Disclosure Statement

I, Patty Ghazvini, do not have a vested interest in or affiliation with any corporate organization offering financial support or grant money for this continuing education program, or any affiliation with an organization whose philosophy could potentially bias my presentation.

Objectives

- Review the clinical guidelines set forth by the VA regarding the assessment and management of Major Depression in war veterans.
- Understand the prevalence and scope of suicide in our society and among our veteran population.
- Recognize warning signs and make necessary referrals.
- Identify treatment modalities and safety planning for patients at risk.

Introduction

- There are over 1.3 million U.S soldiers, sailors, airmen and Marines on active duty, and more than 150,000 of them are stationed in foreign countries.
- Korean War (1950 – 1953):
  - 5 million servicemen and women sent in to help in the war effort.
    - Of those, 140,000 were casualties, and 33,651 were killed in action. Overall, including North Korea, China, Korean Civilians, and the UN forces, there were over 3.2 million deaths.
- Today - 1.2 million veterans are still alive.

Depression, PTSD and the Risk of Suicide in Veterans

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Introduction

- **Vietnam War** – (1964 – 1975):
  - Over 9 million servicemen and women participated in the conflict. There were 211,000 casualties and 47,378 killed in action. Today there are still many veterans who are still living.
  - 1991 **Gulf War (GW)** - Multinational coalition that formed to oppose Iraq's invasion of Kuwait in 1990. The coalition included nearly 700,000 U.S. troops (~ 300 casualties) as well as military personnel from the United Kingdom, Canada, Australia and France; with over 30 partnering countries.
  - 2001 – **GWOT (Global War on Terrorism)**

Epidemiology

- The Global War on Terror (GWOT), including Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), Operation New Dawn (OND) are ongoing... (since 2001).
- Approximately 2.4 million US military personnel have served in Afghanistan and Iraq.
- Around 1.44 million have separated from the military – eligible for VA services and about 772,000 have used VA health care.

Unique HealthCare Needs

- Injuries associated with blast exposures (TBI).
- Mental health conditions: PTSD, depression, anxiety and substance abuse.
- Other health conditions: chronic musculoskeletal pain, medically unexplained symptoms (sequelae of environmental exposures) and sleep disturbances.
- Impairments in family, occupational and social functioning.

Statistics for PTSD, TBI, Depression and Suicide

- As of September 2014, there are about 2.7 million American veterans of the Iraq and Afghanistan wars (compared to 2.6 million Vietnam veterans who fought in Vietnam; there are 8.2 million "Vietnam Era Veterans" personnel who served anywhere during any time of the Vietnam War).
- At least 20% of Iraq and Afghanistan veterans have PTSD and/or Depression (RAND Study).
- Recent research on the Gulf War and Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans - increased risk for mental health problems: posttraumatic stress disorder (PTSD), depression, suicidality, neuropsychological deficits, and alcohol and drug use.

Statistics for PTSD, TBI, Depression and Suicide

- 7% of veterans have both post-traumatic stress disorder and traumatic brain injury.
- 19% of veterans may have traumatic brain injury (TBI).
- Statistical studies - rates of veteran suicide are much higher than previously thought, as much as five to eight thousand a year (22 a day, up from a low of 18 a year in 2007) – 2012 VA Suicide Data Report.
- 2016 VA Suicide Data Report - current analysis indicates that in 2014, an average of 20 Veterans a day died from suicide.

2016 VA Suicide Data Report

- Approximately 65 percent of all Veterans who died from suicide in 2014 were 50 years of age or older.
- Since 2001, the rate of suicide among U.S. Veterans who use VA services increased by 8.8 percent, while the rate of suicide among Veterans who do not use VA services increased by 38.6 percent.
- In the same time period, the rate of suicide among male Veterans who use VA services increased 31 percent, while the rate of suicide increased 35 percent among male Veterans who do not use VA services.
- In the same time period, the rate of suicide among female Veterans who use VA services increased 4.6 percent while the rate of suicide increased 98 percent among female Veterans who do not use VA services.

