DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE OF MENTAL HEALTH

Tragic Trends: Suicide Prevention Among Veterans

Testimony before the

House Committee on Veteran's Affairs

Shelli Avenevoli, Ph.D.

Deputy Director, National Institute of Mental Health

National Institute of Health

April 29, 2019

Good evening, Chairman Takano, Ranking Member Roe, and distinguished Members of the Committee. I am Shelli Avenevoli, Ph.D., Deputy Director of the National Institute of Mental Health (NIMH) within the National Institutes of Health (NIH). It is an honor to appear before you today alongside my colleagues, Richard A. Stone, M.D., Executive in Charge, Veterans Health Administration (VHA); Keita Franklin, LCSW, Ph.D., Executive Director, Suicide Prevention, U.S. Department of Veterans Affairs (VA), Office of Mental Health and Suicide Prevention; and Richard T. McKeon, Ph.D., M.P.H, Chief, Suicide Prevention Branch, Center for Mental Health, Substance Abuse and Mental Health Services Administration (SAMHSA).

I want to thank this Committee for your sustained interest in the NIH, where we work to ensure that our nation remains the global leader in biomedical research and advances in human health. I also want to thank the Committee for bringing us together to address the challenges of suicide prevention in this country, for veterans and all Americans.

The Centers for Disease Control and Prevention (CDC) reported that 47,173 Americans took their own lives in 2017.[1] This is a part of a two-decade trend that has resulted in a 33 percent rise in the national suicide rate.[2] As the national lead for research on suicide risk and prevention, and as part of the National Action Alliance for Suicide Prevention, NIMH works with the CDC, SAMHSA, VA, and other federal agencies and private partners to better understand – and help reduce – suicide risk.[3]

Suicide prevention research is a top priority for NIH.[4] Over the past five years, NIH has steadily increased its support for suicide research across the spectrum, from basic to applied research. NIH spent approximately $52 million on suicide research in fiscal year (FY) 2016, $68

[1] https://webappa.cdc.gov/sasweb/ncipc/mortrate.html
[2] https://www.cdc.gov/nchs/products/databriefs/db330.htm
[3] https://theactionalliance.org/
[4] https://www.nimh.nih.gov/about/director/messages/suicide-prevention.shtml

million in FY 2017, and $96 million in FY 2018. NIMH continues to support research aimed at understanding the complex mechanisms underlying suicide risk to inform the development of transformative prevention and treatment interventions of tomorrow. We also support research to test the effectiveness of treatments, as well as identify promising new clinical interventions to prevent suicide and treat suicide risk. Together with our federal and private partners, we work to translate research findings into practice by facilitating wider use of evidence-based prevention and treatment interventions.

Comprehensive suicide prevention efforts require multiple approaches, within and beyond the healthcare system. I want to begin by focusing on opportunities within the healthcare system related to access and clinical innovations. It is estimated that nearly half of individuals who die by suicide see a healthcare practitioner in the 30 days prior to death, and around 80 percent do so in the year before death.[5,6] In addition, estimates indicate that approximately half of suicide decedents have at least one emergency department (ED) visit in the year before death. Recent research has identified several specific interventions that healthcare systems can implement to identify individuals with suicide risk more quickly, and help treat and reduce suicide risk to save lives.

A key step to helping someone with elevated suicide risk is timely identification. One way to do this is to ask people directly about suicide risk, especially in healthcare settings. The NIMH-funded Emergency Department Safety Assessment and Follow-up Evaluation study (ED-SAFE) demonstrated that a 3-item screening tool improved providers' ability to identify individuals at risk for suicide. This study showed that when screening was conducted on all

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026491/
[6] https://www.ncbi.nlm.nih.gov/pubmed/12042175

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 of NIMH's 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 the VA's 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/
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4286426/
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539821/

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 that are part of NIMH's Mental Health Research 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 decrease the risk of suicidal behavior, such as ways to reduce the patients' 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. NIMH's ED-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 an intervention called "caring communications," in which patients 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 National Protocol Guidance on Ketamine Infusion for Treatment Resistant Depression and Severe Suicidal Ideation since 2017, and there are VA studies, for example, testing ketamine for PTSD and treatment-resistant depression, and esketamine for suicide risk.[19,20]

Earlier I mentioned that comprehensive suicide prevention efforts require multiple approaches, within and beyond the healthcare system. The National Action Alliance for Suicide Prevention identified a range of best healthcare practices, collectively called Zero Suicide,[21] for improving outcomes among individuals at risk for suicide, and NIMH is investing in research to evaluate the real-world experiences of health systems that implement Zero Suicide programs. Zero Suicide practices include suicide risk screening, safety planning, treatments that target suicide risk (e.g. cognitive behavior therapy; dialectical behavior therapy), follow-up phone calls, and caring communication interventions I just described. To estimate the effects of such practices on suicide attempts and deaths, and to inform ongoing quality improvement, it is

[18] https://www.ncbi.nlm.nih.gov/pubmed/28249076
[19] https://www.ncbi.nlm.nih.gov/pubmed/29727073
[20] https://clinicaltrials.gov/ct2/show/NCT03788694?term=Marianne+Goodman&rank=2
[21] https://theactionalliance.org/healthcare/zero-suicide

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 that enhances "usual" primary care by 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

patients' satisfaction 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 the Veteran's Crisis Line.[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 protocols use the Lifeline as part of their safety assurance. NIMH research has shown that it is worth investing in quality improvements in telephone crisis services because these services can decrease distress and suicidal behavior, and improve linkage to care.[31] Utilization of these services is increasing, in general and especially after media coverage of the suicide deaths of celebrities. It is critical that we find ways to support increased capacity for national crisis lines during surges in call volumes after such widely-reported events. Second, researchers estimate that approximately 1,800 additional suicide deaths occurred after

[23] https://www.ncbi.nlm.nih.gov/pubmed/22516495
[24] https://www.ncbi.nlm.nih.gov/pubmed/14996777
[25] https://www.ncbi.nlm.nih.gov/pubmed/17038073
[26] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
[27] https://www.ncbi.nlm.nih.gov/pubmed/27973984
[28] https://suicidepreventionlifeline.org/
[29] https://www.veteranscrisisline.net/
[30] http://reportingonsuicide.org/
[31] https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12339

extensive media coverage of actor and comedian Robin Williams' death.[32] This points to the opportunity for public and private partners to work with the media to implement safer reporting and messaging about suicide, including information on how to get help. We can, and should, work together with the media to minimize "contagion" or "imitation" of suicides, including veteran suicides on VHA campuses.

In sum, there exist evidence-based approaches to reducing suicide risk. However, translating research into real world settings requires strong collaborations in order to facilitate and expand the use of effective suicide prevention practices to all communities, to change the "tragic trend." Our partnerships with the Army, VA, CDC, SAMHSA, and other agencies have led to important findings on suicide risk identification, interventions, follow-up care, and overall healthcare system improvements. As partnered Agencies, we are beginning to see how a growing number of healthcare systems — VA and elsewhere – are implementing evidence-based suicide prevention practices. Through the National Action Alliance for Suicide Prevention, federal and private healthcare partners are sharing information about lessons learned as they work to include suicide prevention efforts as a standard practice. To increase our potential to save lives, we must continue to leverage existing partnerships, build new ones, and improve suicide prevention strategies through scientific research.

[32] https://www.ncbi.nlm.nih.gov/pubmed/29415016