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’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.

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

Community-Based Prevention Strategies

- Veterans Integrated Service Networks (VISN)-Wide Community Prevention Pilots (Community Coalition Building)
- Together With Veterans (Veteran-to-Veteran Building)
- Governor’s/Mayor’s Challenge (State-Driven Suicide Prevention Planning)

Clinically-Based Interventions

- Evidence-Based Psychotherapies Implemented Across the Nation (including Cognitive Behavior Therapy for Suicide Prevention, Dialectical Behavior Therapy, and Problem Solving Therapy)

Foundation of Adequate Mental Health Staffing
(7.72 outpatient mental health full-time equivalent employees/1,000 Veterans in outpatient mental health)
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)

https://www.pdhealth.mil
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
CPG Research Gaps

- 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
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:
Kim Peterson, MS
Nathan Parsons, MS
Kathryn Velz, MLS
Larren M. Dennison, 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.hsrda.research.va.gov/centers/core/sprint.cfm
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<th>Research Gaps from ESP 2019 Compendium</th>
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| **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/OUD, 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

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- Effectiveness and implementation of psychotherapies for Veterans at risk
- Lethal Means Safety
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

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<tr>
<th>VA Studies</th>
<th>Study Count</th>
<th>Study Count (%)</th>
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<tr>
<td>Funding Department</td>
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<tr>
<td>HSRD</td>
<td>32</td>
<td>30%</td>
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<tr>
<td>CSRD</td>
<td>21</td>
<td>20%</td>
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<tr>
<td>BLRD</td>
<td>1</td>
<td>1%</td>
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<tr>
<td>RRD</td>
<td>11</td>
<td>10%</td>
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<tr>
<td>Cooperative Studies</td>
<td>2</td>
<td>2%</td>
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<tr>
<td>Operations</td>
<td>33</td>
<td>31%</td>
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<tr>
<td>Other</td>
<td>6</td>
<td>6%</td>
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<tr>
<td>Total</td>
<td>106</td>
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Public Health Approach

- Indicated: 27%
- Selective: 29%
- Universal: 26%

Socio-ecological level

- Community: 12%
- Individual: 7%
- Relationship: 19%
- Societal: 62%
## High priority research gaps

<table>
<thead>
<tr>
<th>Category</th>
<th>Research Areas</th>
<th>% of VA projects</th>
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<td><strong>Risk Factors and Assessment</strong>, in particular</td>
<td>• Understanding and addressing how risk varies over time; personalized approaches based on risk</td>
<td>21%</td>
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</table>
| **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 (COVID-19) | 16%              |
| **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 | 16%              |
| **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 | 32%              |
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
• 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 Paladin, 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

• 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
Presentation Overview
Depressive Symptoms in Primary Care

- Depressive symptoms are associated with:
  - Mortality, Morbidity, Quality of Life Decrement, Lost Work Days, Healthcare Utilization
  - Suicidal thoughts and behaviors, including completed suicides

- Where do Patients Seek Help? PRIMARY CARE

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(Olfson, Kroenke, Wang, & Blanco, 2014)
HSRD funded Multi-Site RCT (IIR 14-047)
Brief Behavioral Activation for Primary Care
Eligibility Criteria

**INCLUSION**

- PHQ ≥ 10
- No anti-depressants or on stable dose for ≥ 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***
140 Enrolled

72 Usual Care
72 12-week Follow-Up
  63 Completed

68 BA-PC Intervention
68 12-week Follow-Up
  57 Completed
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

Average Mean PHQ Score

Baseline 2 Weeks 4 Weeks 6 Weeks 8 Weeks 10 Weeks 12 Weeks 2 Weeks 4 Weeks 6 Weeks 8 Weeks 10 Weeks 12 Weeks

TAU (n=72) BA-PC (n=68) TAU (n=43) BA-PC (n=55)
12-Week Change in Depressive Symptoms Among the Sample of Patients Who Continued to Report Symptoms of Depression After 2 Weeks

- Clinically Improve
- Partial Treatment Response
- Minimal Change
- Clinically Worsen

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<th>TAU Sample</th>
<th>BA-PC Sample</th>
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<tr>
<td>Clinically Improve</td>
<td>5</td>
<td>12</td>
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<tr>
<td>Partial Treatment Response</td>
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<td>10</td>
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<tr>
<td>Minimal Change</td>
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<td>19</td>
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<tr>
<td>Clinically Worsen</td>
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<td>5</td>
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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.

