plans

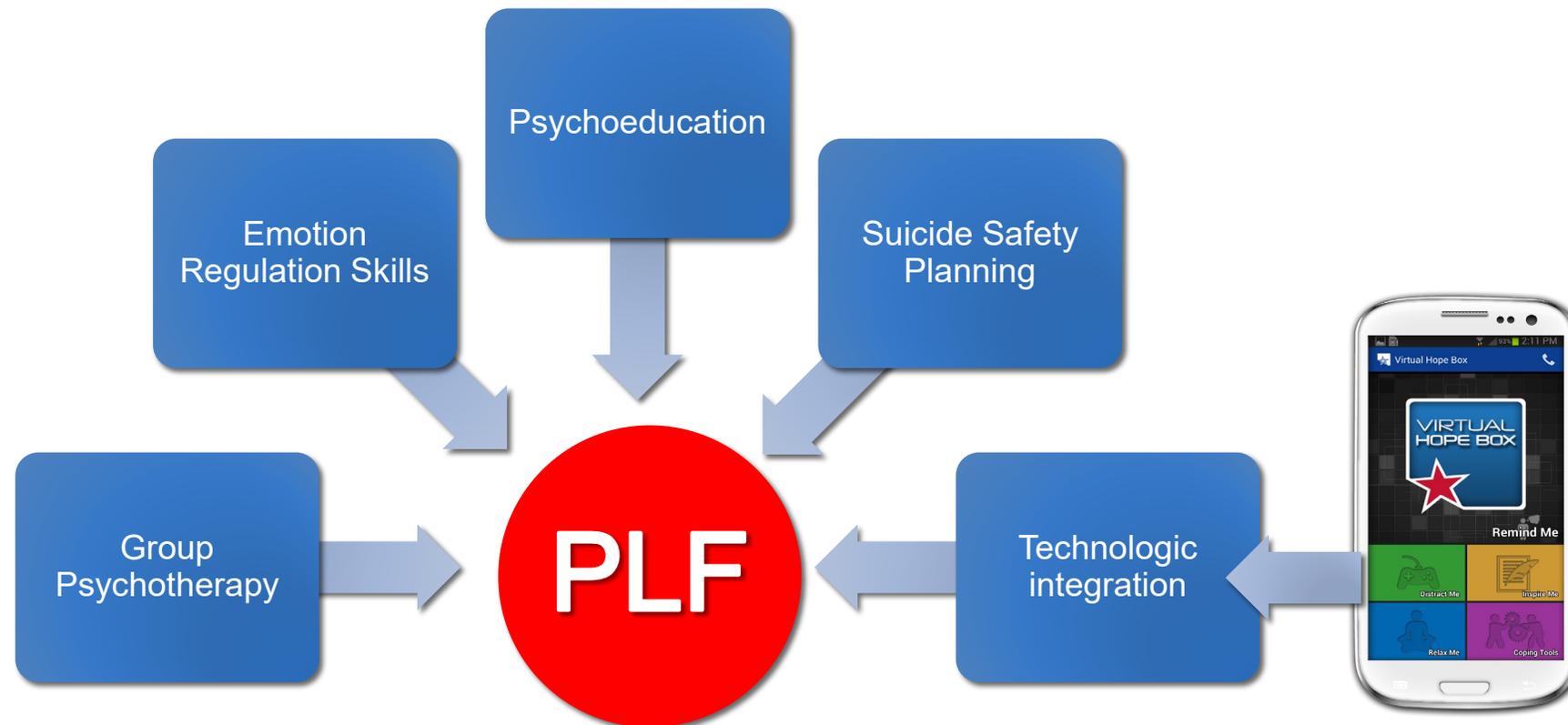


PLF incorporates:

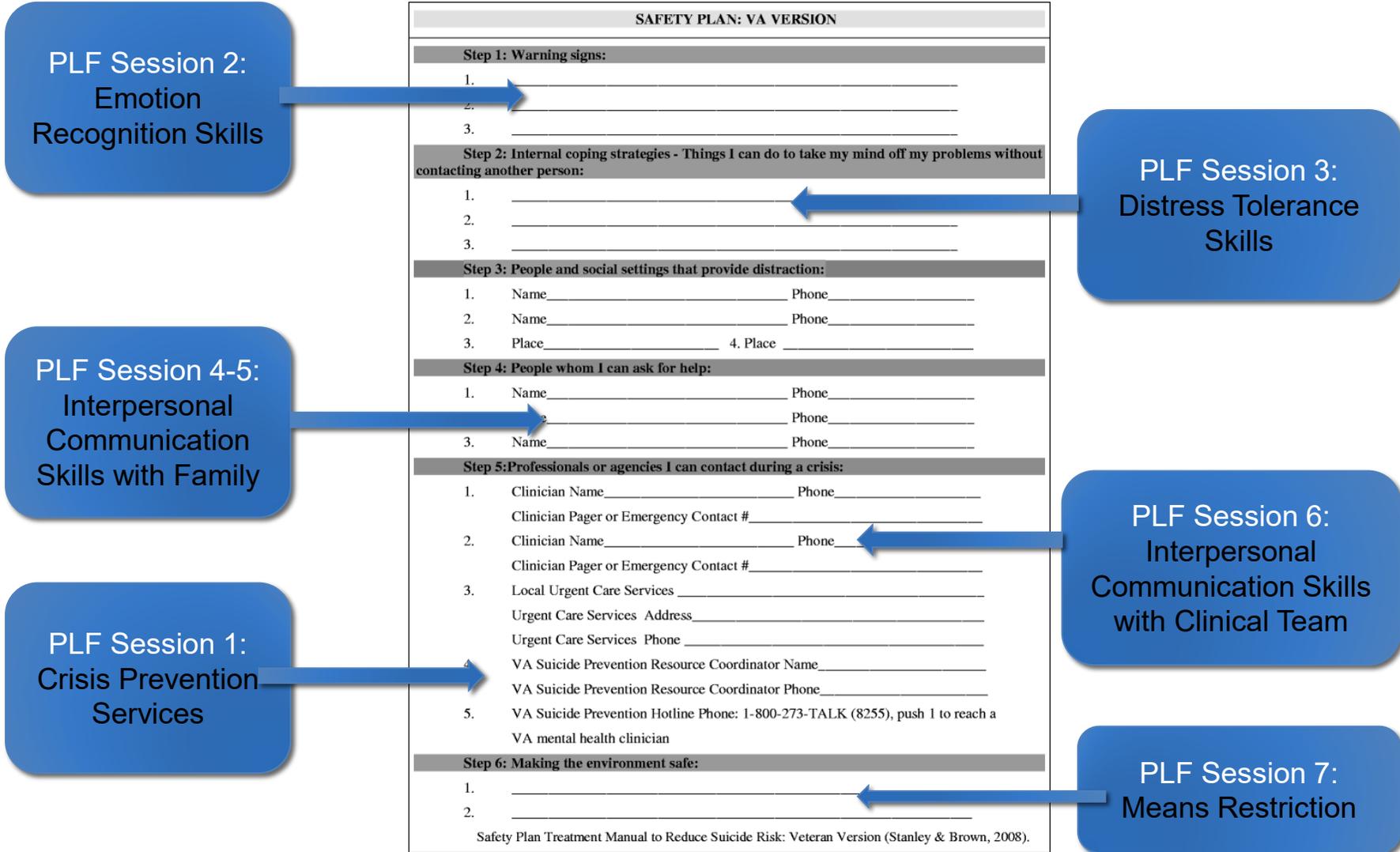
- 1) Teaching of distress tolerance and emotion regulation skills applied to individual steps of the SSP,
- 2) Introduces use of a mobile SSP Application,
- 3) Helps Veterans identify individuals they can call for help, and practice asking for help,
- 4) Aims to develop detailed, personalized and meaningful SSPs,
- 5) Delivered in a group context offering support.

THE SOLUTION: Project Life Force

- **PROJECT LIFE FORCE (PLF)** is a manualized, 90-minute **group therapy** for 10 sessions, lasting 3 months.
 - Combines **psychoeducation** and **emotion regulation skills** with **suicide safety planning** development and implementation.



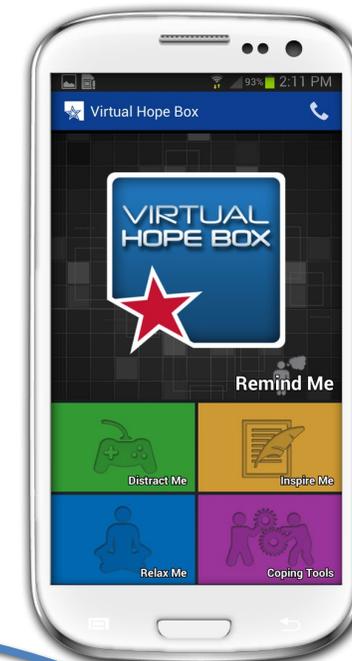
“PROJECT LIFE FORCE” Group Suicide Safety Planning & Skills Intervention



Project Life Force Sessions

- PLF is one of the only manualized outpatient **group treatment** for suicidal individuals

Project Life Force Session Outline		
Session	Session Focus	Skill Covered
1	Introduction, psychoeducation about suicide, SSP step #5 - crisis numbers, meet local SPC	Crisis Management skills Urge Restriction
2	SSP step #1 - Identification of Warning Signs	Emotion, Thought or Behavior Recognition skills
3	SSP step #2 - Internal Coping Strategies	Distraction skills
4	SSP step #3 - Identifying people to help distract	Making Friends Skills
5	SSP step #4 - Sharing SSP with Family	Interpersonal Skills
6	SSP step #5 - Professional Contacts	Skills to maximize Treatment efficacy & Adherence
6	SSP step #6 - Making the Environment Safe	Means restriction, psychoeducation about methods
7	Improving Access to the SSP	Use of Safety Planning Mobile Apps and Virtual Hope Box
8	Physical Health Management	Decreasing Vulnerability to negative Emotion
9	Building a Positive Life	Building Positive Emotion
10	Recap/Review	



SPIRE funded “Project Life Force” Pilot Outcomes



Feasibility/Acceptability Pilot Data (N=45)

- **<2.0 total hours/week** per clinician
- Veteran satisfaction 4.7 out of 5 point Likert scale
- 5.0 of 5 rating on recommending the treatment to others
- **<17%** attrition
- 100% of participants developed updated safety plans and increased use patterns.

After 10 weeks of PLF, Veterans had:
>40% ↓ **suicide** symptom severity/ideation
>30% ↓ **depression**,
>20% ↓ **hopelessness**

**82 page manual finalized



Vet arranges flag honor for doc's life-saving work

Bronx VA psychiatrist-researcher cited for work in suicide prevention



by, Sc, or 24, 2019 10:00 am Health, Inside Veterans Health Mitch Mirkin 3k views

Project Life Force helps Veterans cope with suicidal urges

"You often hear negative news about the VA, specifically related to suicide. We don't recognize the hard work and achievements of our providers, which is why I wanted to honor Dr. Goodman. Sometimes we need to recognize good work in the news."

Those are the words of Iraq combat Veteran Wilfredo Santos, a patient at the James J. Peters VA Medical Center in the Bronx, New York. He took it upon himself to arrange for formal honors for a VA clinician he credits with saving his life.

The life-saving work took place not in an emergency room or surgery suite, but in classrooms at the Bronx VA where groups of Veterans—including Santos—meet on a regular basis. They talk about their problems, their challenges and their experiences in wanting to take their own lives. The idea of the program is to bring together Vets who have a recent history of suicidal thinking or behavior and provide them with group psychotherapy. They use peer support and revise their safety plans as they add the skills they are learning.

The format, known as Project Life Force, was spearheaded by Dr. Marianne Goodman. She's the associate director of the New York Mental Illness Research, Education and Clinical Center (MIRECC), based at the Bronx VA. She is also a professor of psychiatry at the Icahn School of Medicine at Mount Sinai.

