Moderator: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode Diane Hanks, senior editor with the Center for Information, Dissemination, and Education Resources talks with Steven Dobscha, Director of the Center to Improve Veteran Involvement in Care in Portland, Oregon. They're discussing Dr. Dobscha's work around primary care patient perspectives on VA's population-based suicide risk screening program, otherwise known as Risk ID.

Diane Hanks: Dr. Dobscha, could you please describe the Suicide Risk Identification Strategy, which is Risk ID program, which was implemented in late 2018? And why it's being used in VA primary care settings?

Steven Dobscha: Sure. The main purpose of what's called Risk ID is to improve identification and evaluation of Veterans who are treated in VHA who might be at higher risk for suicide. And it represents a population-based screening approach. And it's really important to note that it's really one of a number of different approaches that VHA is taking to enhance suicide prevention.

Diane Hanks: Can you tell me what those factors might be that would put a Veteran at higher risk, and how a primary care physician might know this?

Steven Dobscha: Sure. I think there are some commonly known risk factors that Veterans might encounter at greater rates than the general population. I think life stressors, in particular losses, age range is important. We currently have increasing rates in this country of suicide in the 18 to 24-year range, and in particular, and so that's capturing some of our younger Veterans. There is fairly good evidence that some deployment experiences and traumatic experiences can also enhance suicide risk.

Diane Hanks: Is the diagnosis of PTSD a risk factor?

Steven Dobscha: There actually are some mixed findings on that.

Diane Hanks: How about depression?

Steven Dobscha: Depression is definitely a risk factor.

Diane Hanks: Okay.

Steven Dobscha: Yesh, anxiety disorders, functional decline is a risk factor as well.

Diane Hanks: Is it safe to say that any mental health disorder is a risk factor or just certain ones?

Steven Dobscha: I would say that many –

Diane Hanks: Okay.

Steven Dobscha: – Yesh, many, if not most.

Diane Hanks: Okay.

Steven Dobscha: And you ask about primary care, and I think one of my interests in working in primary care is that we know that, pretty clearly, that people, in particular Veterans who go on to die by suicide, about half of them were seen in primary care settings in the month prior to death. That's true in the general population –

Diane Hanks: Yes.

Steven Dobscha: – As well. But we've seen it with Veterans.

Diane Hanks: Do you think that's usually, like, a cry for help situation or it's just, kind of, they have health issues that they're managing, and?

Steven Dobscha: It's a great question, and I don't think we really know the answer to that. It's probably a combination, but we also know that many people just have chronic medical problems.

Diane Hanks: Okay. Could you briefly describe your mixed method study to characterize Veterans' perspectives on suicide risk screening and assessment in VA primary care settings?

Steven Dobscha: Sure. I mean, maybe I should just take a step back and say Risk ID screening really involves administration, typically on an annual basis for most Veterans of the Columbia Suicide Risk screener. And it's about eight questions. But for those who screen positive, meaning that they have either active ideation and/or recent ideation, then they go on to have a comprehensive Suicide Risk Evaluation, also known as the CSRE.

 What we did is we looked in the corporate data warehouse of the VA and we identified Veterans who'd had a screening, CSSRS, done. And within a week or a little longer we sent them a survey. We sent surveys nationwide to about 6,000 Veterans, and about 2,400 responded to our surveys. And those surveys asked about attitudes towards suicide, attitudes towards screening. There were a number of measures, barriers to care, things like that. And we also asked them if they'd be interested in participating in a follow-up qualitative interview.

 We ended up interviewing about 60 Veterans. Our main focus of our study was on understanding the Veteran experience, although we did also gather some information from staff. We ended up interviewing about 60 staff, or 40 staff.

 There is another piece to the project which we haven't done yet which is to really look at utilization of care following screening. One of our hypotheses or questions was, if someone has a negative or a poor screening experience, are they less likely to follow up with referrals for mental health care or mental health treatment?

Diane Hanks: Do you know what contributes to a poor screening experience?

Steven Dobscha: Well, I can certainly tell you a little bit about –

Diane Hanks: Yes.

Steven Dobscha: – Some of our findings so far.

Diane Hanks: Yes.

Steven Dobscha: I think that, I mean just to skip ahead, due to the findings for the Veterans, one of the things I was a bit surprised about was that in our quantitative analyses over 90% of Veterans felt that screening was appropriate. And that could be a screening done by a primary care provider or by a nurse or a medical assistant. And about half of the group felt that screening should be done at every visit.

 Now, the other half of the group thought it should be done less frequently, but still a pretty large, a lot of support for having a screening process. When we did our qualitative interviews, the findings were concordant with that. The Veterans seemed very aware that Veterans are at higher rate, risk for suicide which was part of the reason that they're supportive of it.

 And they also thought it was an opportunity to intervene that otherwise might not occur. Now, they did say though that screening should be done differently, and that basically means a more personalized care experience.

