Operationalizing the National Strategy: Engaging Your Team and Community

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VA Suicide Prevention Program Mission
Implementing a National Plan at Local Level

**KEY TENETS**

1. Suicide is preventable.
2. Suicide prevention requires a public health approach, combining clinical and community-based approaches.
3. Everyone has a role to play in suicide prevention.

**SHORT TERM PLAN**
The NOW Plan outlines five prevention strategies to implement throughout 2020-2021.

**LONG TERM PLAN**

- **Clinical:** Strategies grounded in evidence from the 2019 VA/DoD Clinical Practice Guidelines.
- **Community:** National call to reach the 11 Veterans who die by suicide each day who are outside VHA care.

Executive in Charge approved implementation to reach all Veterans.

Get a copy of the CPG: [here](#)
Operationalizing VA’s National Strategy to Prevent Suicide

Community-Based Prevention Examples
- 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 Intervention Examples
- Evidence-Based Psychotherapies (CBT-SP, DBT, PST, etc) — Across the Nation

Foundation of Adequate Mental Health Staffing
(7.72 outpatient MH FTE/1000 Veterans in outpatient mental health)

Plank 1: Lethal Means Safety
Plank 2: Suicide Prevention in Medical Populations
Plank 3: Outreach and Understanding of Prior VHA Users
Plank 4: Suicide Prevention Program Enhancement
Plank 5: Paid Media

Have you read the National Strategy?
Mentalhealth.va.gov/suicide_prevention
Community-Based Intervention for Suicide Prevention (CBI-SP)

Unified model from national to community levels, for all community-based efforts to end Veteran suicide.

**The Governor’s Challenge (VA/SAMHSA):** State policy makers partnering with local leaders in comprehensive suicide prevention plans

**Together with Veterans:** Veteran-to-Veteran coalition building and Veteran leadership development for suicide prevention

**Community Engagement and Partnership for Suicide Prevention (VISN 23 Pilot Expansion):** Community coalition building and enhanced capacity for outreach and education

**Outreach and Education:** Provides S.A.V.E. training, VHA facility partnerships, events, etc. through local Suicide Prevention Coordinators (SPCs) and does not change their critical role.
Working with Your Communities in Spreading the Evidence: Focused Priority Areas to Disseminate and Innovate

Identify Service Members, Veterans, and their Families and Screen for Suicide Risk
• Identifying Veterans — "Ask the Question" — enables culturally competent care and access to resources; allows community members, families, and community service providers to connect individuals to appropriate care
• Suicide risk screening in healthcare settings allows providers to recognize and prevent self-harm

Promote Connectedness and Improve Care Transitions
• Connectedness to others (including family members, co-workers, community organizations, and social institutions) is an important protective factor
• Providing caring contacts upon discharge from one setting to another can reduce suicide attempts and increase compliance with treatment recommendations

Increase Lethal Means Safety and Safety Planning
• Limiting access to lethal means during periods of crisis can make it more likely that the person will delay or survive a suicide
• Completing a personal safety plan is a clinical intervention that can help individuals manage and decrease suicidal feelings and help them stay safe when these feelings reoccur
Innovation + Evaluation: Key Partners for Success

- **2.0 Evaluation**
  - Designed evaluation with national experts in implementation science and program evaluation
  - Combination of interrupted time series and modified stepped wedge design
  - Assesses short, intermediate, and long-term impacts
  - Development of logic models for both Community-Based Intervention and Community 2.0 arms
  - Formative evaluation to help with design & roll-out
  - Process measures to assist with implementation

How are you incorporating program evaluation into your local programs?
The NOW Plan:
Five Planks, 19 Strategies (Including COVID-Specific Priorities)

- **Plank 1: Lethal Means Safety**
- **Plank 2: Suicide Prevention in Medical Populations**
- **Plank 3: Outreach and Understanding of Prior VHA Users**
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- **Plank 5: Paid Media**

Plank 4 strategy self-check: [Where are you? REACH-VET link] [Where are you? SPED Dashboard]
Foundation of 2.0: Associations Between MH Staffing and Suicide

• The **full** MH continuum of care is critical to suicide prevention.

• Greater mental health and staff FTEs per 1,000 patients has been shown to be associated with lower risk for suicide (Richardson, McCarthy, & Katz, 2017).

• Increases in mental health staffing are associated with decreases in suicide rates (Katz, et al., 2013).