Project being expanded to other VA sites

PLF in the News



Jesse Brown (center) and Chris Murray (second from right) are part of a suicide-prevention group led by Drs. Marianne Goodman (third from right) and Kalpana Nidhi Kapil-Pair (left) at the Bronx VA Medical Center. (Photo by Yang Zhao)

They've got each other's backs

Researchers help Vets at risk of suicide build mutual support network

CSRSD Merit: PLF Randomized Control Trial & Protocol Paper

CSRSD funded Merit (3/18)

- 3 sites

Bronx and Philadelphia VA (recruitment sites) & Columbia University (training and adherence monitoring)

- Goal: 265 patients Randomized to PLF vs. TAU, followed for 1 year
- Primary outcome= suicidal behavior

Contemporary Clinical Trials Communications 17 (2020) 100520

Contents lists available at ScienceDirect

 Contemporary Clinical Trials Communications

journal homepage: <http://www.elsevier.com/locate/conctc>

Research paper

Group (“Project Life Force”) versus individual suicide safety planning: A randomized clinical trial

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ARTICLE INFO

Keywords:
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Treatment
Group
Safety plan
Depression
Veteran

ABSTRACT

One in five suicide deaths is a Veteran and in spite of enhanced suicide prevention services in the Veterans Health Administration (VHA), twenty Veterans die by suicide each day. One component of the VHA’s coordinated effort to treat high-risk suicidal Veterans, and diminish suicide risk, is the use of the safety plan. The current study aims to examine a novel intervention integrating skills training and social support with safety planning for Veterans at high-risk for suicide, “Project Life Force” (PLF). A randomized clinical trial (RCT) will be conducted examining if Veterans who are at high-risk for suicide will benefit from the novel group intervention, PLF, compared to Veterans who receive treatment as usual (TAU). We plan to randomize 265 Veterans over the course of the study. The primary outcome variable is the incidence of suicidal behavior, during follow-up, established using a rigorous, multi-method assessment. Secondary outcomes include depression, hopelessness, suicide coping and treatment utilization. Exploratory analyses include safety plan quality and belongingness for those in both arms as well as group cohesion for those in the PLF intervention. Strengths and limitations of this protocol are discussed.

1. Introduction

In the United States, Veterans have a significantly higher suicide risk relative to the general population [1]. Veterans account for about 20% of suicide deaths and, despite the Veterans Health Administration’s (VHA) provision of enhanced suicide prevention services, an estimated 20 Veterans die by suicide each day [2]. This highlights an urgent need to develop additional, empirically validated, interventions for suicidal Veterans.

One component of the VHA’s efforts to diminish suicide risk is the Safety Planning Intervention (SPI) [3]. Considered best practice, the SPI is developed collaboratively with the patient and therapist and involves identification of: personal warning signs of suicide; internal coping strategies; social contacts or settings offering support and distraction from suicidal thoughts; contact information for VHA professionals, the crisis line and emergency services; and specific steps for how to make the immediate environment safer [3]. The patient takes the safety plan home for their use during a suicidal crisis. Safety planning is based on the idea that suicide risk fluctuates over time, aims to prevent suicidal crises from escalating, as well as presenting individuals from acting on their suicidal urges [3].

Stanley and colleagues (2018) recently administered the SPI in emergency departments to Veterans with suicidal behavior [4]. Participants who completed the SPI, and received at least two structured follow-up phone calls, were half as likely to exhibit suicidal behavior [4]. They were also more than twice as likely to attend at least one mental health appointment than usual care [4]. Therefore, the SPI may be an efficacious intervention.

To further explore the utility of the SPI, 20 Veterans participated in semi-structured longitudinal interviews and expressed that creating the

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Available online 10 January 2020
2451-8654/Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

RCT Progress to Date

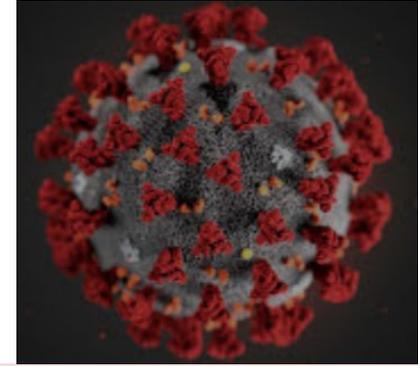
Site	Total Number Enrolled
JJPVA (Bronx)	101
CMCVAMC (Philadelphia)	39
Total	140



- 94 group sessions between both sites
INCLUDING 16 OVER VVC
since November 2018

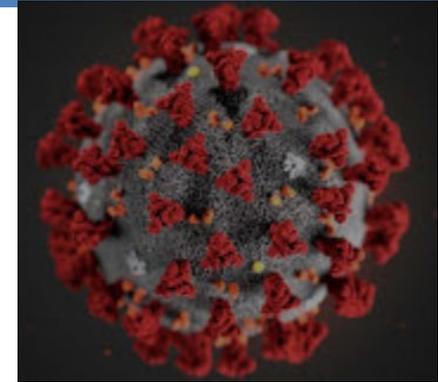
PLF Adaptations due to COVID-19

→ Treatment trial continued during pandemic



- Study was never placed on hold!
- Assessments now performed by phone
 - Self-reports via Qualtrics
- Just received approval for Waiver of Signed Consent to allow consent remotely
- PLF Groups all now conducted over VVC (n=16 to date)
 - Combined Veterans and PLF therapists across sites
 - Philadelphia and Bronx Veterans now in the same group
 - Co-lead by Bronx and Philadelphia PLF therapists

Project Life Force - Corona Virus (PLF-CV) Pilot Project



- Developed PLF Adaptation for COVID-19 pandemic distress
- Emphasizes skills training, resource identification and peer support in group setting over VVC
- Manual Developed (n=75 pages)
 - 9 Sessions
 - Goal= Build a COVID-19 Action/Resiliency Plan
- VISN 2 MIRECC Pilot Funding awarded
- Completed 1st cycle, 2ND group underway
- This project featured in upcoming “VA Insider” Blog

PLF-CV Manual and 9 Sessions

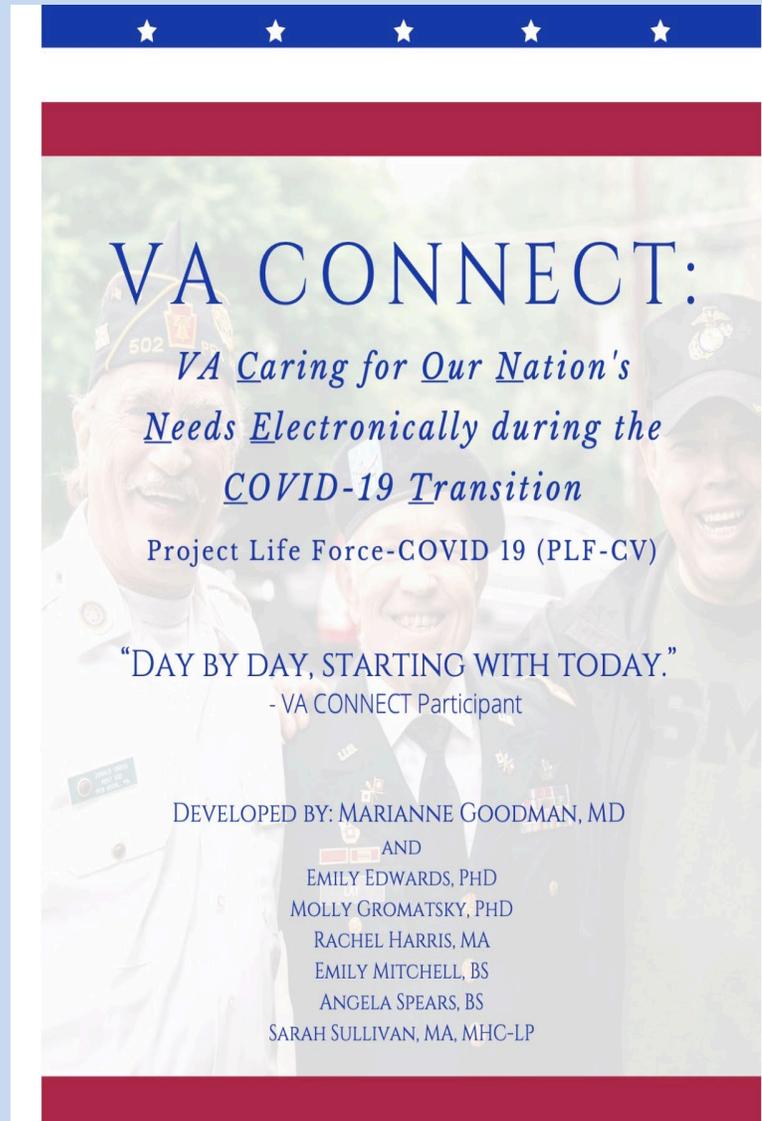


Table of Contents

Session	Content
1	Background to group <ul style="list-style-type: none">• Introductions• Information about COVID-19• Other recommendations for COVID-19• Description of Resilience & Safety Plan• Group Rules• Challenges to Telehealth• Understanding crisis services:<ul style="list-style-type: none">• VA Crisis Line• OMH Emotional Support Line• SAMHSA Disaster Distress Helpline• COVID-19 Peer Support Group - Mayo Clinic
2	Meditation, Mindfulness, & Relaxation Techniques <ul style="list-style-type: none">• Breathing, Meditation, Visualization• Resources
3	Developing Internal Coping Strategies <ul style="list-style-type: none">• Distraction• Self-Soothing
4	Recognizing and Coping with Emotions <ul style="list-style-type: none">• Emotion mapping• Matching emotions to coping strategies
5	Managing Interpersonal Relationships During COVID-19 <ul style="list-style-type: none">• What is physical distancing?• Combatting isolation• Staying connected
6	Maximizing your Mental and Physical Health Treatment <ul style="list-style-type: none">• Pain management, medications, & sleep
7	Improving your Physical Well-Being <ul style="list-style-type: none">• Diet & Exercise
8	Building Positive Emotion <ul style="list-style-type: none">• Gratitude & Reasons for Living
9	Recap and Moving Forward Amidst COVID-19

Thank you to all my collaborators and staff on the PLF project:

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Hanga Galfalvy, PhD

Michelle Gordon, MPH

Liat Itzhaky, Ph.D.

Shari Jager-Hyman, Ph.D.

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V I S I O N
VETERAN-INFORMED SAFETY
INTERVENTION & OUTREACH NETWORK

Suicide Prevention Research in VA: Developing a Continuum of Intervention

July 9, 2020

Funding: VA HSR&D INV 19-294

Our Team



Joseph Constans, Ph.D
Co-Principal Investigator



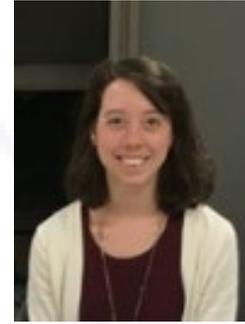
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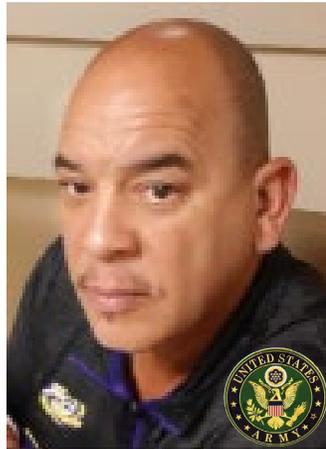
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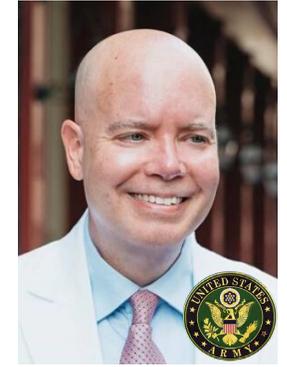
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Advocate



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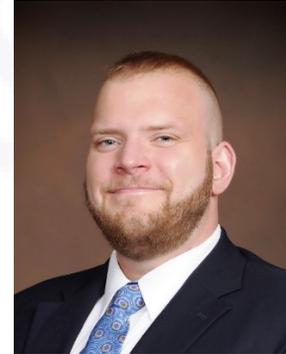
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Caregiver, Veteran Advocate



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Background

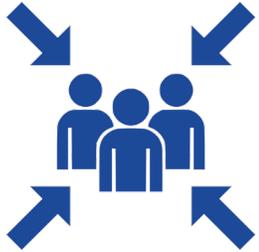
Despite widespread concern and attention over the past decade, the continuing high rate of suicide among U.S. service members and Veterans remains a pressing public health issue.

- **65%** of Veteran suicides involved a firearm.^{[1]*}
- In highly rural states with high gun ownership rates, **84%** of suicide deaths involved firearms.^[2]
- **58%** of Veterans enrolled in the VA Healthcare System live in rural areas, compared to **37%** in urban areas.

1. McCarten, J.M., C.A. Hoffmire, and R.M. Bossarte, *Changes in overall and firearm veteran suicide rates by gender, 2001-2010*. Am J Prev Med, 2015. **48**(3): p. 360-4.

2. Mohatt, N.V., et al., *A menu of options: Resources for preventing veteran suicide in rural communities*. Psychol Serv, 2018. **15**(3): p. 262-269.