Presenting Problems

- Marriage, relationship problems and family
- Unemployment issues or work stress
- Lack of motivation
- Guilt, shame and anger...
- Financial hardships
- Lack of structure
- Nightmares, sleeplessness
- Education or training needs
- Feeling irritable, anxious or "on edge"

Stigma Associated with Mental Health Problems in the Military

- I would be seen as weak – 65%
- Unit leaders would treat me differently – 63%
- Other unit members would have less confidence in me – 59%
- Leaders would blame me for the problems – 51%
- It would harm my career – 50%
- Too embarrassing – 41%
- Don’t trust mental health professionals – 38%
- Didn’t know where to get help – 22%
- Don’t have adequate transportation – 18%
Case Presentation

★ A 24-year-old combat veteran presents to your clinic. He returned from Iraq 5 months ago after a year-long deployment as an army medic. He was exposed to several blasts from improvised explosive devices, and tell you he suffered a traumatic brain injury after one incident during which he momentarily blacked out.

★ He injured his back running on uneven ground while wearing a body armor, and has chronic pain for which he is taking oxycodone. He reports having a “short fuse”, and feels “constantly on edge”.

Case Presentation con’t

★ He also reports difficulty sleeping and frequent vivid nightmares. He drinks at least 6 beers a night to calm down.

★ His wife is upset that he doesn’t trust anyone, and she is frightened that he sleeps with a gun under his pillow. He has not been able to find a steady job, citing an inability to concentrate at work.

★ He tells you “it has gotten to the point where I really don’t care what happens to me.....”


GWOT

★ The Global War on Terrorism - September 11, 2001 terrorist attacks.

★ There were two major wars: Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF): Afghanistan

★ Soldiers have been involved for over 10 years and it is estimated that 2 million soldiers have been deployed. (Friends Committee on National Legislation, 2011; Lara-Cinisomo et al., 2012)

★ One in three returning Veterans from Iraq and/or Afghanistan will develop Posttraumatic Stress Disorder (PTSD) and Veterans returning home have a higher prevalence rate for depression, anxiety, suicide and substance abuse. (Friends Committee on National Legislation, 2011; Lasker et al., 2011; Veterans and PTSD Statistics, 2010)

★ Returning Veterans experience communication breakdown and decreased relationship bond with family/friends. (Pfefferbaum et al., 2011; Macan & Bolling, 2011)

Prevalence

★ 1.16 million veterans have registered for VA health care

★ December 2014 - 57.2% (662,722) received at least a provisional mental health diagnosis
  - PTSD (55%)
  - Depressive disorders (45%)
  - Anxiety disorders other than PTSD (43%)

2015 VA Report.
**Differences OIF/OEF & Past Wars**

- Younger group
- Less likely to be married
- Less likely to have been incarcerated
- Less often diagnosed with substance abuse disorders
- Fewer African-Americans
- More Latinos
- More females
- Required less VA disability compensation for PTSD

**Total number of soldiers who have been deployed during OIF/OEF**

- 1.6 million

**Total number of soldiers who have been deployed to a war zone twice or more**

- 700,000+

**77% Have shot at or directed fire at the enemy.**
U.S. Veteran-Specific Health Issues

- Chronic Pain – 82%; caution (use of opioids).
- Amputations – many develop mental problems related to the event (body issue images) – 1,573 vets have suffered major loss of limb amputations from battle injuries since 2010.
- Hazardous Exposures – Nuclear weapons and occupational hazards.
- Homelessness - 49,933 are homeless (12% of homeless adult population).
- Rehabilitation Care.

US Veteran-Specific Health Issues

- Substance Abuse Disorders – alcohol, tobacco, drugs; treat comorbid condition (depression, pain, PTSD).
- PTSD – experience almost 4-fold increase; associated with TBI, military sexual trauma (MST), sleep problems - treatment (psychotherapy, antidepressants).
- TBI – mild, moderate and severe
- Depression – one of the most common mental health disorders; diagnosis rate – 14%; more likely to commit suicide; 80 - 90% success rate (medications, psychotherapy, ECT).

Depression

- More prone to depression, at least partially as a result of exposure to traumatic experiences - witnessing combat and separation from family during deployment or military trainings.
- Army Study to Assess Risk and Resilience in Service members (Army STARRS) - 30-day prevalence of MDD as 4.8% compared to less than 1% – five times higher – among a civilian comparison group.
- A meta-analysis of 25 epidemiological studies - the prevalence of recent major depression based on the DSM-5 criteria at rates of 12.0% among currently deployed U.S. military personnel, 13.1% among previously deployed.


* Depression - 18-22 daily; young (18-44 years of age) – most risk; 11% of those survived will reattempt within 9 months.