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<tr>
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<tr>
<td></td>
<td>M (SD)</td>
<td>n (%)</td>
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<tr>
<td>Baseline</td>
<td>22.29 (1.90)</td>
<td>17 (100)</td>
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<td>6 weeks</td>
<td>15.36 (6.57)</td>
<td>14 (82.4)</td>
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<td>12 weeks*</td>
<td>16.13 (5.46)</td>
<td>15 (88.2)</td>
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<td>24 weeks*</td>
<td>14.54 (5.30)</td>
<td>13 (76.5)</td>
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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


Key References cont.


Resources

- VA Center for Integrated Healthcare
  - http://www.mirecc.va.gov/cih-visn2/

- VA Center for Integrated Healthcare Evidence-Informed Interventions for PCMHI Clinicians

Center of Excellence for Suicide Prevention
- https://www.mirecc.va.gov/suicideprevention/index.asp
Feel Free to Contact Us

Jennifer.Funderburk@va.gov
VA Center for Integrated Healthcare

Wifred.Pigeon@va.gov
VA Center of Excellence for Suicide Prevention
PROJECT LIFE FORCE:
Keeping High-Risk Veterans Alive Through a Group Safety Planning Intervention

Marianne Goodman, M.D.
Icahn School of Medicine, Mount Sinai
James J. Peters VAMC
Bronx, NY

In collaboration with:
Greg Brown, PhD
Michael Thase, MD
University of Pennsylvania
Philadelphia VA
Barbara Stanley, PhD
Columbia University
Psychiatric Institute
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. Beck Scale for Suicide Ideation
B. Beck Depression Inventory
C. Beck Hopelessness Scale
D. Beck Anxiety Inventory°

°Means are adjusted for the following covariates: age, sex, education, and previous hospitalizations.
°Post hoc analysis for Beck Anxiety Inventory ($F_{1,11} = 4.52, P = .04$).
### Personal Anecdote with Suicidal Veteran

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<th>Step 3: People and social settings that provide distraction:</th>
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<td>1. Name__________________________________________________</td>
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<td>3. Place ________________________________________________</td>
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<td>4. Place ________________________________________________</td>
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<tr>
<th>Step 4: People who I can ask for help:</th>
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<tbody>
<tr>
<td>1. Name________________________________</td>
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<td>Phone________________________________</td>
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<td>Phone________________________________</td>
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<thead>
<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
<th></th>
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<tbody>
<tr>
<td>1. Clinician Name____________________________________________</td>
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<tr>
<td>Phone________________________________________________________</td>
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<tr>
<td>Clinician Pager or Emergency Contact #_________________________</td>
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<tr>
<td>2. Clinician Name____________________________________________</td>
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<td>Phone________________________________________________________</td>
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<tr>
<td>Clinician Pager or Emergency Contact #_________________________</td>
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<tr>
<td>3. Local Urgent Care Services</td>
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<tr>
<td>Urgent Care Services Address_________________________________</td>
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<tr>
<td>Urgent Care Services Phone___________________________________</td>
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<tr>
<td>4. VA Suicide Prevention Resource Coordinator Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA Suicide Prevention Resource Coordinator Phone:</td>
<td></td>
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<tr>
<td>5. 1-800-273 TALK (8255) push 1 to reach a VA mental health clinician:</td>
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<tr>
<th>Step 6: Making the environment safe:</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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</table>

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

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 aims to address these concerns

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

PLF Session 1: Crisis Prevention Services

PLF Session 2: Emotion Recognition Skills

PLF Session 3: Distress Tolerance Skills

PLF Session 4-5: Interpersonal Communication Skills with Family

PLF Session 6: Interpersonal Communication Skills with Clinical Team

PLF Session 7: Means Restriction
Project Life Force Sessions

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

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

Vet arranges flag honor for doc’s life-saving work
Bronx VA psychiatrist-researcher cited for work in suicide prevention

Mohni Cuenca is presented a flag by VA Secretary Robert Wilkie, 2019. (Photo by Frank D. Shashaty, 2019)

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 accomplishments 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