Study Aims



1. Identify Veteran Peer Champions to inform the project and assist with outreach activities.



2. Engage key stakeholders in a series of deliberative discussion forums.

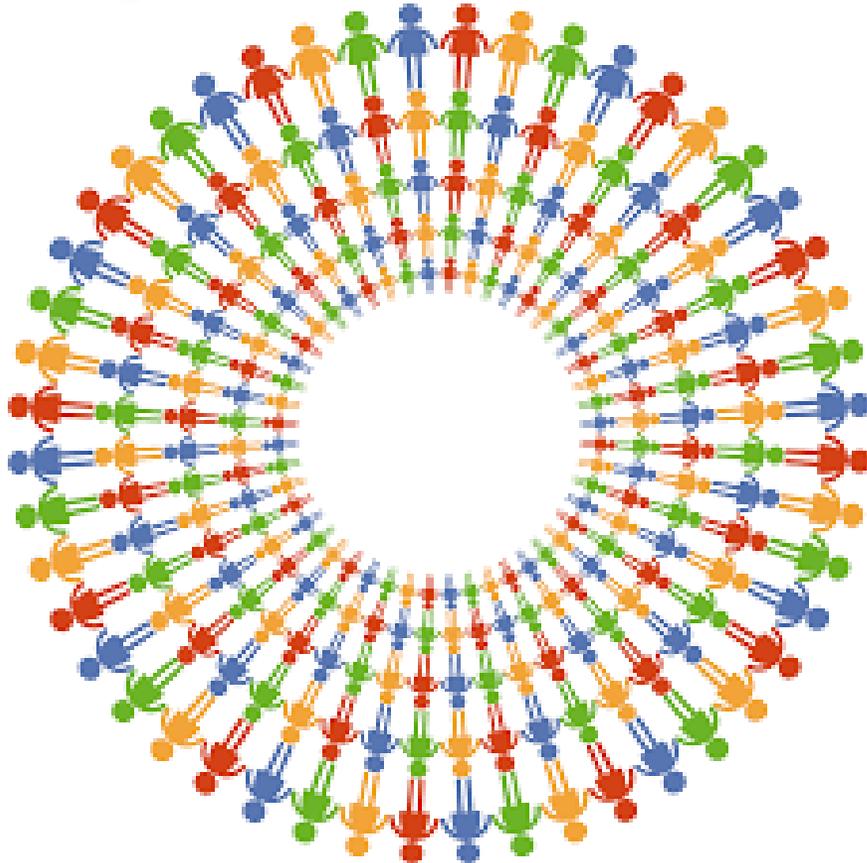


3. Develop and pilot an implementation toolkit.



Why deliberative discussion forums?

Deliberative discussion is “a structured forum for eliciting public input on specific health care issues, particularly when the problems faced... involve values-based or ethical tensions.”¹



Goals of our forums:

- Building trust and rapport within the community.
- Identifying areas of common ground upon which to build an intervention.
- Proactively addressing barriers to acceptability and feasibility of implementation in community-based settings.

Methods



Team meets with community members by phone (or in-person).



Individuals are invited to a Town Hall meeting and discussion.



Team summarizes findings, discusses with advisory board and community partners.

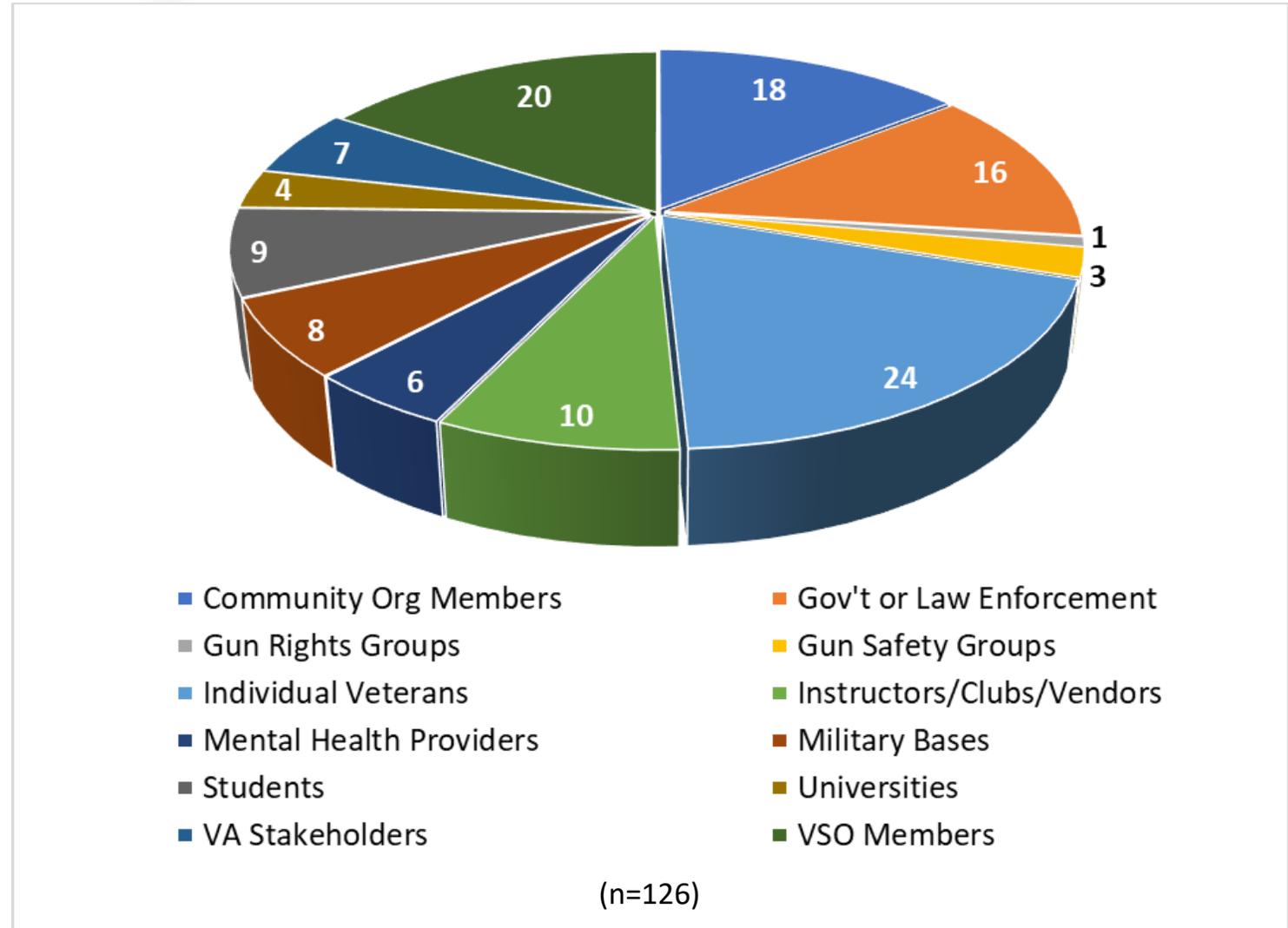


Team and community partners collaborate on development and piloting of toolkit.

Coalition Building

As of June 2020, we have connected with 126 individuals in various communities of service members, Veterans, families, and allies.

We have also consulted projects and organizations engaged in parallel/related initiatives.



Response to COVID-19

March 18

- HSR&D suspends most in-person research activity

March 23

- Project Team begins drafting a **newsletter** with health and community resources for coalition members
- Team decides to adapt townhall forums to **online video meetings**

April 13

- Project Team sends newsletter to coalition members

April 27, 28, May 6

- First series of Video Townhall meetings

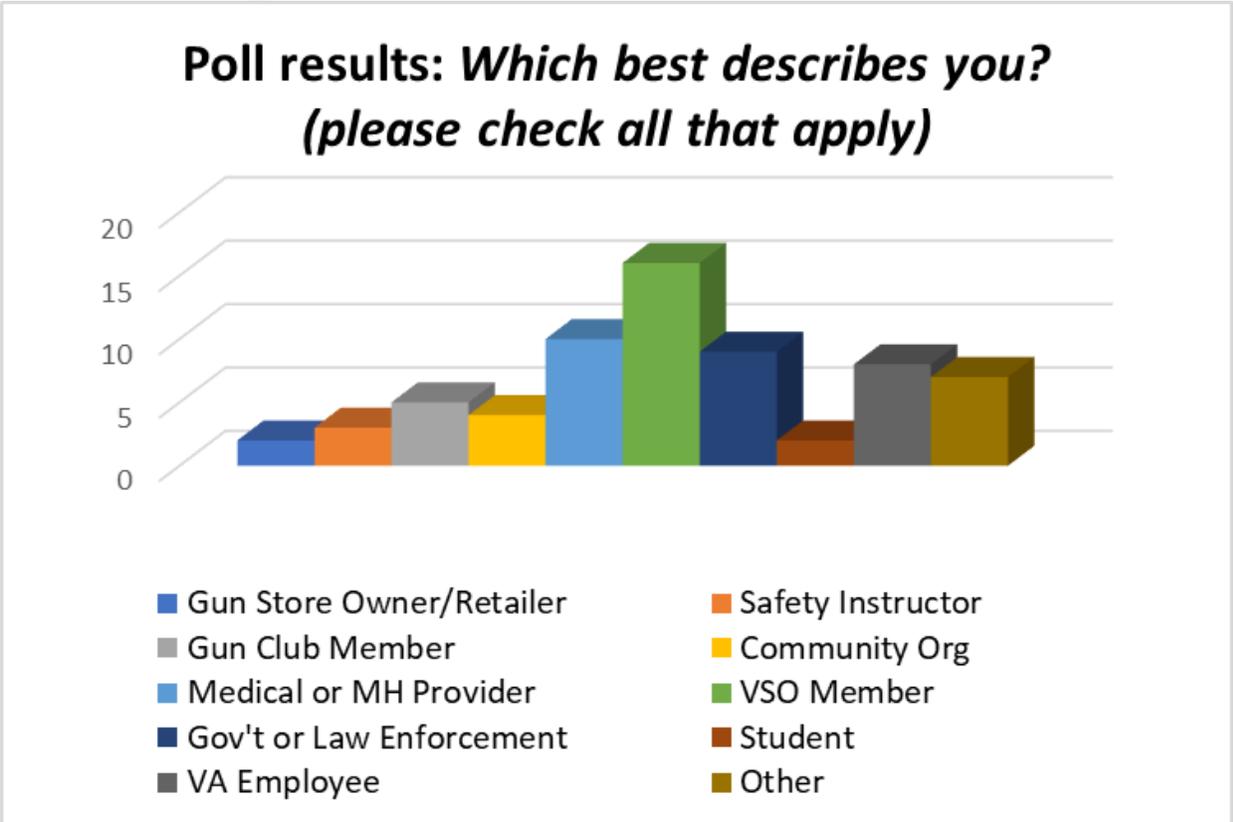
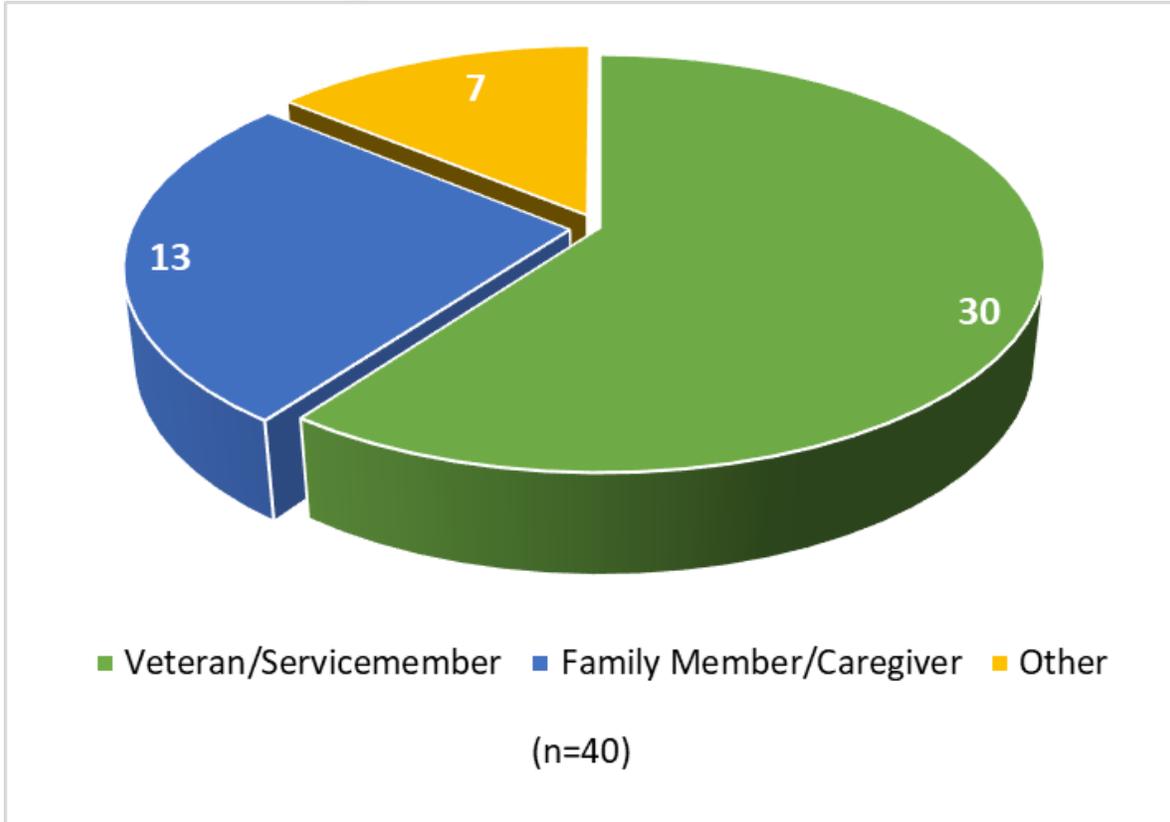
June 23, 24, 29

