Action Alliance for Suicide Prevention (AASP)
Date: January 24, 2019, 9:30 -12:00pm
In-person with webinar option: Department of Health Tumwater office, PPE, Room 152

Attendees: Peter Schmidt, Cal Beyer, Julie Garver, Camille Goldy, Therese Hansen, Pama Joyner, Matthew Layton, Duncan MacQuarrie, Jan Olmstead, Dan Overton, Billy Reamer, Jenn Stuber, Beth Vandehey, Roy Walker, David Windom, Derek Smolenski, Andrea O'Malley-Jones, Carl Duman, Brett Bass, Colbie Caughlan, Reese Holford, Marshall Sana, Xinyao DeGrauw, Conrad Otterness, Jennifer Alvisurez, George Banks, Neetha Mony

Meeting Notes

Topic	Lead	Notes	Discussion
Welcome and agenda review	Peter Schmidt, WA Dept. of Veterans Affairs		
Introductions	ALL		• Matt Layton mentioned his students had a case of the week that included suicide assessment.

Native youth update	Jan Olmstead, American Indian Health Commission	• Youth at the 2018 summit wanted more skill-building activities. The 2019 summit will have more.
		• Confederated Tribes of Chehalis is co-sponsoring the 2019 Intertribal Youth Summit. There are 52 people signed up so far for the planning group.
		  ○ This year's summit will be Aug. 12-14 at the Great Wolf Lodge.
			• Question: Is there interest in a tribal hotline like the Veterans Crisis Line?
			  ○ Answer: AIHC can help get feedback on this.
			• Question: Is there any funding for tribes in the decision package?
			  ○ Answer: Of the proposals that made it in the Governor's budget, tribes could be eligible to apply for the community grants out of DBHR.

Department of Defense's suicide data	Derek Smolenski, Defense Health Agency	• The data is from the Armed Forces Medical Examiner (ME) System (for those currently serving) and the local ME (if in Reserves, regardless if currently serving).
		  ○ All reports are online and the 2017 report will be released soon.
		• The data are approximate values not exact.
		• While the total number of suicides might be increasing, the rate is relatively the same.
		• The suicides in active services match the expected suicide rates in the national adult population.
		  ○ WA has a much smaller population but our military suicide data is consistent with national rates.
			• Question: Why not include ages 60+ in the data?
			  ○ Answer: Fewer suicides lead to unstable data.
			• Question: Was 2012 an anomaly?
			  ○ Answer: Cannot say if something changed that year or not.
			• Question: Is there data on active reservists?
			  ○ Answer: Yes, in the annual reports.
			• Question: What about military families?
			  ○ Answer: The Defense Suicide Prevention Office might have some data.
			• Question: Is there additional info on means?
			  ○ Answer: The most common means are firearms followed by hanging. Most firearms used are personally owned, not military issued.
			• Question: What is the source data for suicide attempts?
			  ○ Answer: Taken from hospitalization records or evacuation from combat. Most of the time, an investigation is done.

Topic	Lead	Notes	Discussion
			• Question: Does the data differ by military branch? ○ Answer: The Army and Marine Corps suicide data has been consistent. The Air Force is seeing increases to match the Army and Marines.