They’ve got each other’s back

Researchers help Vets at risk of suicide build mutual support network

Josee Brown (center) and Chris Murray (second from right) are part of a suicide-prevention group led by Drs. Marianne Goodman (third from right) and Kavuna Nidhi Kapli-Parr (left) at the Bronx VA Medical Center. (Photo by Yang Zhao)
CSRD Merit: PLF Randomized Control Trial & Protocol Paper

CSRD 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
## RCT Progress to Date

<table>
<thead>
<tr>
<th>Site</th>
<th>Total Number Enrolled</th>
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<tbody>
<tr>
<td>JJPVA (Bronx)</td>
<td>101</td>
</tr>
<tr>
<td>CMCVAMC (Philadelphia)</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
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</table>

• 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 1$^{st}$ cycle, 2$^{nd}$ group underway
- This project featured in upcoming “VA Insider” Blog
# PLF-CV Manual and 9 Sessions

## Table of Contents

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
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</table>
| 1       | Background to group  
  - Introductions  
  - Information about COVID-19  
  - Other recommendations for COVID-19  
  - Description of Resilience & Safety Plan  
  - Group Rules  
  - Challenges to Telehealth  
  - Understanding crisis services:  
    - VA Crisis Line  
    - OMH Emotional Support Line  
    - SAMHSA Disaster Distress Helpline  
    - COVID-19 Peer Support Group - Mayo Clinic |
| 2       | Meditation, Mindfulness, & Relaxation Techniques  
  - Breathing, Meditation, Visualization  
  - Resources |
| 3       | Developing Internal Coping Strategies  
  - Distraction  
  - Self-Soothing |
| 4       | Recognizing and Coping with Emotions  
  - Emotion mapping  
  - Matching emotions to coping strategies |
| 5       | Managing Interpersonal Relationships During COVID-19  
  - What is physical distancing?  
  - Combatting isolation  
  - Staying connected |
| 6       | Maximizing your Mental and Physical Health Treatment  
  - Pain management, medications, & sleep |
| 7       | Improving your Physical Well-Being  
  - Diet & Exercise |
| 8       | Building Positive Emotion  
  - Gratitude & Reasons for Living |
| 9       | Recap and Moving Forward Amidst COVID-19 |
Thank you to all my collaborators and staff on the PLF project:

Greg Brown, PhD
Hanga Galfalvy, PhD
Michelle Gordon, MPH
Liat Itzhaky, Ph.D.
Shari Jager-Hyman, Ph.D.
Emily Mitchell, BA
Karoline Nordmo-Myhre, M.Ed
Angela Page Spears, BS
Barbara Stanley, PhD
Sarah Sullivan, MHC-LP
Michael Thase, MD

Contact Information/request for PLF-CV manual
• Marianne Goodman MD
Marianne.goodman@va.gov
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

Gala True, Ph.D
Co-Principal Investigator

Amanda Raines, Ph.D
Co-Investigator

Ray Facundo, MSW
Project Manager

Claire Houtsma, MA
Psychology Intern

Mike Anestis, Ph.D
Consultant

Annie Asher
Research Assistant

Gary Ballier
Veteran Champion

Chimeko Patterson
Veteran Champion

Carlos Urbina
Veteran Champion

Matt Bailey
Veteran Champion
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.

---

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.
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.”

**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

Poll results: Which best describes you? (please check all that apply)

- Veteran/Servicemember
- Family Member/Caregiver
- Other

(n=40)
Townhall Forums (cont.)

Physical locations (by zip code) of coalition members who have attended a video townhall.
Leveraging Existing Resources

Some of the organizations and initiatives we’ve consulted:

- Hold My Guns
- Project ChildSafe
- In-Transition Program
- LOSS Team
- LivingWorks ASIST
- ASIST Program
- Zero Suicide Project
- Project Safeguard
- Together With Veterans Campaign
- VA
- U.S. Department of Veterans Affairs
- OMHSP – Safe Firearm Storage Toolkit
- VA
- U.S. Department of Veterans Affairs
- Resilience, Risk Reduction & Suicide Prevention (R3SP)
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?
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

Exogenous factors that may influence the behavior directly or by influencing susceptibility to campaign exposure (arrows not presented for clarity) (demographics, prior behavior, personality traits, characteristics of the social environment)
**Evidence-Base for Campaign Use (r)^2**

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

- **Youth**
  - Alcohol use (Snyder et al., 2004)
  - Fruit & vegetables (Snyder et al., 2006)
  - Smoking prevention (Parcell et al., 2006; Snyder et al., 2004)
  - Fat consumption (Snyder et al., 2006)