- Second series of Video Townhall meetings



Townhall Forums

Coalition Members who attended Video Townhall Discussions



Leveraging Existing Resources

Some of the organizations and initiatives we've consulted:



Hold My Guns



Project ChildSafe

In-Transition Program

In- Transition Program



LOSS Team

LivingWorks ASIST

ASIST Program

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Zero Suicide Project



Project Safeguard



Resilience, Risk
Reduction & Suicide
Prevention (R3SP)



OMHSP – Safe Firearm
Storage Toolkit



Together With Veterans
Campaign

Students Demand Action

What we've learned

Messaging

- Important to acknowledge and provide resources beyond focus on firearms
- One size will not fit all– tailor at the level of organizations and individuals; reasons for owning a firearm matter
- Emphasis on intervention delivery and messaging coming from SM/V&F
- SM/V&F are highly motivated to help others

Out of Home Storage

- Universally well-received in concept, if voluntary and veteran operated
- Military mindset consistent with belief that, in times of crisis, someone should hold onto your firearms
- Concerns about stigma, paper trail
- Liability for firearm damage would need to be addressed

In Home Storage

- At least one firearm intended for home defense; presents challenges to restricting immediate access
- Cable/trigger locks seen as cumbersome and interfering with home defense; this belief is firmly held and nearly universal
- Cases and lock boxes more desirable but have their own challenges

Next Steps

Series of small pilots
with selected
Coalition Members

Connect with
individual Veteran
firearm owners
through Coalition
Members, learn more
about challenges and
facilitators

Engage Coalition
Members in working
groups to develop
outcome measures,
explore additional
partnerships for
implementation

Continue coalition
and capacity building
to develop multi-site
intervention

Wrap Up

Questions?

Comments?

VA



U.S. Department
of Veterans Affairs



The use of public messaging strategies to facilitate help seeking among Veterans at risk for suicide

Elizabeth Karras, PhD

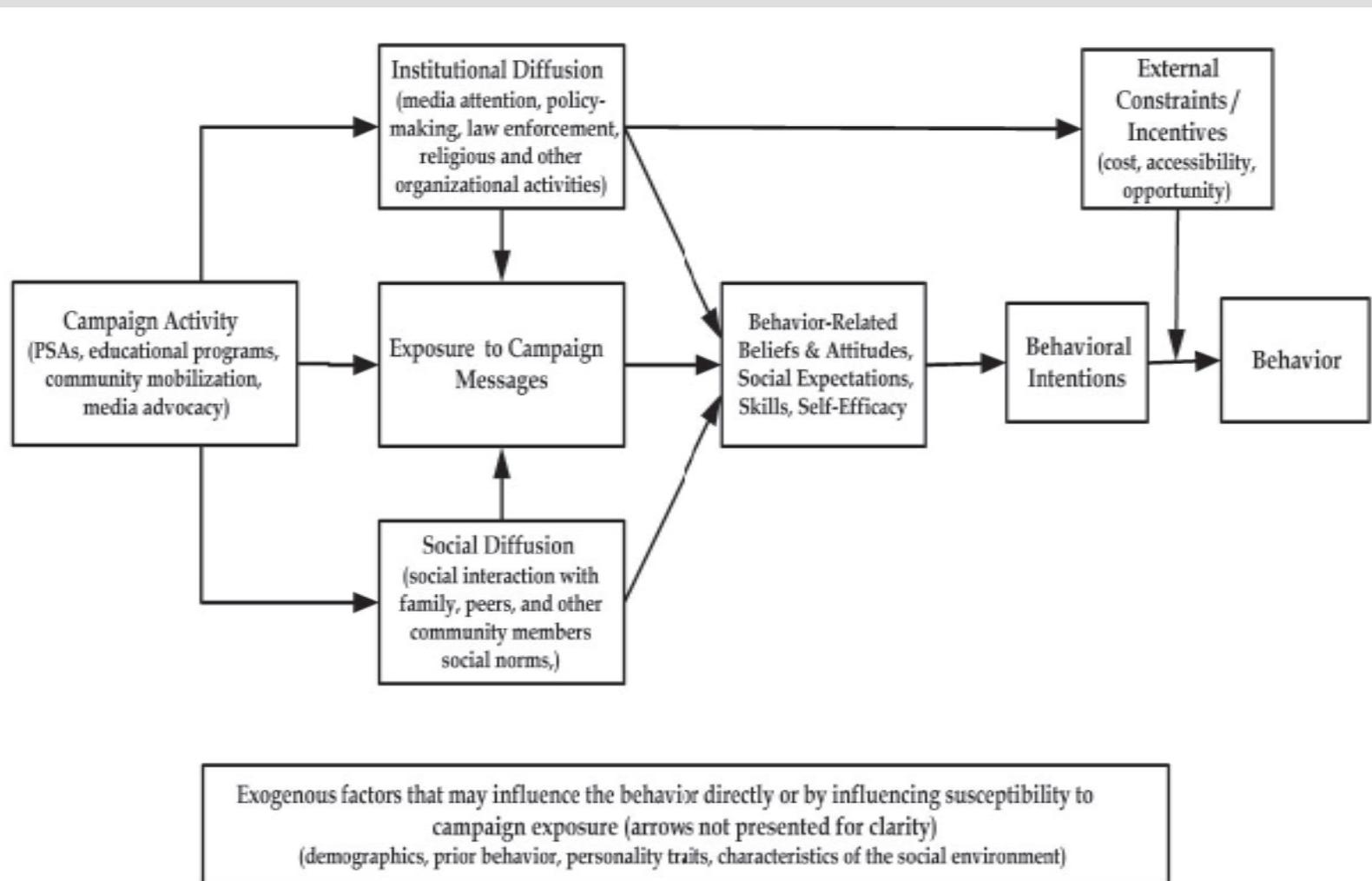
Center of Excellence for Suicide Prevention

Presentation Highlights

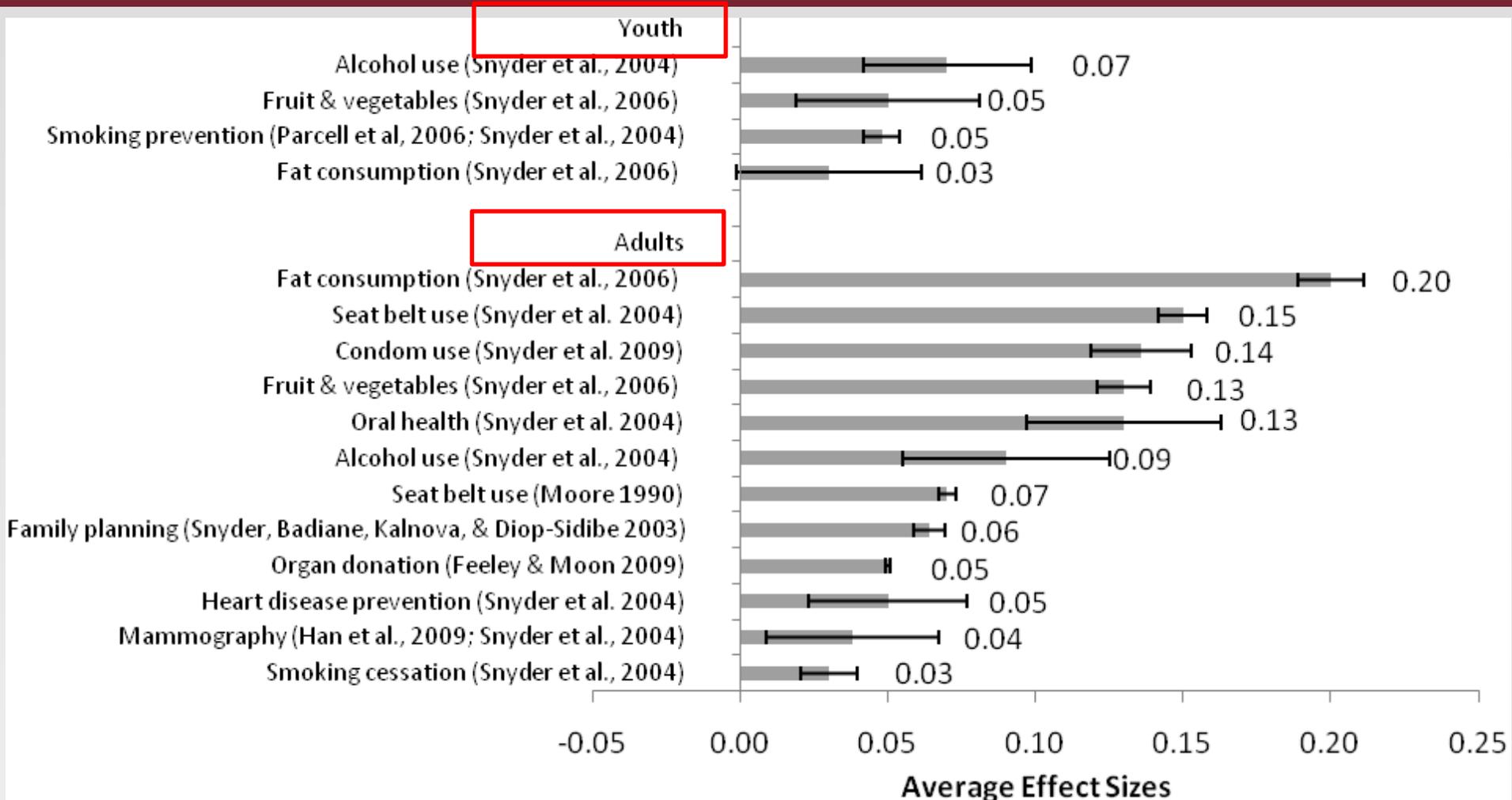
- Why invest in health campaign research
- What is known & unknown for suicide prevention
- Past, present & pending research
- Future directions



Why Campaigns?¹



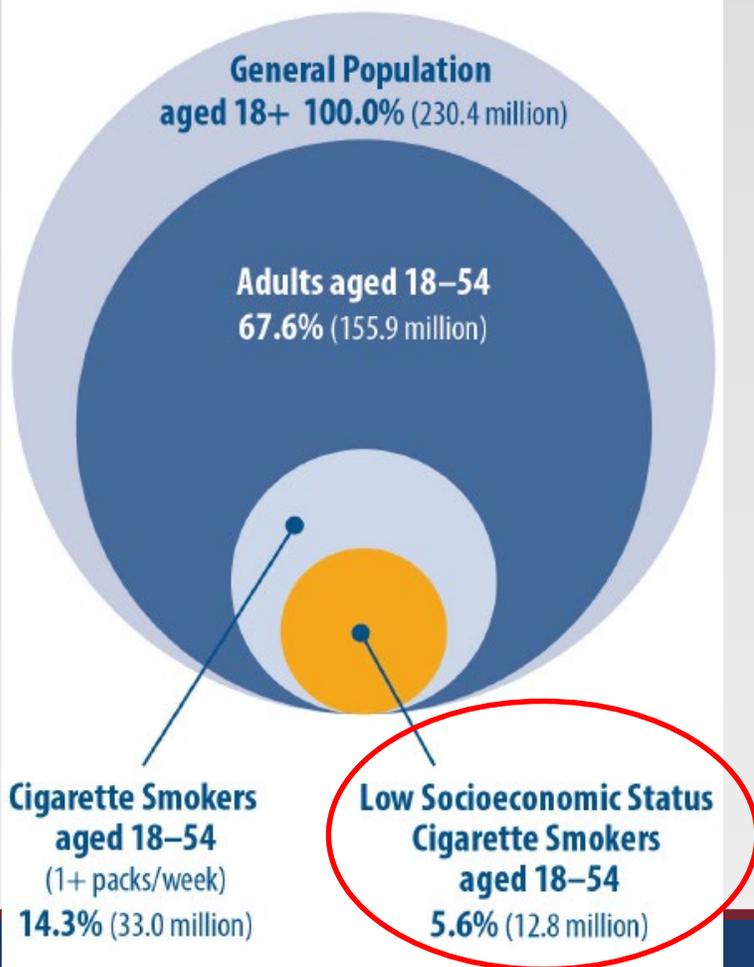
Evidence-Base for Campaign Use (r)²



**Average effect sizes (r) from campaigns on behavior, by health topic

Translating Effect Sizes: Small but Mighty^{3,4}

Figure 3. Narrowing the Audience for a Communications Campaign



Source: Plowshare Group Inc.⁷⁹



50% reach intended audience

Smallest Effect: 192,000

Average Effect: 576,000

Larger Effect: 1.28 million



Improving Effect Size: Campaign Best Practices^{3,4}

- ✓ Formative Research
- ✓ Use of Theory
- ✓ Segment Audience
- ✓ Targeted Message Design/Pre-Testing
- ✓ Strategic Channel Selection
- ✓ Conduct Process Evaluation
- ✓ Sensitive Outcome Evaluation