Diane Hanks: Yes. I was wondering if there was a difference between who was administering the screening? Whether it was just, I don't know if they even do this, give someone a questionnaire and have them fill it out; or whether a nurse does it or a doctor does it or an NP does it? I wondered if that made a difference?

Steven Dobscha: Yes, it –

Diane Hanks: \_\_\_\_\_ [00:06:27].

Steven Dobscha: – Does make a difference.

Diane Hanks: Yes.

Steven Dobscha: They felt that someone should be looking you in the eye and not typing their note while they're talking to you. And there were a little bit of differences which I'll come to in a minute and in terms of who does the screening. The other thing they felt is – there's a lot of concerns they have about being screened. Is someone gonna put me in the hospital?

Diane Hanks: Yes.

Steven Dobscha: Right?

Diane Hanks: Yes.

Steven Dobscha: Now, we wondered, "Is someone going to take my firearm away? Or they have concerns, and so it definitely helps to have a more trusting relationship with the person –

Diane Hanks: Yes.

Steven Dobscha: – Doing the screening.

Diane Hanks: Well, I think movies and TV have contributed to the notion that if you're suicidal, they're going to put you on a lockdown for two or three days or whatever it is. And people might be hesitant because of that. And I wondered if, how much of that is true? And is the VA taking any steps to correct that misperception, if it is a misperception?

Steven Dobscha: Yes, and it typically is. I mean there are some circumstances but they're pretty rare where someone –

Diane Hanks: Yes.

Steven Dobscha: – Will end up having to be in the hospital that same day, and put on a hold, per say. But for the most part, usually ideation isn't that severe, and that doesn't need to happen. It does help and we found this in both the current and in prior work that we've done, if people have a little bit more education about the screening process, and what –

Diane Hanks: Yes.

Steven Dobscha: – It means. And I think the VA has some work to do in that respect, maybe somehow orienting patients a little bit more to that. I think that that would help.

Diane Hanks: Well, I have another question. I don't know if you could answer it, if you know the answer to it. But I know the statistics have gone down in the past few years as far as how many Veterans are committing suicide every day. And they've gone down from, like, 21 or 22 to 17, I think. I know the VA has a lot of different interventions in place. But do you know what accounts for the decrease?

Steven Dobscha: I don't think we're able to tease out –

Diane Hanks: Yes.

Steven Dobscha: – What parts of the strategies that are being used are really having that impact. I mean, there has been increases in mental health staffing. I think expectations for following up with patients who are at higher risk, VA has a high risk for suicide flag system. But where that really is helpful, I think, is it puts somebody into a structured treatment plan for a period of time where they're getting frequent outreach. We have a REACH VET program, our –

Diane Hanks: Yes.

Steven Dobscha: – Predictive analytics program, which is also identifying Veterans at very high risk, who then get additional outreach. We do have our Risk ID program, which is likely, undoubtedly really, identifying people who are at elevated risk who otherwise might not have been identified. There's so many different things that are happening right now.

Diane Hanks: I know also that the numbers for homeless Veterans are going down. Do you think there's a correlation there? Because you would think being homeless might be a contributing factor to depression and suicide.

Steven Dobscha: Absolutely. I know that a lot of the suicide prevention programs are also being adapted for the homelessness programs. And I'm guessing that the homelessness program staff are better educated about suicide risk.

Diane Hanks: But I think people assume that if a Veteran is homeless that they don't have access to VA services. I think a lot of people would be surprised to know that they do have access, that there is outreach to homeless Veterans. And that there is a way for them to get help even if they don't have a home and an address. And because people just assume, well, if you don't have an address, you can't get Social Security checks. You can't get health insurance. You can't get help. But that's not the case.

Steven Dobscha: Right. And we are getting a lot of Veterans housed –

Diane Hanks: Yes.

Steven Dobscha: – Who weren't –

Diane Hanks: Yes.

Steven Dobscha: – Housed.

Diane Hanks: Or more previously housed.

Steven Dobscha: Yes. I would imagine that's having a positive effect.

Diane Hanks: Right, right. And next steps, you talked about what you're doing next in the study. Is there anything else that you'd want to add to that?

Steven Dobscha: Yeah, I mean the other things that came out of the study may be worth mentioning. We did interview staff –

Diane Hanks: Yes.

Steven Dobscha: – Primary care and mental health staff. And that was also an interesting finding for me because the staff were also fairly accepting of a structured program for screening for suicidal thoughts. And the reason I was surprised is because staff had a lot, there is so much –

Diane Hanks: So much that they have to cover.

Steven Dobscha: – Coming at them all the time –

Diane Hanks: Yes.