* Depression - Millennium Cohort Study - July 1, 2001 to December 31, 2008, the risk of suicide increased in men and in those who were depressed.
* 2015 - among Veterans served by the Veterans Health Administration (VHA), the documented prevalence of any depression was 19.8%.
Clinical Guidelines for Major Depressive Disorder (MDD)

- 2009 - VA and DoD - Management of Major Depressive Disorder (2009 MDD CPG), which was based on evidence reviewed through 2007.
- 2014 – Updated;
  - Objective, evidence-based information on the management of MDD.
  - It also brought diagnostic criteria for MDD in congruent with DSM-5.

Outcomes of Interest

- Improvement in quality of life and social and occupational functioning.
- Improvement of symptoms.
- Retention (keeping patients engaged in treatment).
- Improvement in co-occurring conditions.
- Reduced mortality.
- Prevention of recurrence or relapse.

Goals of the Guideline

- Offer best practice advice on the care of adults who have a diagnosis of MDD.
- Recommend optimal assessment and diagnosis for MDD.
- Recommend best practices for treatment interventions (pharmacotherapy, psychotherapies and somatic therapies) in patients with MDD.
- Address indications for consultation and referral to specialty care.

Recommendations

- First four sections (Identification, Assessment and Triage, Treatment Setting and Management) - the core activities and decisions involved in caring for an individual with MDD.
- Last section (Other Treatment Considerations) - specific populations, complementary alternatives and secondary treatment options.
Identification
* All patients not currently receiving treatment for depression be screened for depression using the Patient Health Questionnaire-2 (PHQ-2).

PHQ-2 Interpretation
* PHQ-2 Interpretation – 1-6.
* PHQ-2 = 1, probability of MDD = 15.4%, probability of any depressive disorder = 36.9%.
* PHQ-2 = 6, probability of MDD = 72.6%, probability of any depressive disorder = 92%.

Assessment and Triage
* Suspected depression - assessment for acute safety risks (e.g., harm to self or others, psychotic features) during the initial assessment and periodically thereafter as needed.
* Appropriate diagnostic evaluation - determination of functional status, medical history, past treatment history and relevant family history.
* Diagnosis of MDD - Patient Health Questionnaire-9 (PHQ-9) - quantitative measure of depression severity in the initial treatment planning and to monitor treatment progress.
**Treatment Setting**

- Patients with complex MDD (severe, chronic or recurrent)- specialty care by providers with mental health expertise in order to ensure better outcomes and effective delivery of evidence-based treatment strategies.
- **Two studies:**
  - Cuijpers et al, found that combination treatments were more effective in managing depression when delivered in an outpatient mental health setting.
  - Krahn et al, found that referral of patients with more severe depressive symptoms to specialty mental health settings yielded significantly better outcomes.
- Additionally, in these patients with complex MDD, providers should assess for presence of psychosis and treat appropriately.

**Management**

- Non-pharmacological interventions and education
- Treatment for uncomplicated mild to moderate MDD
- Treatment of Severe, Chronic or Recurrent MDD (Complex)
- Monitoring (All Severities and Complexities of MDD)
- Continuation and Maintenance Treatments (All Severities and Complexities of MDD)

**Non-Pharmacological**

- Nutrition
- Exercise
- Sleep hygiene
- Tobacco use
- Alcohol use and abuse
- Caffeine use
- Pleasurable activities
Education and Communication

- Common symptoms and relapsing nature of MDD. Relapse risk increases as the number of prior MDD episodes increases.
- Take the medication daily or as directed by the prescribing provider.
- Takes four to six weeks before improvements are seen.
- Most people need to be on medication for at least 6 to 12 months after adequate response to prevent relapses.
- Education on side effects, which can precede therapeutic benefit, but may recede over time and can be addressed if the prescriber is informed.
- Do not discontinue taking medications without first discussing with their provider.

Uncomplicated Mild to Moderate MDD

- **Psychotherapy** –
  - Cognitive behavioral therapy (CBT)
  - Interpersonal therapy (IPT)
- **Pharmacotherapy** –
  - Selective serotonin reuptake inhibitor (except fluvoxamine) (SSRIs)
  - Serotonin-norepinephrine reuptake inhibitor (SNRIs)
  - Mirtazapine
  - Bupropion

Antidepressants

- Dose should be maximized in patients that show no response or a partial response using an appropriate titration schedule.
- Drug-drug interactions
- Sertraline may be the best choice for pregnant women and postpartum women who intend to breastfeed, due to the lower levels of medication transmitted to infants via breast milk.
- Fluoxetine has a long half-life and therefore may not be the best SSRI during pregnancy, in women planning to breastfeed, or in the elderly.