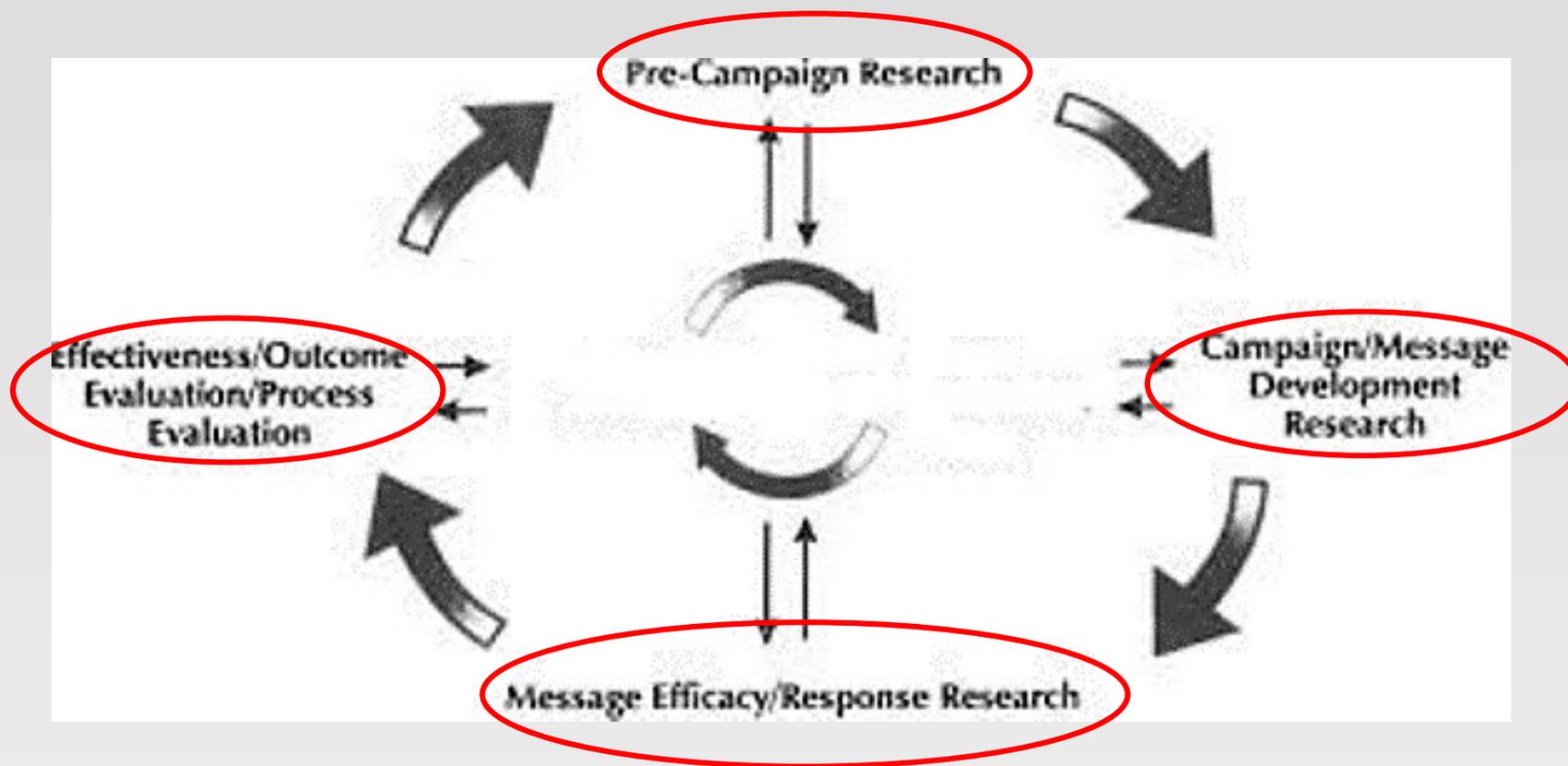


What is Known & Unknown for Suicide Prevention

- Initial evidence to suggest promise for suicide prevention messages to engage at-risk populations
 - Improved knowledge of and attitudes towards suicide and related help-seeking⁵⁻⁷
 - Increased awareness and use of crisis support services associated with campaign use (including VA campaigns from 2010 & 2011)⁸⁻¹⁰
 - Awareness of risk factors for suicide (firearms)^{11,12}
- Little investigation of message factors that might affect persuasive outcomes, particularly among individuals at known risk for suicide¹²
- Few randomized trials conducted; limited efficacy or effectiveness data available for suicide prevention¹²

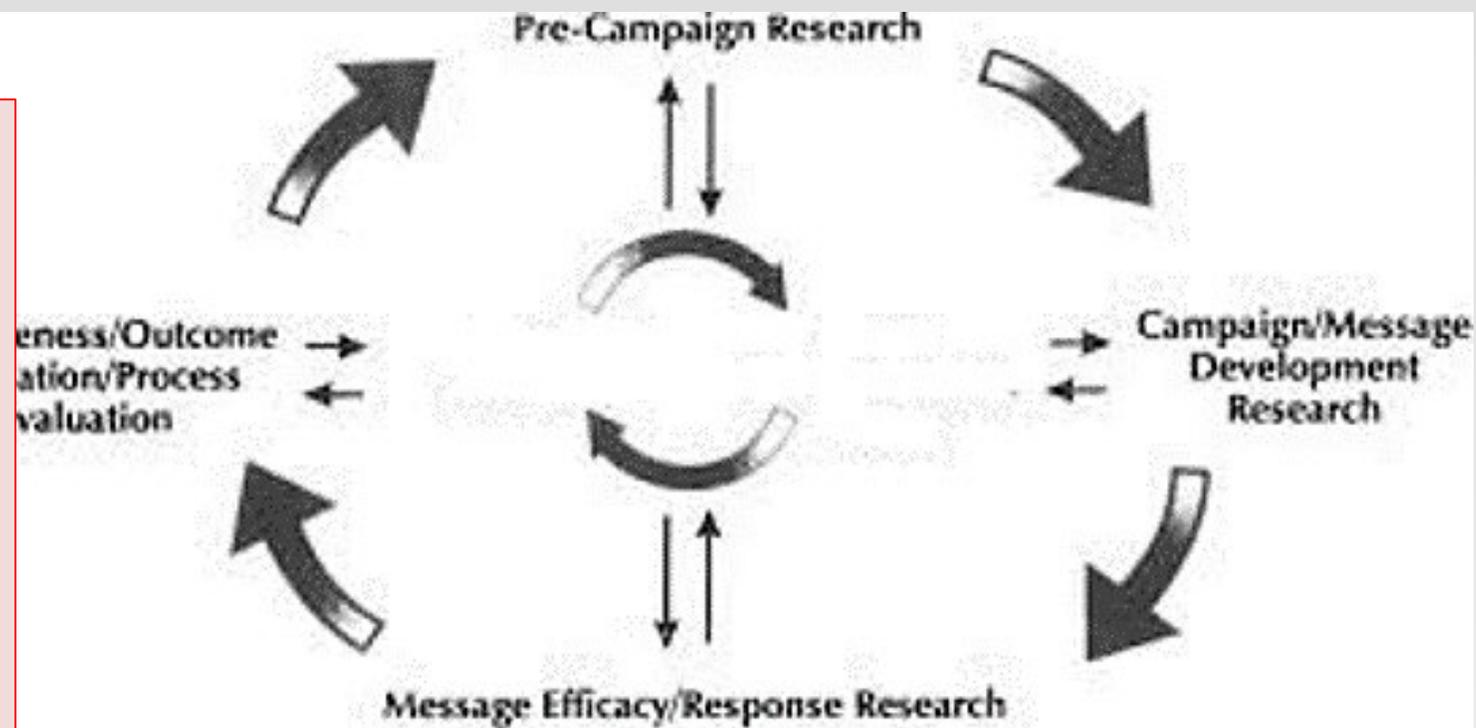


Past, Present & Pending Research



Future Directions

- ✓ Goal-oriented messaging
- ✓ Audience segments
- ✓ Cont'd trials of messaging for targeted populations/periods of interest
- ✓ Effectiveness studies of new/existing messages
- ✓ Implementation factors



References

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Health Services Research & Development
VA Office of Research & Development

American Foundation for Suicide Prevention

VA Office of Mental Health & Suicide Prevention



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Center of Excellence for Suicide Prevention
Elizabeth.Karras-Pilato@va.gov



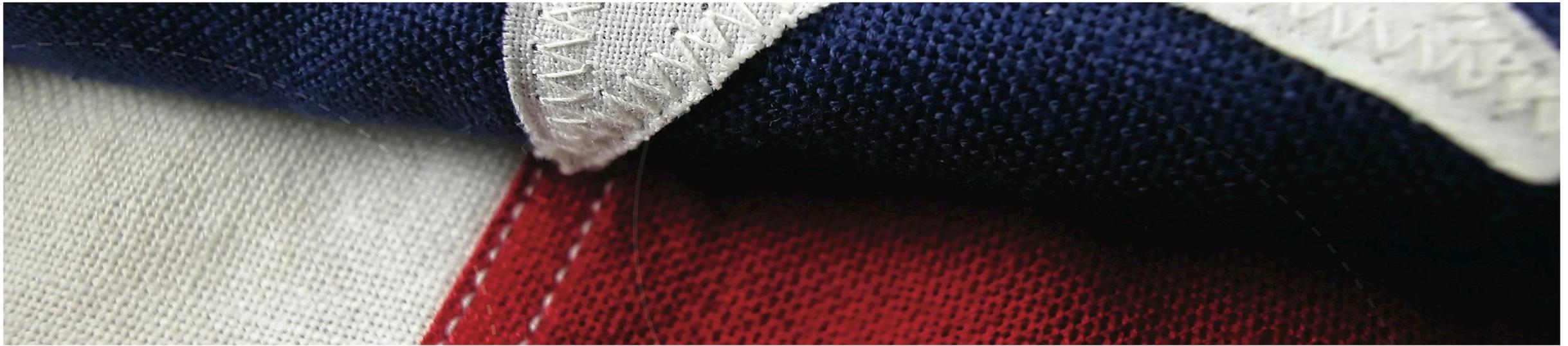
Panel Discussion

- **David Carroll PhD**, Executive Director, Office of Mental Health and Suicide Prevention
- **Wendy Tenhula, PhD**, Deputy Chief Research and Development Officer
- **Jeffrey Pyne MD**, Research Scientist, Center for Mental Health Outcomes Research, Central Arkansas Veterans Healthcare System
- **Carolyn Clancy MD**, Deputy Under Secretary for Discovery, Education and Affiliate Networks





Break until 12:15pm Pacific



COVID-19 and Impacts of Pandemics

Panel Presentation

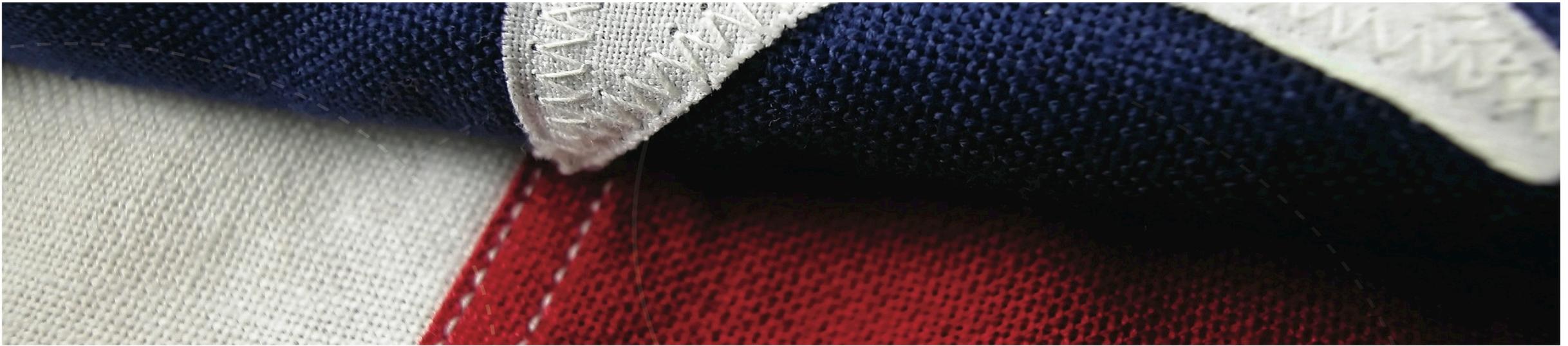
July 9, 2020



VA
HEALTH
CARE | Defining
EXCELLENCE
in the 21st Century

Presenters

- **Mark Reger, PhD** Chief of Psychology Services, VA Puget Sound
- **Alan R. Teo, MD, MS** Core Investigator, CIVIC, VA Portland Health
- **Bryann DeBeer, PhD** Director, VA Patient Center of Inquiry-Suicide Prevention Collaborative; Clinical Research Psychologist, RM MIRECC
- **Lindsey L. Monteith, PhD** Clinical Research Psychologist, RM MIRECC
- **John McCarthy, PhD, MPH** Director for Suicide Prevention Data and Surveillance in the Office of Mental Health and Suicide Prevention and Director of SMITREC
- **Matthew Miller, PhD, MPH** Director VA Suicide Prevention Program, VHA Office of Mental Health & Suicide Prevention



Prior Pandemics and Suicide Risk: What is Known and Where are We Now?