- **Adults**
  - Fat consumption (Snyder et al., 2006)
  - Seat belt use (Snyder et al., 2004)
  - Condom use (Snyder et al., 2009)
  - Fruit & vegetables (Snyder et al., 2006)
  - Oral health (Snyder et al., 2004)
  - Alcohol use (Snyder et al., 2004)
  - Seat belt use (Moore, 1990)
  - Family planning (Snyder, Badiane, Kalnova, & Diop-Sidibe, 2003)
  - Organ donation (Feeley & Moon, 2009)
  - Heart disease prevention (Snyder et al., 2004)
  - Mammography (Han et al., 2009; Snyder et al., 2004)
  - Smoking cessation (Snyder et al., 2004)

**Average Effect Sizes**
Translating Effect Sizes: Small but Mighty

Figure 3. Narrowing the Audience for a Communications Campaign

General Population
aged 18+ 100.0% (230.4 million)

Adults aged 18–54
67.6% (155.9 million)

Cigarette Smokers
aged 18–54
(1+ packs/week)
14.3% (33.0 million)

Low Socioeconomic Status
Cigarette Smokers
aged 18–54
5.6% (12.8 million)

50% reach intended audience

Smallest Effect: 192,000

Average Effect: 576,000

Larger Effect: 1.28 million
Improving Effect Size: Campaign Best Practices

- 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-seeking\textsuperscript{5-7}
  
  • Increased awareness and use of crisis support services associated with campaign use (including VA campaigns from 2010 & 2011)\textsuperscript{8-10}
  
  • Awareness of risk factors for suicide (firearms)\textsuperscript{11,12}

• Little investigation of message factors that might affect persuasive outcomes, particularly among individuals at known risk for suicide\textsuperscript{12}

• Few randomized trials conducted; limited efficacy or effectiveness data available for suicide prevention\textsuperscript{12}
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


References


Health Services Research & Development
VA Office of Research & Development

American Foundation for Suicide Prevention

VA Office of Mental Health & Suicide Prevention
Contact

Elizabeth Karras, PhD
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
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,
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**

![Mortality and Suicide Rates](image)

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


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.

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

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

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.”

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.
teoa@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

- 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
VA Suicide Surveillance in COVID-19 Era

John McCarthy, PhD, MPH

Director, Data and Surveillance, Suicide Prevention
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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

Most recent Veteran suicide data, 2005 to 2017.

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

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

[Source](https://www.mentalhealth.va.gov/mentalhealth/suicide_prevention/data.asp)
Suicide rates were greater among Veterans seeking VHA care.

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

Department of Veterans Affairs

Date: OCT 29 2003

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

To: Network Director (10N1-23)

Subj: Recent VHA Findings Regarding TBI History and Suicide Risk

1. The purpose of this memorandum is to update the Department on the recent findings regarding suicide risk among VHA patients with traumatic brain injury (TBI).

2. New VHA findings from the Serious Mental Illness Treatment Research Enterprise (SMITREC), in collaboration with the National Institutes of Health Research Center (NCI), have indicated that veterans with a history of TBI are at increased risk for suicide than those without a history of TBI.

Memorandum

Department of Veterans Affairs

Date: MAR 29 2009

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

To: Network Directors (10N1-23)

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

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).

Memorandum

Department of Veterans Affairs

Date: SEP 03 2009

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

To: Major Depression Research (10N1-23)

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

1. The purpose of this memorandum is to provide additional guidance to clinicians regarding suicide risk among OEF/OIF veterans who have been in Iraq and Afghanistan. Recent VHA findings indicate that patients with a history of major depression have a significantly higher risk of suicide.

2. While the risk associated with PTSD is well-known, these findings highlight the importance of recognizing and addressing major depression in OEF/OIF veterans to reduce suicide risk.

3. These findings are broadly consistent with prior research, and clinicians should consider integrating these findings into their practice to improve care for OEF/OIF veterans.
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. However, suicide rates in VHA have been stable, without decreases that can be attributed to these enhancements. The stable rates stand in contrast to increased rates in other US populations, especially middle-aged men, and in veterans who do not use VHA. 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. 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.
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:
Suicide Surveillance in the COVID-19 Era


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


VA Mental Health

Coronavirus

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).
Thank you!

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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