Antidepressants

- Bupropion may be considered for patients with MDD who desire to stop smoking, (contraindicated in seizure disorder or history of anorexia nervosa or bulimia and can potentially worsen anxiety).
- Bupropion and mirtazapine - for patients who have experienced intolerable sexual side effects with other antidepressants (e.g., decreased desire).
- Mirtazapine should be avoided in patients for whom weight gain or sedation would be problematic.
Mild to Moderate MDD

- Partial or no response to initial pharmacotherapy monotherapy (maximized) after a minimum of four to six weeks of treatment - switch to another monotherapy (medication or psychotherapy) OR augment with a second medication or psychotherapy:
  - Bupropion-SR to SSRI treatment (STAR*D trial)
  - Buspirone (STAR*D trial)
  - Lithium
  - Liothyronine (STAR*D trial)
  - 2nd Generation/Atypical Antipsychotics

Atypical Antipsychotics

- FDA approved for MDD as adjunctive treatment/augmentation: aripiprazole and quetiapine-XR
- Olanzapine is approved for the treatment of acute treatment-resistant MDD when used in combination with fluoxetine
- Treatment resistance - lack of full response despite at least two adequate treatment trials
- Two systematic reviews have demonstrated significant benefit of SGAs (alone or augmentation) for remission in MDD
- But also significant adverse effects (weight gain and sedation)

Treatment of Severe, Chronic or Recurrent MDD (Complex)

- Combination of pharmacotherapy and evidence-based psychotherapy
- MDD is characterized as:
  - Severe (i.e., PHQ-9 >20)
  - Chronic (duration greater than two years)
  - Recurrent (with three or more episodes)
- A large RCT (n=452) of antidepressants alone or in combination with cognitive therapy - combination treatment was more effective in severe, but non-chronically depressed individuals compared to monotherapy

Monitoring (All Severities and Complexities of MDD)

- At least monthly until the patient achieves remission
- Monitor:
  - Assessment of symptomatology using the PHQ-9
  - Adherence to medication and psychotherapy
  - Emergence of adverse effects
  - Symptom breakthrough
  - Suicidality
  - Psychosocial stress.
Continuation and Maintenance Treatments

- Continue antidepressants at the therapeutic dose for at least six months to decrease risk of relapse.
- Studies - among patients who achieve response with antidepressants, the six-month risk of relapse is about 41% if antidepressants are discontinued.
- Second phase - the continuation phase - necessary to sustain remission and prevent relapse.
- Three recent meta-analyses consistently reported that continuation treatment with antidepressants reduced relapse rates by approximately 70% compared with placebo.
- Patients at high risk for recurrent depressive episodes - treated with pharmacotherapy - maintenance pharmacotherapy for at least 12 months and possibly indefinitely.

Indications for Maintenance Therapy

- Two or more prior episodes, chronic major depression (greater than one year), or a major depressive episode in a patient with persistent depressive disorder.
- A family history - bipolar disorder and more severe depression as defined (the need for hospitalization, strong suicidal ideation or behaviors, longer duration of symptoms, and more residual symptoms after response to treatment).
- Co-occurring substance abuse disorder or anxiety disorders.
- Ongoing psychosocial stressors - inadequate financial resources, significant relationship difficulties, poor social support and chronic/severe medical illness.

Other Treatment Considerations

- **Specific Populations With Mild to Moderate MDD:**
  - Initiation of treatment in pregnant or breastfeeding women with mild to moderate MDD: psychotherapy (i.e., ACT, BA/BT, CBT, IPT, MBCT, PST) as a first-line treatment.
  - For older adults (≥65 years) - evidence-based psychotherapy (i.e., ACT, BT/BA, CBT, IPT, MBCT, PST) as a first-line treatment.
  - Light therapy for adult patients with mild to moderate MDD with a seasonal pattern (formerly seasonal affective disorder (SAD))

- **Severe, Chronic or Recurrent MDD (Complex):**
  - Patients with at least two adequate pharmacotherapy trials - monoamine oxidase inhibitors (MAOIs) or tricyclic antidepressants (TCAs) along with patient education about safety and side effect profiles of these medications.
  - Electroconvulsive Therapy (ECT)
  - Treatment with repetitive transcranial magnetic stimulation (rTMS) for treatment during a major depressive episode in patients with treatment-resistant MDD.
Suicide in Veterans

- Veterans account for one of every five suicides.
- Are less likely to seek care for psychiatric disorders
- Are more likely to successfully complete suicide and have a significantly higher suicide risk.
- In 2014, the Office of Suicide Prevention of the U.S. Department of Veterans Affairs (VA) - veterans have a 21% higher risk for suicide when compared to civilian adults.
- Combat exposure to trauma and death are associated with the development of various mental health conditions (posttraumatic stress disorder (PTSD) and major depression).