Mark A. Reger, PhD,

July 9, 2020



VA
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CARE | Defining
EXCELLENCE
in the 21st Century

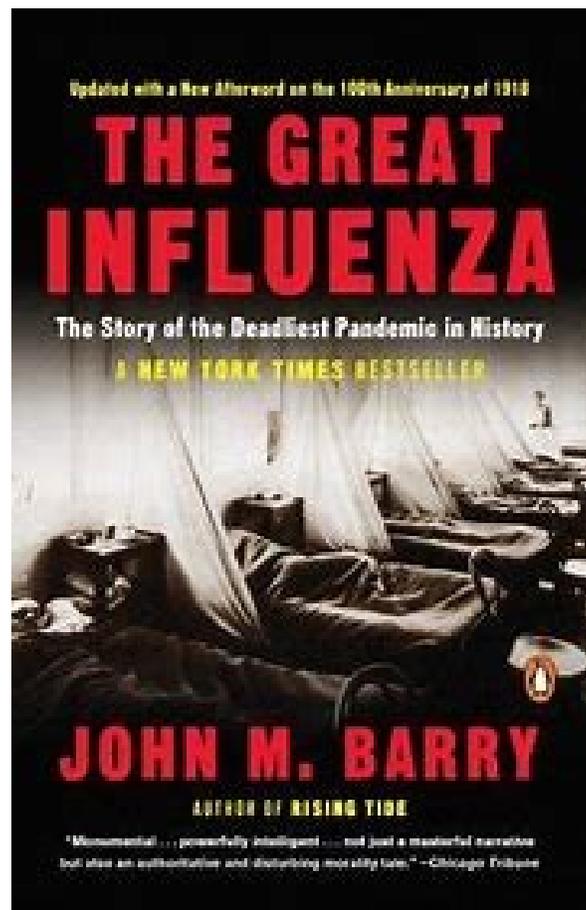
Acknowledgements

Ian H. Stanley, MS

Thomas E. Joiner, PhD

Disclosure

The views expressed here are those of the presenter and do not necessarily reflect the position or policy of the Department of Veterans Affairs or University of Washington.



Camp Grant

- 9/21 – Several soldiers reported ill
- By midnight 108 admitted
- 9/23 – 194 hospitalizations
- 9/24 – 371 hospitalizations
- 9/25 – 492 hospitalizations; *1st death
- In 6 days, went from 610 occupied beds to 4102
- 1000's of cots crammed in every hallway and storage closet
- 10 barracks converted to hospitals
- Enclosed 39 verandas
- 10/4 – 100 deaths, >5000 ill
- 10/8

Suicide Rates Related to Past Pandemics

SARS (2003): Hong Kong

- Suicide rates stable from 1998-2002
- SARS struck Hong Kong in 2003
- The elderly suicide rate in Hong Kong increased in 2003
 - Increase only significant for older adult females (not males)
 - Elevated rates appeared to persist beyond the acute phase of the epidemic
- Suicide rates in younger cohorts did not materially increase related to SARS

Chan et al. (2006), *IJGP*
Cheung et al. (2008), *IJGP*

1918 Influenza

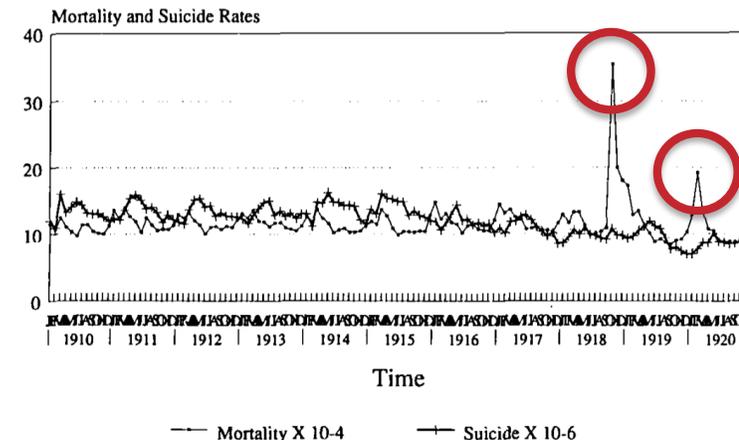
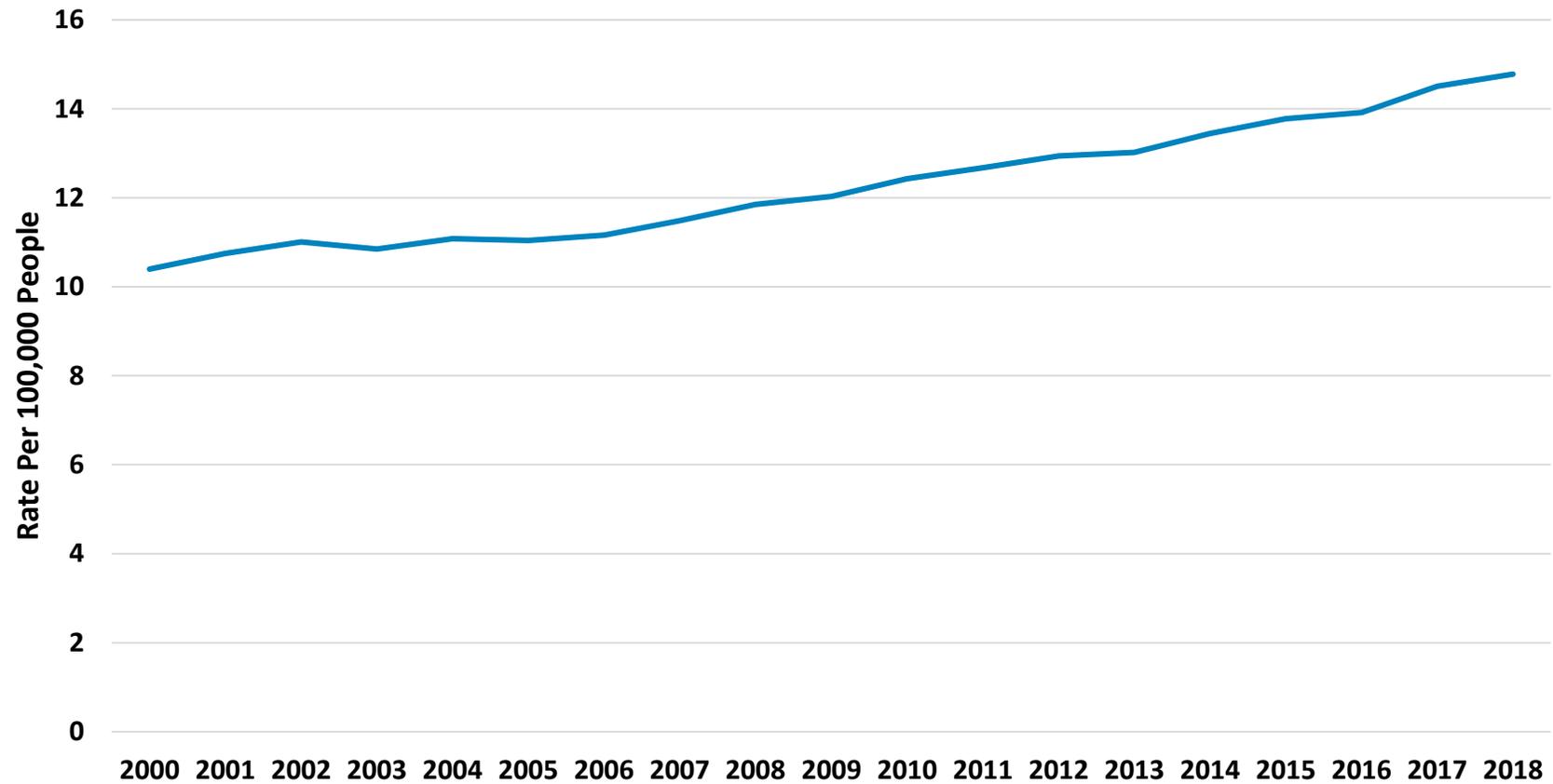


Figure 1. Mortality and Suicide Rates in the United States between 1910 and 1920.

Wasserman IM. The impact of epidemic, war, prohibition and media on suicide: United States, 1910-1920. *SLTB.* , 1992, Vol.22(2), p.240-254

Context in the U.S.: Suicide Rates (2000-2018)



CDC (2020)

COVID-19

- Physical Distancing
- Unemployment/Fears of Economic Recession
- Barriers to Care
- Physical Health Problems
- National Anxiety
- Increased Alcohol Sales, Substance Use
- Health Care Professionals and Suicide Risk
- Firearm Sales

COVID-19 & Suicide: What do we know so far?

Lots of papers, not much known yet...

Case Studies

Example:

- 69 suicide cases reviewed in India – judged to be related to COVID-19
- Fear of COVID-19 infection (n=21), followed by financial crisis (n=19), loneliness and others.

Dsouza et al., *Psychiatry Res.* 2020 May 28;290:113145. doi: 10.1016/j.psychres.2020.113145

Projections

Example:

- Time-trend regression models to assess and forecast excess suicides attributable to the economic downturn in US
- Predicted 2020 suicide rate of 15.7 to 17.0
- 2021 suicide rate predicted to increase to 16.2 to 17.4

McIntyre & Lee, *World Psychiatry*. 2020 Jun; 19(2): 250–251

Cross-Sectional Studies of Psychiatric Symptoms and Associations

- General Population Survey in China: 27.9% had symptoms of depression, 31.6% had symptoms of anxiety, 29.2% had symptoms of insomnia, and 24.4% had symptoms of acute stress
- Sx associated with having confirmed or suspected COVID-19, having a relative with confirmed or suspected COVID-19, having occupational exposure risk

Shi et al., JAMA Netw Open. 2020; 3(7):e2014053. doi: 10.1001/jamanetworkopen.2020.14053

Optimistic Considerations

- Suicide rates have *decreased* during some past disasters
 - Distinct features of COVID-19?
- Pulling together effect

“Epidemics and pandemics may also alter one’s views on health and mortality, making life more precious, death more fearsome, and suicide less likely.”

Reger, Stanley, & Joiner. *JAMA Psychiatry*. 2020 Apr 10. doi: 10.1001/jamapsychiatry.2020.1060.

Conclusion

- Research on prior epidemics and pandemics should be interpreted with caution
 - Very different contexts
- Overall, research suggests suicide rates may rise
- Concerns are not inevitable
- More research on suicide and COVID-19 is needed



New COVID-19 projects

Adapting Caring Contacts to Counteract Adverse Effects of Social Distancing During COVID-19 (HSR&D grant C19 20-216)

Alan R. Teo, M.D., M.S.
teo@ohsu.edu

- **Aim 1:** Convene a panel of subject matter experts and Veterans who will develop an adapted intervention (“Crisis Caring Contacts”).
- **Aim 2:** Identify a cohort of high-risk Veterans from which to recruit participants for an RCT of Crisis Caring Contacts.
- **Aim 3:** Create data collection instruments, human subjects and safety protocols, and all other procedures and documents required for conduct of a pragmatic RCT of Crisis Caring Contacts.

Challenges and key questions

Dear [Mr./Ms. Name]

It was an honor to serve you in the emergency department.
We are here for you. Should you need anything, please
contact us.

Lori Davis, RN and Your Emergency Department Team
501-257-5683



Central Arkansas Veterans Healthcare System | 4300 W 7th St. 116/NLR CC | Little Rock, AR 72205

Decision-making process for the expert panel that balances desire for consensus with expediency?