Steven Dobscha: – So much they have to cover. But they definitely appreciated the need. I think the staff, we mainly interviewed primary care and mental health staff, and they, both groups felt that better, more work could be done in care coordination after the screening. There were some challenges there. Someone screens positive in primary care, say, and what do you do next, right? And how do you get help and so forth?

 There were some challenges raised there. And mental health clinicians were also concerned about other effects on treatment. In other words, if they're spending a lot of time doing screening maybe they're not getting as much time to talk to the Veteran about the things that the Veteran wants to talk about or other things the clinician wants to talk about.

Diane Hanks: What is the typical wait time? Like, if a Veteran screens positive, what is the typical wait time? And what is the next step –?

Steven Dobscha: Well, the next step would be the –

Diane Hanks: – And in the process?

Steven Dobscha: – CSRE, the comprehensive evaluation. And that needs to be done the same day or at the very least, within 24 hours.

Diane Hanks: Okay.

Steven Dobscha: And that typically is done by a mental health professional, although it doesn't have to be. It can be another clinician as well. They pretty immediately get into some in-depth assessment.

Diane Hanks: Is there anything else in the findings that you'd like to talk about?

Steven Dobscha: I guess the last one is under disclosure. In our surveys we asked Veterans to what extent they were accurate in reporting their suicidal thoughts during the screening? And they had three choices, very accurately, somewhat accurately, and not at all accurately. And basically, we found that 14 to 40%, depending on which group, were less than very accurate in responding to the screening. And we found that for the people who had positive CSSRSs –

Diane Hanks: Yes.

Steven Dobscha: – They actually had higher rates of under disclosure or not being as accurate. In other words, they might screen positive, but my interpretation is, then when they're talking with the providers afterwards, they were more comfortable. They were not as disclosing –

Diane Hanks: Yes.

Steven Dobscha: – As how severe -

Diane Hanks: Yes.

Steven Dobscha: – It might be or maybe not on the screen itself. In that group they also, we also found that, if they were being screened by their providers, they were more likely to be accurate than by nurses and medical assistants. And then the other interesting finding is that non-white Veterans, and Veterans who had more psychological distress, and Veterans who were reporting more barriers to care in general were less likely to disclose accurately. And if people reported a strong treatment relate, therapeutic relationship or were more satisfied with screening, they were more likely to disclose accurately.

Diane Hanks: Do you think that finding, because this, one of the themes of this conference is equity and disparities, do you think it's because they mistrust all health systems as far as getting help? Or do you think it's something else? Or do you think it's an embarrassment about having a mental illness or having someone think they had a mental illness or?

Steven Dobscha: I think we don't know.

Diane Hanks: You don't know yet?

Steven Dobscha: I think –

Diane Hanks: Yes.

Steven Dobscha: – We can imagine that there is greater distrust in general of the healthcare system, but I think it's, that would be a next step, I think, would be to explore. Because that was a pretty striking finding that came out. We haven't looked at our mental health screened population in depth, and nor have we looked at our emergency department screening. We've got a lot left to do to understand –

Diane Hanks: Right.

Steven Dobscha: – People's experiences. And we need, as I mentioned earlier, we want to look at care utilization following screening.

Diane Hanks: Right. Do you know if suicide rates are higher among minority populations, minority Veterans populations?

Steven Dobscha: I think in general, they've traditionally been lower, although I think in the people of Hispanic ethnicity, there is some elevated rates. And we've seen that in some of our work.

Diane Hanks: Yes, I was just wondering. Okay. And is there anything else about the study that you'd like to talk about?

Steven Dobscha: No.

Diane Hanks: Okay. Is there anything that you'd like to say about the benefits or challenges of working within HSR&D research and behavior research in general?

Steven Dobscha: I think for me, I've been doing research in the VA for 20 years. I've been in the VA longer. I find it incredibly collaborative, at least in the HSR&D world. I appreciate the opportunity to work pretty closely with operations leaders. It's a fairly, in some ways it's a fairly flat system in that I –

Diane Hanks: Yes.

Steven Dobscha: – Feel like I can communicate with operations, and they actually are interested in some of the work we do. It's important and cross-cutting work.

Diane Hanks: Yes. I think that's becoming more of a thing these days where both sides are understanding how the other half lives, and what's important, and how they can help. And if you help me, I can help you, and that kind of a thing. That's becoming more and more beneficial. In VA research the data is pretty rich. That's also a benefit.

Steven Dobscha: Absolutely.

Diane Hanks: \_\_\_\_\_ [00:16:09].

Steven Dobscha: Yes, having –

Diane Hanks: Yes.

Steven Dobscha: – Access to all the large administrative data sets.

Diane Hanks: Yes. All right. Well, thank you. And I think that does it for us.

Steven Dobscha: Okay.

Moderator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research and do not necessarily reflect current or to be implemented VA policy. To learn more about this research, visit the VA HSR&D website at www dot hsrd dot research dot VA dot gov.

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