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Tragic Trends: Suicide Prevention Among Veterans

Testimony before the

Shelli Avenevoli, Ph.D.

Deputy Director, National Institute of Mental Health

National Institute of Health

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patients regardless of the reason for their ED visit - the number of patients identified as being at risk for suicide was double the number identified under usual care.[7] If used universally, the ED-SAFE researchers estimated that suicide risk screening tools could identify more than three million additional adults at risk for suicide each year. Use of enhanced suicide risk screening is expanding including in the VA, which began a new screening initiative in 2018.[8]

In addition to screening people for suicide risk during healthcare visits, we now know that it is possible for healthcare systems to use data from electronic health records in novel ways to help identify people with suicide risk. The first application of these methods to identify suicide risk occurred as part partnership with the Department of the Army in conducting the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS; the largest U.S. study of mental health risk and resilience ever conducted among military personnel).[9] Researchers from NIMH and Army STARRS then partnered with the VA to develop predictive models of suicide risk among veterans receiving VA health care. This research demonstrated the feasibility of developing algorithms to identify patients within the VA system whose predicted suicide risk was 20-30 times higher than average. While these patients with very high predicted risk were already receiving a lot of health care, most of them had not been flagged as having elevated suicide risk using existing identification methods.[10]

Using analyses of VA electronic health records, the research led directly to Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH-VET) program, which currently applies an algorithm each month to the VA patient care

[7] https://www.ncbi.nlm.nih.gov/pubmed/26654691
[8] https://www.blogs.va.gov/VAntage/55281/va-sets-standards-in-suicide-risk-assessment-offers-support-to-community-providers/

population to identify a small fraction (0.1 percent) of patients with the highest predicted suicide risk. Suicide prevention coordinators at each VA facility work with these patients and their clinicians on suicide-focused clinical assessment and ways to enhance treatment. The VA was the first healthcare system in the United States to utilize these methods in their suicide prevention programs. Other systems are beginning to follow the VA, including some of the 13 healthcare systems across the United States

Network.[11]

Identifying people who need help is a key first step, but screening alone is not sufficient. Improving patient outcomes requires that effective interventions be initiated during the health care encounter when someone is identified with suicide risk. Moreover, to enhance continuity of care, follow-up with the patient should be made when the patient is discharged back into the community. During the initial encounter, one promising approach is the Safety Planning Intervention adapted by the VA,[12] in which a clinician collaborates with the patient to identify specific strategies to

access to lethal means during a time of crisis, and to identify personalized coping strategies.[13] Safety planning can be combined with proactive follow-up with the patient, by telephone and/or in writing, to provide psychosocial support and encourage engagement in follow-up care.

-SAFE study, which focused on ED patients at risk for suicide, found that brief interventions in the ED, plus up to seven follow-up phone calls to the patient by a clinician, reduced suicide attempts by about 30 percent during a 12-month period.[14] Consistent with this

[11] https://www.ncbi.nlm.nih.gov/pubmed/29792051
[12] https://amhcajournal.org/doi/abs/10.17744/mehc.34.2.a77036631424nmq7
[13] https://www.mentalhealth.va.gov/docs/VA_SafetyPlan_quickguide.pdf
[14] https://www.ncbi.nlm.nih.gov/pubmed/28456130

finding, a recent study conducted in VA EDs found that a Safety Planning Intervention with follow-up phone calls reduced suicidal behavior by nearly 50 percent over 6 months, and doubled the likelihood of individuals receiving follow-up mental health treatment.[15]

Multiple agencies, including NIMH and VA, are supporting several research studies that have uncovered benefits from

are sent follow-up written communication by postcard or letter, or now also by text message in the weeks and months after they are identified with suicide risk. Such communications, which convey general support to the patient, have been found to reduce suicidal behaviors up to a half in the subsequent year.[16] While we do not yet know the exact how and why these follow-up interventions work, the common element is regular and supportive contact with the patient during a critical period when they transition between structured healthcare settings and the community. Research shows that caring communications is a very high-value intervention; that is, it is a relatively low-cost intervention compared to its benefits.[17] Telephone or written follow-up communications can be provided by the hospital where the patient was identified, from a centralized facility coordinated by the health system, or by staff from Crisis Line programs such as the National Suicide Prevention Lifeline or the Veterans Crisis Line. This type of proactive follow-up is, unfortunately, not yet part of standard practice.

For individuals who cannot be safely discharged to outpatient care because of severe suicide risk, there is an urgent need for fast-acting interventions. These individuals could receive rapid acting treatment in EDs and inpatient psychiatric units. Several potential fast acting medications have received recent Food and Drug Administration (FDA) approval: brexanolone

[15] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2687370
[16] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2723658
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750130/

infusion for severe postpartum depression, and esketamine nasal spray for rapid resolution of treatment resistant depression. Both of these medications must be delivered under an FDA approved Risk Evaluation and Mitigation Strategy. Other promising rapid acting interventions have been available for some time but have not been tested as a first-line intervention for acute suicide risk. We need studies that can determine safety, dosing, duration and combinations of treatments,[18] so that we avoid risk of addiction for some of these treatments (e.g., ketamine and/or related compounds), and find combinations of treatment that result in longer recovery periods. The VA has had Na

necessary to monitor the outcomes of patients who are identified as being at risk and treated. The 21st Century Cures Act (Pub. L. 114-255) called for the development of the federal Interdepartmental Serious Mental Illness Coordinating Committee,[22] which has specifically recommended that health systems track patient survival after events like an ED visit during which suicide risk is identified. The VA already tracks the mortality of all veterans, and links mortality data to healthcare data for veterans receiving VHA care. Some other U.S. health systems do so as well, including Medicare, Medicaid, and many of the systems that are part of the NIMH Mental Health Research Network. But most U.S. healthcare systems and health insurers currently do not link their populations to information on mortality, which has significantly limited the ability to both study and improve healthcare practices that could prevent suicide.

For many people, suicide risk is associated with comorbid mental illness. Early identification and effective treatment of such illnesses is important for many reasons, including the potential to prevent people from becoming suicidal in the first place. There are too few mental health service providers in the United States, and individuals who go on to die by suicide are most commonly seen by a primary care provider. Therefore, I want to highlight an evidence-based approach for treating mental illnesses in primary care settings called the Collaborative Care model. Collaborative Care is a specific approach

adding two key services: care management support for patients receiving mental health treatment; and regular consultation between a mental health service provider and the primary care team, particularly for patients who are not improving. Numerous studies including some conducted in the VA have shown that Collaborative Care improves the quality of care and

[22] https://www.samhsa.gov/ismicc

of their care, mental and physical health outcomes including faster recovery, and improved functioning in people with common mental illnesses.[23] Importantly, several studies have also found that Collaborative Care reduces suicidal ideation.[24,25] Medicare added payment for Collaborative Care in 2017, and some other healthcare systems and insurers are now also doing so.[26, 27]

In addition, I would like to highlight two other areas of research relevant to this hearing. First, access to 24/7 suicide crisis support anywhere in the United States is available through the toll-free National Suicide Prevention Lifeline.[28] The Lifeline is a critical component to U.S. suicide prevention, and offers access to .[29] NIMH includes the Lifeline as a crisis resource in all suicide prevention materials; media recommendations[30] for safe messaging on suicide state that providing ways to access crisis support is key. In addition, many NIMH suicide prevention research pro000050 g 543.22 Tm0 g0 G[ )]TJETQ0.00000912 0 612 792 reW*nBT3(a)-

access to

extensive media coverage of actor and comedian Robin Williams .[32] This points to the opportunity for public and private partners to work with the media to implement safer reporting and messaging about suicide,