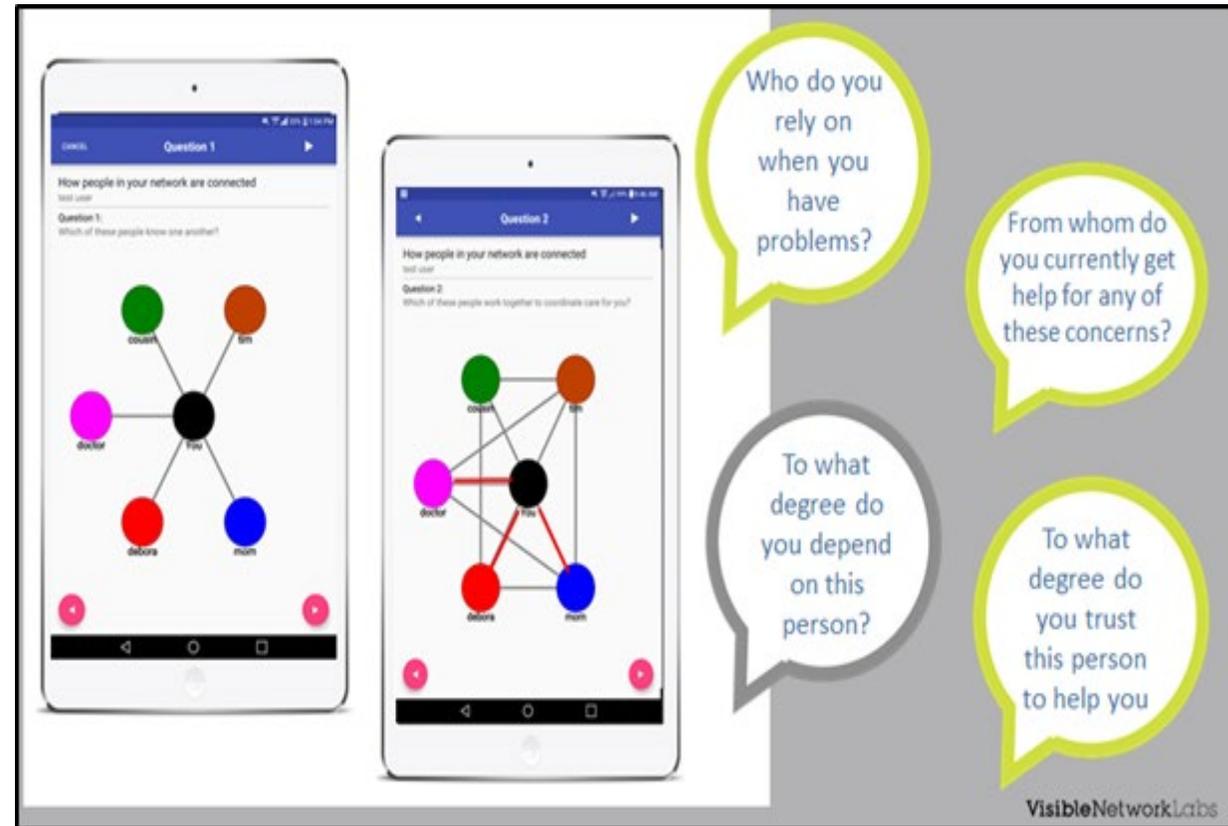
How close to adhere to original Caring Contacts messages and design?

Outcomes of interest besides suicide risk?



The Impact of COVID-19 and Social Distancing on Mental Health and Suicide Risk in Veterans (PI: DeBeer)

- Examine effects of COVID-19 and social distancing on social support system and mental health symptoms in 200 Veterans
 - Social network analysis
 - Oversample for mental health disorders
- Examine moderators
 - Social cognition
 - Expressed emotion
 - Psychological inflexibility
- Use information to mobilize mental health response to pandemic



Assessing the Perceived Impact of the COVID-19 Pandemic on Veterans in the ASCEND Survey

Project: Assessing Social and Community Environments with National Data

MPIs: Claire Hoffmire, Lindsey Monteith

Co-Is: Nathaniel Mohatt, Ryan Holliday, Sean Barnes, Lisa Brenner

Funder: VA Office of Mental Health & Suicide Prevention

ASCEND Overview

- Develop and implement a national recurring survey of Veterans to document prevalence and trends in suicidal ideation (SI) and suicide attempt (SA)
- Examine social/community risk and protective factors
- Oversample women, rural, transitioning, non-VHA

Timeline

- Pilot survey launch* (n = 500): Fall 2020
- Full survey launch (n = 50,000): 2021

COVID-19 Aims:

Describe...

- Perceived impact of the pandemic
- COVID-19 related stressors and fear of contamination/illness
- How Veterans cope
- Perceived impact on firearm access
- Extent to which Veterans report experiencing SI and SA during/following the pandemic

Examine...

- How these factors (e.g., coping, stressors, fear) relate to SI and SA
- If the prevalence of post-COVID 19 SI and SA differs based on gender, rurality, and VHA use



DEPARTMENT OF VETERANS AFFAIRS

VA Suicide Surveillance in COVID-19 Era

John McCarthy, PhD, MPH

Director, Data and Surveillance, Suicide Prevention

Director, Serious Mental Illness Treatment Resource and Evaluation Center

Office of Mental Health and Suicide Prevention

Department of Veterans Affairs



Overview

VA Veteran Suicide Surveillance
COVID-19 Related Surveillance

I have no
financial relationships
to disclose.





Surveillance

Ongoing and systematic data collection, analysis, interpretation, and dissemination for use in public health action.¹

- **Ongoing and systematic data collection**
- **Analysis**
- **Interpretation**
- **Dissemination**
- **Action**

1. Crosby A, Ortega L, Melanson A. 2011. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): CDC, National Center for Injury Prevention and Control.

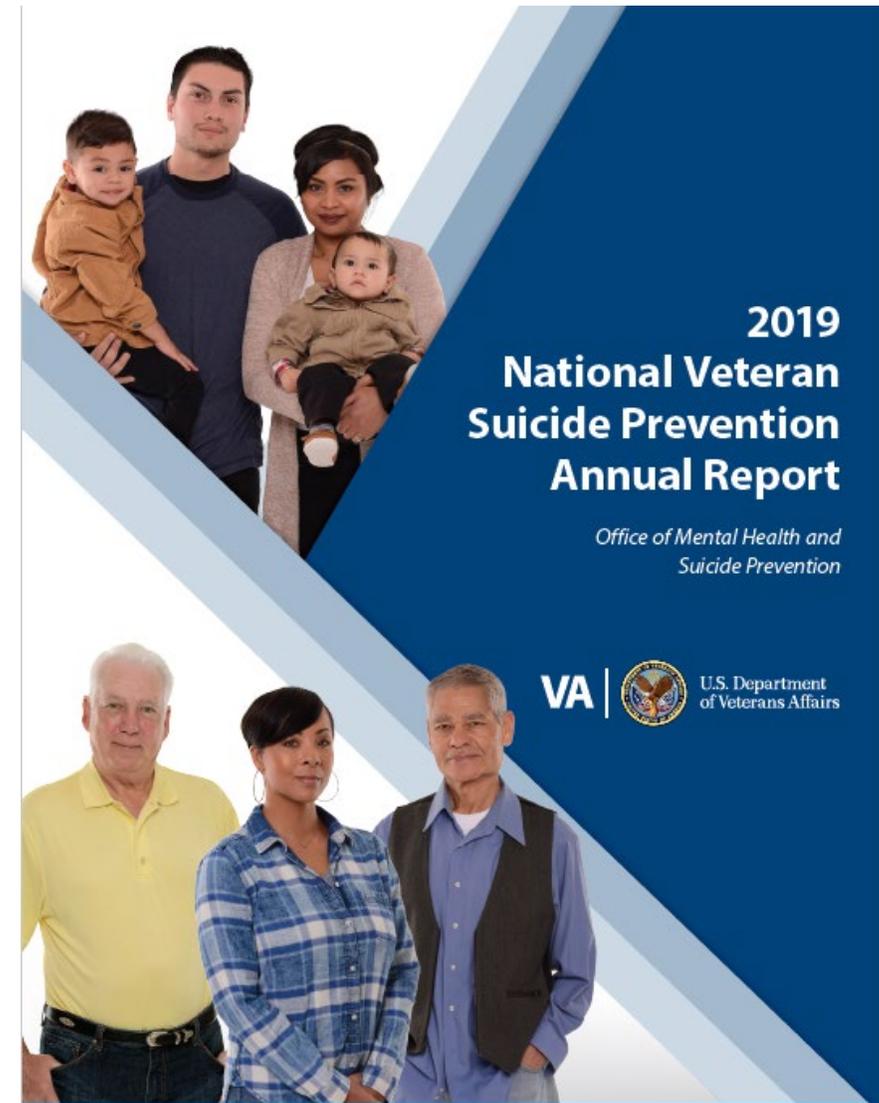


2019 National Veteran Suicide Prevention Annual Report

Most recent Veteran suicide data, 2005 to 2017.

www.mentalhealth.va.gov/suicide_prevention/data.asp

Please contact VASPDataRequest@va.gov if you are interested in learning more.



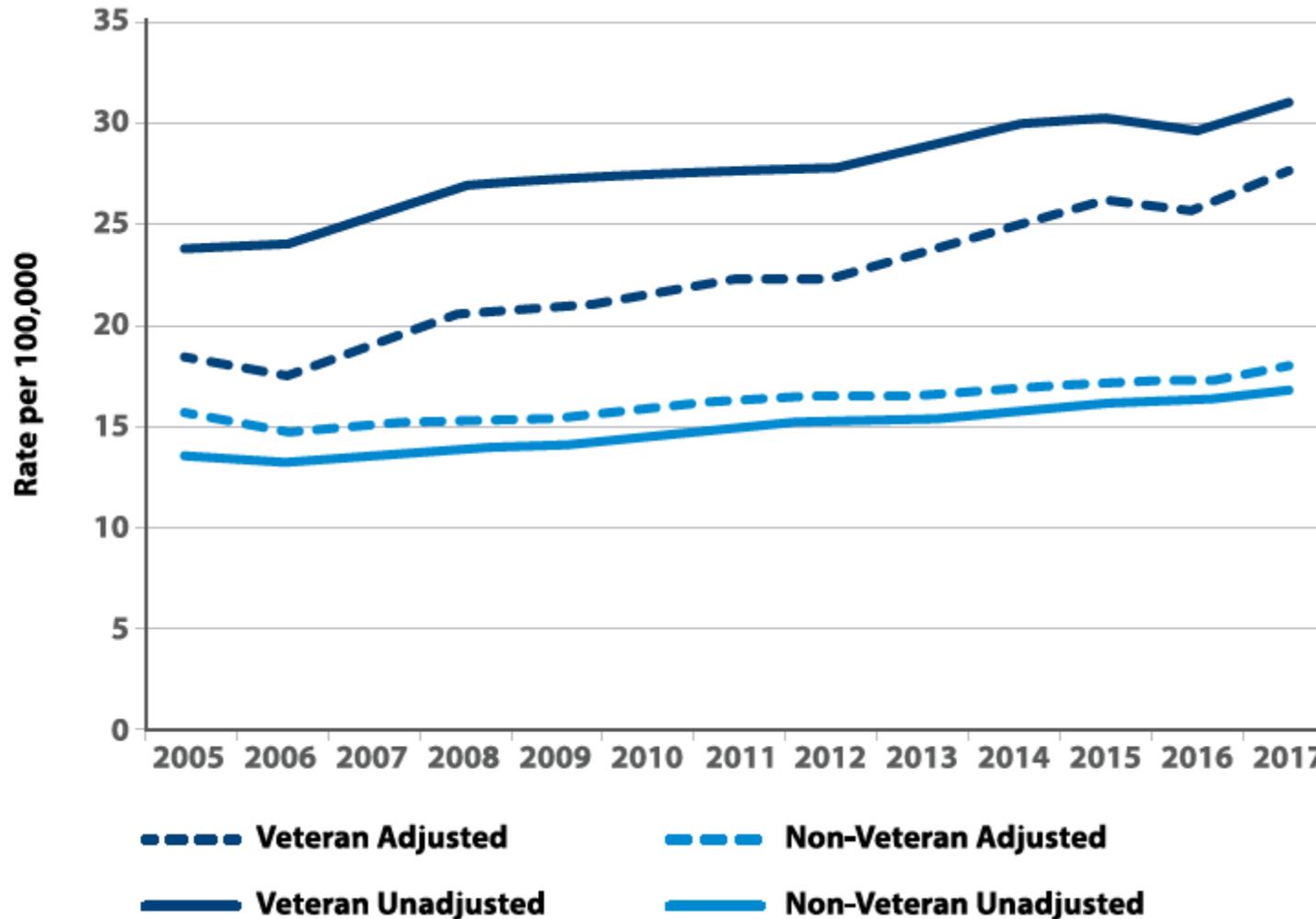
Choose **VA**

VA



U.S. Department
of Veterans Affairs

Suicide Surveillance: Unadjusted and Age- and Sex-Adjusted Rates, Veteran and Non-Veteran Adults, 2005-2017