• **QUESTION:** How have YOU engaged all parts of MH into SP implementation?
Lowering VA VHA Veteran suicide and slowing non-VHA Veteran Suicide

• **Decreasing suicide:** From 2017-2018 decreased suicide rate for VHA Veterans by 2.4%

• **Flattening the curve:** 2017-2018 increase in non-VHA suicide rate by 2.5%, compared to 8.7% increase in 2016-2017

Expanding life-saving interventions

• **Suicide Prevention Now Initiative** (Plank 4)
  • **Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH-VET):** exceeded all benchmarks as of 12/20, 6500+ Veterans served monthly. [Where are you? REACH-VET link]

  • **Safety Planning in the Emergency Department (SPED):** increased attempted safety planning from 28.5% at onset to 86% as of 3/21 [Where are you? SPED Dashboard]

  • **Suicide Prevention 2.0 Clinical Telehealth:** through 100+ hires across all telehubs across all 140 HCSs, targeting outreach to approximately 20,000 Veterans at high risk for suicide

Empowering and equipping communities

• Partnering with local/state communities through **Governor’s Challenge, Interstate VISN community prevention**, and **Together with Veterans** (Veteran to Veteran): covering 2,381 counties including 13.2 million Veterans

• Partnering with state and national policy makers in implementation of new legislation (e.g., Public Law 116-171, the Commander John Scott Hannon Mental Health Care Improvement Act, including grant making authority)

• In FY20Q4, partnered with Homeless Program to award $1.3 million in grants to 11 regional homelessness nonprofits to bolster suicide prevention
And So Does the Work of Your SPC Teams…

- Study: 1,364 Veterans high risk for suicide, association with SP contacts
- Each additional SPC contact = 4%–5% lower odds of suicide attempt, suicidal behavior, and reactivation of high-risk status in next year (p < 0.05)

“...regular contacts from a dedicated suicide prevention team during a high-risk period may reduce the risk of new suicidal behavior over time. During times of personal or community crisis...the SPC program provides a model for addressing risks related to mental health and for recovery enhancement.”

Yet Our Work is Not Done

Graph 3. Unadjusted and Age- and Sex-Adjusted Suicide Rates for Veterans and Non-Veteran Adults, 2005–2018

Do you know the National and State Veteran suicide data?

2020 National Veteran Suicide Prevention

How about your own facility’s Veteran suicide data?

Suicide Mortality Dashboard
What is the challenge?

**Research-Practice Gap**

It takes 17 years for research to reach practice.

Only 14% of research reaches a target recipient.

Only 18% of administrators and practitioners report using evidence-based practices frequently.


Not everybody loves a new idea

- Rate of adoption varies within a population or group exposed to an innovation
- Proportions reflect bell-curve
  - Innovators
  - Early-adopters
  - Early majority
  - Late majority
  - Laggards*

*Note: this is Rogers’ term and one I would rename. It’s not meant to be a judgment but rather denoting these are the last ones to adopt. Lots of contextual factors may cause organizations to be in this latter category.

Quick Poll:
How many of you apply Motivational Interviewing in your day to day work?

Applying Implementation Science to Our Efforts

• Grew out of Diffusion of Innovations research – applied to many areas of healthcare
• Studies barriers and facilitators for implementing new health care practices and programs
• Identifies key factors, principles and activities during:
  • Pre-implementation phase
  • Implementation phase
  • Sustainability Phase

Implementation Checklists and More: Developing Strategic Plans and Putting them in Motion

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Considerations for Your Plans
• Overarching program structure?
• Target population?
• Team members needed? Other stakeholders?
• Communication plans?
• Activities to implement?
• Methods to measure success?
• Methods of reporting?
We Are Progressing and Yet More Work Is Needed With All of You

Estimated Impact of the Anchors of Hope

- 91 Veteran souls with Depression alive in 2018
- 146 Veteran souls with Anxiety alive in 2018
- 36 Veteran souls with Mental Health/Substance Use Disorder alive in 2018
- 13 female Veteran souls alive in 2018
- 56 Veteran souls in VHA care alive in 2018
- 49,000 projected lives spared from exposure to suicide

While we are heartened by the Anchors of Hope, we are simultaneously burdened by the loss of every Veteran to suicide. We recognize the work yet needing to be done. We welcome your partnership and collaboration in this Mission.

Suicide is preventable. Each of us has a role to play in suicide prevention.