VA Healthcare	Andrea O'Malley-Jones, VA Puget Sound
	Carl Duman, VA Puget Sound
		• The National Strategy for Preventing Veteran Suicide is a great resource.
		• In WA, VA Puget Sound serves 15 Western WA counties. There are VA centers in Walla Walla and Spokane too. Portland serves some southwest WA counties.
		• VA Puget Sound recently got some funding to send out caring letters to veterans. (Caring contacts is a best practice)
		• The VA uses standardized tools: PHQ-9 for screening, C-SSRS for assessment, and CSRE.
		• About 7% of the national population are veterans and about 1% are active service and reserves. Veterans make up about 13% of all adult suicides in the U.S.
		• "From 2005 to 2016, there was a smaller increase in the suicide rate among Veterans in VHA care (13.7%) than among Veterans who were not in VHA care (26.0%)."
		• There has been an 800% increase of VA healthcare use due to increased outreach. The VA has taken a Zero Suicide approach to reduce suicide.
		• www.coachingintocare.org for family guidance
		• Since June 2018, the Veterans Crisis Line has received more than 178,000 calls, chats, and texts.
		  ○ These calls are answered at 2 national hub centers and reports are sent to local VAs for follow-up within 24 hours. There is always a suicide assessment to determine care and referrals.
		  ○ VA Puget Sound service area has one of the highest call volumes in the nation.
		• In November, there was a GAO report on Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation
		• See handout on MIRECC Risk Management (p. 5-6).
			• Question: How can communities work with the VA for local suicide prevention work?
			  ○ Answer: The VA has free swag promoting the Veterans Crisis Line. Communities can contact Carl Duman to get materials. Larry Pruitt can be contacted for speaker requests.
			• Question: Are suicide rates higher for those just entering service or those in their first deployment and haven't seen war?
			  ○ Answer: Research shows both so it's hard to say.
			  ○ Comment: There is often an inability to deal with broken relationships.
			• From Justine McClure
			  ○ AFSP is partnering with the VA at the national level.
			  ○ Video on importance of partnership - https://vimeo.com/296050327
			  ○ Veterans and suicide - https://vimeo.com/293435647
			  ○ AFSP has a MOU with the Cohn Veterans Network- there will be an office opening in Tacoma soon - https://www.cohenveteransnetwork.org/about-us/
			  ○ AFSP's webpage dedicated to veterans - https://afsp.org/afsp-supports-veterans/
			  ○ They also hope to offer more Talk Saves Lives presentations to veterans and active duty dependents.
			• From Cal Beyer
			  ○ Helmets to Hardhats is a national, nonprofit program that connects National Guard, Reserve, retired and transitioning active-duty military service members with skilled training and quality career opportunities in the construction industry. It is affiliated with a sister program Wounded Warrior. - https://helmetstohardhats.org/
			  ○ For information regarding press and media, please contact: Darrell Roberts, 866-741-6210, droberts@helmetstohardhats.org

Department of Veterans Affairs	Peter Schmidt, DVA Daniel Overton, DVA	• Counseling and Wellness Program ○ Provide no cost counseling services for veterans, including for those serving in the reserves.	• Each of the cohorts (Counselors, Vet Corps, Vet Peer Corps, VCC-Interns all receive suicide prevention training and the Veterans Training Support Center (VTSC) offers suicide prevention training on a periodic basis.

Topic	Lead	Notes	Discussion
		○ Using funding from the state and King County to fill gaps that the VA can't serve. • Ecotherapy with veteran farmers for health and growth. • Veteran Peer Corps through the state legislature has 100 trained peer mentors. • Those with traumatic brain injuries (TBI) are more likely to die by suicide. • Other resources mentioned are the Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) and locally, the Max Impact TBI app. ○ Providers who serve veterans can consult on suicide risk management by emailing SRMconsult@va.gov.	
Veteran suicide prevention brainstorm	ALL	Open discussion	• What are we doing with upstream prevention for relationship issues and lifeskills during transitions? • 500,000 letters recently went out to people who might be eligible for VA services. • What is the transition process and resources? • Forefront attend a Resiliency standout at JBLM and distributed gun locks. • Add suicide prevention messaging in the private sector to mirror the expansive messaging in the military. • People lose touch when transitioning from military service to the private sector. Work with labor unions and industries to support veterans. • Collaborate with VA and DVA on spreading the provider network for veterans throughout communities. • In the UK, doctors can prescribe alternative therapies like equine or art therapy. • Continue work with veterans in higher education. • Presentation ideas: ○ Military transition process ○ How to reach out to providers in the community or VA ○ VA Choice program ○ The handshake process mentioned at the VA Behavioral Health summit
Legislative updates	ALL		• Bills of interest include ○ HB 1216, SB 5317 Concerning non-firearm measures to increase school safety and student well-being (OSPI's decision package proposal included)