Suicide rate was **1.5 times greater** for Veterans, adjusting for age and sex

https://www.mentalhealth.va.gov/mentalhealth/suicide_prevention/data.asp



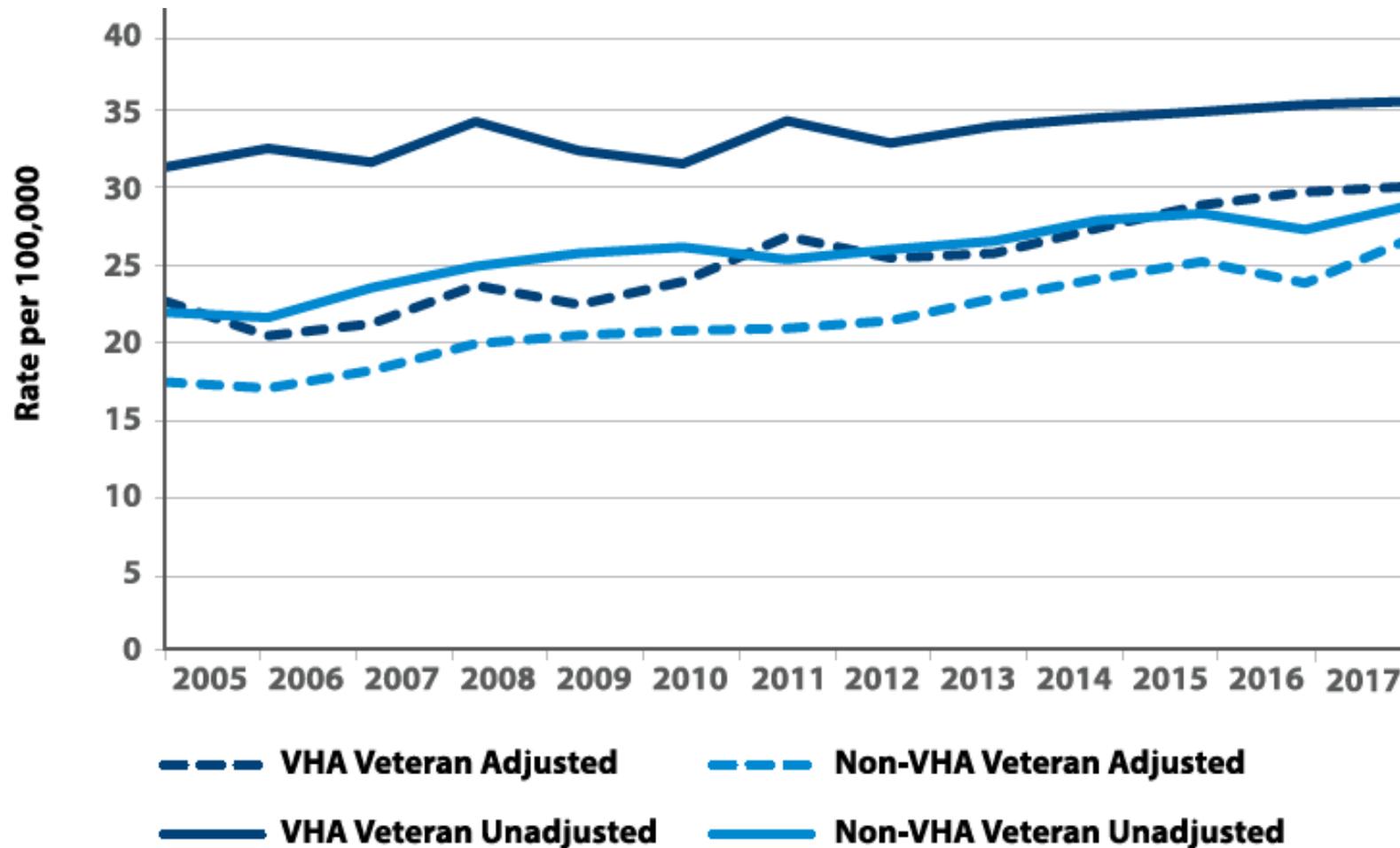
Choose **VA**

VA



U.S. Department
of Veterans Affairs

Age- and Sex-Adjusted Veteran Suicide Rates, by Recent Receipt of VHA Care



Suicide rates were **greater** among Veterans seeking VHA care.

https://www.mentalhealth.va.gov/mentalhealth/suicide_prevention/data.asp



Choose **VA**

VA



U.S. Department
of Veterans Affairs

**Department of
Veterans Affairs**

Memorandum

Date: DEC 24 2009

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Recent VHA Findings Regarding Chronic Pain Conditions and Suicide Risk

**Department of
Veterans Affairs**

Memorandum

Date: OCT 29 2009

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Recent VHA Findings Regarding TBI History and Suicide Risk

To: Network Director (10N1-23)

1. The purpose of this memorandum is to provide additional information to clinicians regarding suicide risk among VHA patients with a history of Traumatic Brain Injury (TBI).

2. Recent findings from the Serious Mental Illness Treatment Research Center (SMITREC), in collaboration with the National Center for Education and Clinical Center (MIRECC), indicate that Veterans with a history of TBI are at greater risk for suicide than the general VHA population.

provide additional guidance to clinicians regarding the management of Veterans with clinical diagnoses of non-cancerous mental health conditions.

Mental Health Treatment, Research, and Education Center (MIRECC)

**Department of
Veterans Affairs**

Memorandum

Date: SEP 03 2009

From: Acting Deputy Under Secretary for Health for Operations and Management (10N)

Subj: New VHA findings on Risk Factors for Suicide in OEF/OIF Veterans- Specific Importance of Major Depression

To: Network Directors (10N1-23)

**Department of
Veterans Affairs**

Memorandum

Date: MAR 29 2010

From: Acting Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)

Subj: Recent Veterans Health Administration (VHA) Findings Regarding Community Living Center Post-Discharge Suicide Risk (VAIQ # 7202260)

To: Network Directors (10N1-23)
Chief Medical Officers

1. The purpose of this memorandum is to provide additional information to clinicians regarding suicide risk among Veterans Health Administration (VHA) patients following discharge from Community Living Centers (CLCs).

to provide additional guidance to Network Directors regarding VHA patients who have served in Iraq and Afghanistan.

Mental Health Treatment, Research, and Education Center (MIRECC) information on causes of death through VHA health care services confirmed that Veterans with these conditions are at increased risk for statistically significant for depression, bipolar disorder, anxiety disorders, and schizophrenia. In addition, the risk associated with PTSD fell just above the national average. These findings are broadly consistent with findings of prior eras.

patients who have served in OEF/OIF and are particularly high risk for death by suicide without a diagnosis of major depression or other mental health conditions.



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

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}

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*. Published online ahead of print June 11, 2015: e1–e8. doi:10.2105/AJPH.2015.302737)



Veteran Suicide

- Firearms were the method of suicide in 70.7% of male Veteran suicide deaths and 43.2% of female Veteran suicide deaths in 2017.
- The interpersonal theory of suicide posits that risk is increased for individuals who experience *thwarted belongingness* (e.g., social isolation), *perceived burdensomeness* (e.g., unemployment, health problems), and who have an *increased capability* to engage in suicidal behavior (e.g., exposure to trauma and pain).
- Access to lethal means is associated with increased risk and suicide attempts that involve firearms have the highest case fatality rate.



Coronavirus (COVID-19) Pandemic

December 2019	COVID-19 detected, Wuhan, China
January 2020	Cases detected, United States
March 11, 2020	World Health Organization declared COVID-19 a pandemic
March 13, 2020	President Trump declared pandemic of sufficient severity and magnitude to warrant national emergency declaration
July 4, 2020	Over 2,803,000 cases in US. VA has identified over 24,670 cases Over 119,000 deaths in US. VA has identified over 1,680 VA deaths

Select **social changes** associated with pandemic:

Substantial job losses among Veterans

- In April 2020, there were 833,000 more unemployed Veterans than in April 2019
- Over this time, Veteran unemployment rate increased from 2.3% to 11.7%

Increased access to lethal means

- In the week following the March 13th declaration...
 - Record numbers firearm background checks
 - Included *five* of the “top ten” daily totals for background checks in the period 9/30/1998 to 4/30/2020
- Estimated gun sales in March 2020...
 - 85% greater than March 2019
 - Handgun sales increased by 91%

SPP Surveillance:

Ongoing surveillance of VHA care-seeking and suicide-related behaviors in COVID-19 pandemic era.

Suicide Surveillance in the COVID-19 Era

1. Assessment of impact on Veteran suicide awaits CDC National Death Index searches for 2020, available in 2022.
2. VHA site reports provide a timely, though incomplete, source of information.
Current findings do not indicate an increase in site-reported Veteran suicides since mid-March 2020.
This may be due to delayed notification and reduced information flow.
3. We do not see increases since mid-March 2020 in:
 - VHA documentation of suicide attempts
 - Documented VHA On-Campus suicide attempts
 - VHA Emergency Department visits for suicide attempts
 - Urgent Care visits for suicide attempts
 - Completed screens for suicide, assessed suicidal ideation
 - Completed PTSD screens, suicidal ideation among patients with PTSD screens
 - New and reactivated VHA High-Risk Flags
 - New diagnoses of depression in Primary Care
4. Ongoing monitoring of mortality



VA Mental Health, Coronavirus Information

<https://www.mentalhealth.va.gov/coronavirus/index.asp>

The screenshot shows the U.S. Department of Veterans Affairs website. At the top left is the VA logo. To its right is the text "U.S. Department of Veterans Affairs". In the top right corner, there is a "Get help from Veterans Crisis Line" button, a search bar, and a "Search" button. Below these are social media icons for email, Facebook, Twitter, YouTube, and Instagram, along with a "SITE MAP [A-Z]" link. A navigation menu contains links for Health, Benefits, Burials & Memorials, About VA, Resources, Media Room, Locations, and Contact Us. The breadcrumb trail reads "VA » Health Care » Mental Health » Coronavirus » Coronavirus". The main heading is "Mental Health". A left sidebar menu is open to "Mental Health", with sub-links for Mental Health Home, Coronavirus (highlighted), Get Help, Self-Help Resources, Explore by Topic, I am a..., About VA Mental Health, Site Map, and More Health Care. The main content area has a "Coronavirus" header with "Overview" and "Resources" tabs. The featured article is "Maintaining and Enhancing Your Mental Health and Well-Being During the Novel Coronavirus Disease (COVID-19) Outbreak". Below it is a blue banner for "How To Manage Stress and Anxiety During the COVID-19 Outbreak". The text explains that taking care of well-being is essential and lists several tips: exercise regularly, limit alcohol, practice breathing exercises and/or meditation, and take breaks from the news. A "QUICK LINKS" section at the bottom left features a "Hospital Locator" with a "Zip Code" input field and a "Go" button.

U.S. Department of Veterans Affairs

Get help from Veterans Crisis Line

Search

SITE MAP [A-Z]

Health Benefits Burials & Memorials About VA Resources Media Room Locations Contact Us

VA » Health Care » Mental Health » Coronavirus » Coronavirus

Mental Health

▼ Mental Health

- Mental Health Home
- Coronavirus
- Get Help
- Self-Help Resources
- Explore by Topic
- I am a...
- About VA Mental Health
- Site Map
- More Health Care

Coronavirus

Overview Resources

Maintaining and Enhancing Your Mental Health and Well-Being During the Novel Coronavirus Disease (COVID-19) Outbreak

How To Manage Stress and Anxiety During the COVID-19 Outbreak

Taking care of your well-being, including your mental health, is essential during this time. Everyone reacts differently to stressful situations. Many people may experience stress, fear, anxiety, or feelings of depression. This is normal. There are things that you can do to manage your stress and anxiety:

- Exercise regularly, try to eat well-balanced meals, and [get plenty of sleep](#).
- Limit alcohol.
- Practice breathing exercises and/or meditation. VA has many free [mental health apps for Veterans](#) like [Mood Coach](#), [COVID Coach](#), and [Mindfulness Coach](#).
- Take breaks from the news (see below for tips).

QUICK LINKS

Hospital Locator

Zip Code



Choose

U.S. Department of Veterans Affairs

Thank you!

John F. McCarthy, PhD, MPH
VA Office of Mental Health and Suicide Prevention

John.McCarthy2@va.gov
(734) 277-8737



Choose **VA**

VA



U.S. Department
of Veterans Affairs

Close of Meeting



Slides will be available
next week



Post-meeting survey



SPRINT is starting a new
HSR&D cyberseminar
series—be on the look out...



If you are not yet a member
of the SPRINT network, and
would like to receive regular
updates, please reach out to
us at:

SuicidePreventionRes@va.gov

Thank you!

- Presenters and Discussants
- Gloria Workman and Office of Mental Health and Suicide Prevention
- Molly Kessner, SPRINT Project Manager
- Additional members of the Program Planning Committee:
 - Lauren Denneson
 - Lindsey Monteith
 - Teresa Hudson
- Bob O'Brien and HSR&D
- Mark Ilgen and the other members of the SPRINT Core Team