Risks of Veterans throughout the Lifespan:
20's and 30's

- Afghanistan and Iraq Veterans (OEF/OIF)
- Age of normal onset of Mental Illness
- Transitional Veterans (Military Lifestyle to a Civilian Lifestyle)
- Fearlessness, Recklessness and Impulsivity
- Increase risk for substance abuse/dependence

Risks of Veterans throughout the Lifespan:
30’s and 40’s

- Afghanistan and Iraq Veterans (OEF/OIF)
- Persian Gulf Veterans
- Career and Unemployment Issues ("searching for purpose")
- Transitional Veterans (Military to Civilian)
- Marital and Family Issues
- Increase risk for substance abuse/dependence
Risks of Veterans throughout the Lifespan: 50’s - 70’s
- Mandatory Military Draft
- Vietnam War Veterans (1964-1975)
- Anti-War Movements
- Grief & Loss Issues (Retirement/Death)
- Disability/Increase of Medical Issues
- Loss of Independence
- Retrospectively Thinking Back on Life
- Increased Risk for Substance Abuse Issues

Risks of Veterans Throughout the Lifespan: 70 Years and Older
- Korean War Veterans
- WWII Veterans
- Financial Issues/Cost of Living Increases
- Increase in Medical Problems
- Life Threatening Health Concerns
- Loss of Independence
- End of Life Issues

Suicide Risk in Veterans
- Veterans suffering from such psychiatric disorders have up to a 5.7-fold increase in the risk of suicidal ideation.
- The FDA has identified medications and drug classes with increased suicidality, designating them with black box warnings (BBWs). Addition of such medications to a veteran’s drug regimen can further potentiate the risk of suicide.

Risk Factors:
- History of suicide attempt
- Hopelessness
- Family history of suicide or suicide attempts
- Pain, particularly unremitting
- Presence of firearm in home or vehicle
- History of sexual abuse
- Homelessness
- Illicit Drug Use/Dependence
- Alcohol Abuse/Dependence
- Fearlessness
- Lack of social support
- Changes in financial status
- Unemployment
- Disability (Medical/MH Issues)
- Cancer
- HIV/AIDS
- Head injury (TBI)
- Impulsivity
- Legal Issues
- Family Dysfunction
- Lack of Coping Skills
Risk Assessment

- In 2013, the VA and the Department of Defense (DoD) - clinical practice guideline for the assessment and management of patients at risk for suicide.
- Updated in 2016
- The risk assessment should include evaluating suicidal ideation, suicidal intention, suicidal impulse, and suicidal attempt or preparatory behavior.


Methods of Suicide

- Firearms are the most lethal method of suicide
- In 2005, 55% of handgun deaths were self-inflicted (compared to 40% used in homicides)
- Veterans are trained to handle/use weapons
- Veterans usually have access to firearms, some have a collection of firearms

VA Clinical Practice Guidelines

- Organized into 4 modules with 3 algorithms.
- Algorithm A: Assessment and Management of Risk for Suicide in Primary Care.
- Algorithm B: Evaluation and Management of Risk for Suicide by Behavioral Health Providers.
- Algorithm C: Management of Patient at High Acute Risk for Suicide.
VA/DoD CLINICAL PRACTICE GUIDELINES - Modules

- Module A: Assessment and Determination of the Risk for Suicide
- Module B: Initial Management of Patient at Risk for Suicide
- Module C: Treatment of the Patient at Risk for Suicide
- Module D: Follow-up and Monitoring of Patient at Risk for Suicide

Goals of the Guidelines

- Promote evidence-based management of patients presenting with Suicidal Self-Directed Violent behavior.
- To promote efficient and effective assessment of patients’ risks.
- To identify efficacious intervention to prevent death in individuals presenting with Suicidal Self-Directed Violent behavior.
- To identify the critical decision points in management of patients at risk for Suicidal Self-Directed Violence.
- To promote evidence-based management of individuals with (post-deployment) health concerns and behaviors related to Suicidal Self-Directed Violence.
Assessment and Determination of the Risk for Suicide – Module A

★ Early identification of suicide ideation - the greatest opportunity to reduce the risk of suicidal behavior including death.