Topic	Lead	Notes	Discussion
			○ HB 1221 Improving crisis planning in schools to prevent youth suicide. ○ HB 1240 Concerning suicide review teams. ○ HB 1648 Providing for suicide awareness and prevention programs to create safer homes and reduce suicide among service members, veterans, and their families. ○ HB 1876 Concerning children's mental health. ○ HB 1920 Assessing patient anxiety ○ SB 5027/SB 5072 – Extreme Risk Protection Orders
Announcements	ALL		• Continued progress on answering WA calls to the National Suicide Prevention Lifeline in-state. • The 2019 Suicide Prevention Education Day has been moved to March 6.
Summary and Path Forward	Peter Schmidt	*We understand meetings during legislative session might be challenging so all our meetings until July will be in Tumwater.*	The next meeting will be a webinar meeting with an in-person option 1-3:30pm on March 14 at the DOH Tumwater office.

CHRONIC Therapeutic Risk Management – *Risk Stratification Table*

ROCKY MOUNTAIN MIRECC

HIGH CHRONIC RISK

Essential Features

Common Warning Sign

- Chronic suicidal ideation

Common Risk Factors

- Chronic major mental illness and/or personality disorder
- History of prior suicide attempt(s)
- History of substance abuse/dependence
- Chronic pain
- Chronic medical condition
- Limited coping skills
- Unstable or turbulent psychosocial status (e.g. unstable housing, erratic relationships, marginal employment)
- Limited ability to identify reasons for living

Action

These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, and relapse on drugs).

These individuals typically require:

- routine mental health follow-up
- a well-articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- routine suicide risk screening
- coping skills building
- management of co-occurring psychiatric symptoms

INTERMEDIATE CHRONIC RISK

Essential Features

These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance abuse, medical and painful conditions.

Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without resorting to self-directed violence.

Action

These individuals typically require:

- routine mental health care to optimize psychiatric condition and maintain/enhance coping skills and protective factors.
- a well articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- management of co-occurring psychiatric symptoms

LOW CHRONIC RISK

Essential Features

These individuals may range from persons with no or little in the way of mental health or substance abuse problems, to persons with significant mental illness that is associated with relatively abundant strengths/resources.

Stressors historically have typically been endured absent suicidal ideation.

The following factors will generally be missing

- history of self-directed violence
- chronic suicidal ideation
- tendency towards being highly impulsive
- risky behaviors
- marginal psychosocial functioning

Action

Appropriate for mental health care on an as needed basis, some may be managed in primary care settings. Others may require mental health follow-up to continue successful treatments.

For more training and information on Therapeutic Risk Management of the Suicidal Patient please visit our website: www.mirecc.va.gov/visn19/trm

ACUTE Therapeutic Risk Management – *Risk Stratification Table*

ROCKY MOUNTAIN MIRECC

HIGH ACUTE RISK

Essential Features

- **Suicidal ideation with intent to die by suicide**
- **Inability to maintain safety independent external support/help**

Common Warning Signs

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

Common Risk Factors

- Access to means
- Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)

Action

Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.

These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances).

During hospitalization co-occurring psychiatric symptoms should also be addressed.

INTERMEDIATE ACUTE RISK

Essential Features

- **Suicidal ideation to die by suicide**
- **Ability to maintain safety, independent of external support/help**

These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.

Action

Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).

Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:

- frequent contact,
- regular re-assessment of risk, and
- a well-articulated safety plan

Mental health treatment should also address co-occurring psychiatric symptoms.

LOW ACUTE RISK

Essential Features

- **No current suicidal intent AND**
- **No specific and current suicidal plan AND**
- **No preparatory behaviors AND**
- **Collective high confidence** (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Individuals may have suicidal ideation, but it will be **with little or no intent or specific current plan**. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.

Action

Can be managed in primary care.

Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.

For more training and information on Therapeutic Risk Management of the Suicidal Patient please visit our website: www.mirecc.va.gov/visn19/trm

*Overall level of individual risk may be increased or decreased based upon warning signs, risk factors and **protective factors**