★ A. Any patient with the following conditions should be assessed:
- Person is identified as possibly having risk for suicide during evaluation and management of mental disorders (Depression, bipolar, schizophrenia, PTSD), or medical condition (TBI, pain, sleep disturbance) known to be associated with increased risk for suicide.
- Scores very high on depression screening tool and is identified as having concerns of suicide.
- Person reports suicidal thoughts on depression screening tool.
- Service member referred to health care provider by command, clergy, or family/unit members who have expressed concerns about the person’s behavior.
- Person with history of suicide attempt or recent history of self-directed violence.

Module A

★ B. Assess Risk:
- Evaluate the three domains: suicidal thoughts, intent and behavior.
- Observation and existence of warning signs and the evaluation of suicidal thoughts, intent and behaviors.
- Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk for suicide should be re-assessed regularly, particularly if their circumstances have changed.
- Observe the patient's behavior during the clinical interview (disconnectedness or a lack of rapport).
- Direct non-judgmental approach allows the provider to gather the most reliable information in a collaborative way and the patient to accept help.

Module A

★ C. Suicidal Ideation/Thought/Intent/Preparatory Behavior
★ D. Risk Factors (history of depression)/Precipitants/Impulsivity/ Substance Abuse/Assess access to lethal means
★ E. Determine the Level of Risk (Severity of Suicidality)
  - High acute/Intermediate acute/Low acute

Initial Management of Patient at Risk for Suicide – Module B

★ Three areas must be addressed: a safety plan, limitation of access to lethal means and patient and family education.

★ Safety plan:
- Early identification of warning signs or stressors
- Enhancing coping strategies (e.g., to distract and support)
- Utilizing social support contacts (discuss with whom to share the plan)
- Contact information about access to professional help
- Minimizing access to lethal means (such as weapons and ammunition or large quantities of medication)
Module C: Treatment of the Patient at Risk for Suicide

- Optimal evidence-based treatment for any mental health and medical conditions that may be related to the risk of suicide.
- Psychotherapy/Suicide-Focused Psychotherapy Addressing the Suicide Risk
- Pharmacotherapy:
  - Antidepressants
  - Antipsychotics
  - Lithium
  - Indication for clozapine – pts w/ a hx of suicide attempt, high risk for suicide, or who are symptomatic after two adequate trials with other antipsychotics.

- Anti-anxiety - caution when prescribing benzodiazepines to. risk of disinhibition and respiratory depression (particularly when combined with other depressants). Avoid benzodiazepines with a short half-life and the long-term use of any benzodiazepine to minimize the risk of addiction.
- Methadone substitution therapy should be considered in opiate dependent patients to reduce the risk of death by overdose.

Module D: Follow-up and Monitoring of Patient at Risk for Suicide

- Follow up: Establish timely and ongoing follow-up care
- Duration of Care Focused on Suicide Prevention: Patients who survived a suicide attempt or identified as high acute risk for suicide should be monitored for at least one year
- Reassessment and Monitoring
- Adherence to Treatment
- Documentation of Clinical Care
Best Practices for Care

- An interdisciplinary approach involving integrated teams of primary care, mental health, pharmacy and social work.
- Utilize local resources and facilitating interagency collaboration with local Vet Centers or with the VA.

VA Suicide Prevention Programs

Veterans Crisis Line: more than five years of saving lives

- 814,000 calls
- 94,000 chats
- 28,000 rescues
- 7,300 texts

Clinical Pearls

- Address barriers to care
- Establish a strong connection
- Conduct a specialized review of systems: combat exposures, illness/injuries during deployments, chronic pain, depression screen, PTSD screen and suicide assessment
- Involve all members of healthcare team
- Close follow-up is recommended
- Focus on function and reintegration
Conclusion

- Veterans returning from deployment – increased risk for a wide variety of physical, psychological and psychosocial health concerns with an increased risk for suicide.
- Many studies point out that PTSD has a pronounced effect on suicide risk especially in comorbidity with depression.
- More effective monitoring of active military service members and veterans are needed to ensure that their mental health and wellbeing needs are identified before they become suicidal.
- Evidence-based treatment - integrated into suicide management and prevention strategies.