Scott Tirocchi: Welcome, my name is Scott Tirocchi. I'm the Division Director for NADCP's Justice For Vets. We are very honored today to have Dr. Christa Marshall with us. She will be presenting on the topic, as you can see, suicide awareness and prevention, addressing the needs of our justice-involved Veteran population.

Before we get started, I'd like to say that this presentation is going to run for about 60 minutes, and then some Q&A at the end. That will be available on our website, and it will be recorded, and it will actually, it will be available for several months there. So please, refer back to it when you can.

And we're going to go ahead and I'm going to provide an introduction to Dr. Marshall. Dr. Christa Marshall completed her doctoral training at Roosevelt University in Chicago. Her dissertation examined differential diagnosis of posttraumatic stress disorder, and traumatic brain injury in Iraq, and Afghanistan Veterans.

She completed her postdoctoral training in Medical Rehabilitation Psychology at Heinz VA Hospital, specializing in spinal cord injury, polytrauma rehabilitation, neuropsychology, and blind rehabilitation. She has worked for the Veterans Health Administration to, delivering general mental health services via telehealth to rural clinic in Emporia, Virginia.

She has also worked in the Polytrauma Rehabilitation Center's Acute Inpatient Rehabilitation Unit, assessing, and treating Veterans recovering from from a variety of physical, psychological, and cognitive issues. She served as a national VA consultant for prolonged exposure and evidence-based psychotherapy used to treat posttraumatic stress disorder.

Dr. Marshall is currently in private practice in Rochester, New York, specializing in assessment, and treatment of neurocognitive, and emotional conditions. Without any further ado, Dr. Marshall, please take it away, and thank you.

Dr. Christa Marshall: Thanks, Scott. Good morning, everyone. I'm really excited to be here with you this morning. As Scott mentioned, I have a history of working in the VA. I trained and worked in the VA for about ten years, so this population is really near and dear to my heart.

And I have a long history of working with folks who have both physical and emotional trauma, both within the VA, and externally to the VA. So that's, kind of, where my area of clinical expertise comes from. I've also worked on a suicide crisis line when I was in college, and done a lot of work on assessing, and intervening with folks who are experiencing suicidal ideation.

And I currently am teaching in a graduate program where I teach students who are working for their doctorate in clinical psychology, how to assess, and handle clients who are suicidal. So this is a topic in a population that's

very near and dear to my heart.

So just to just as a disclosure, I am, this is being funded by the Bureau of Justice Assistance, but these views are my own, and are not a reflection of the Department of Justice, or the Bureau. Also, I worked for the VA for a long time, but the views that I'm expressing today are my own, not the VA's, or the Department of Defense's, or the U.S. government's; I'm just not cool or important enough for that to be an issue. I also have no financial conflicts of interest to disclose today.

Okay so I want to talk initially about the suicidal trends we're experiencing nationally, and then I want to talk a little bit more specifically about some subpopulations, and Veteran populations, and suicidal trends. I want to talk to you about the risk factors and warning signs of suicide within that specific Veteran population.

And then I want to talk about the nuts and bolts of how we actually deal with and approach suicidal clients, specifically within the Veteran population, and give you some, hopefully, tangible tools to take away with you. So, let's talk about suicide in the United States, generally.

It is the tenth leading cause of death in the United States. We lost about 50,000 people to suicide in 2019, with, and that was about little less than one and a half million suicide attempts. White men accounted for about 70% of deaths by suicide, and most of those deaths involved death by firearm.

Okay and so this is obviously, just the general population, this isn't a Veteran-centric population. But you can see, there's some pretty specific gaps there in, by race in terms of the prevalence of suicide. And I, you can see the implications here, especially in death by firearm for our Veteran populations, but we'll talk more about that in a moment.

I also just want to mention, I forgot to mention, if you have questions, please go ahead, and put them in the chat. And Cindy and Scott have agreed to be my, to help facilitate those questions toward the end of the hour. So, if you have any questions as we're going along, please don't hesitate to ask them. I just won't be taking them right now because I am not a good multitasker on Zoom. Okay.

We saw a general trend, which is pretty alarming, between 1999 and 2018, that the suicide rate increased 35%. Men are more likely to complete suicide than women. And from '99 to 2006, we had an increase average of approximately 1% per year, and then that doubled to 2% between 2006, and 2018. I can't sit here and specifically cite why this is, but I have a strong feeling that the the housing bubble, and the Great Recession that happened around 2008 did not help the situation from, in that time period.

So obviously, we're facing or we're in, we're still in, and Scott, and Cindy,

and I were talking about this before we got on, we got online for the discussion today. We're still in a very unique time, although some places are moving on, and mass mandates are disappearing, we still have a large population, a portion of our children, five and under who are not vaccinated.

And we have a significant portion of people who are immunocompromised who don't respond to the vaccine, and who still feel the need to protect themselves from COVID. And and it's been a long two years, and we've all been in survival mode.

So even though some of this data is relatively old, it was coming out just at the beginning of the pandemic, we're, we're still emerging from that. And I think we're going to be seeing repercussions emotionally for quite some time.

So there's some early data that suggested a 13% increase in pandemic related suicides in Fresno, California; that was 70%. In New Mexico, suicides tripled in 2020 as compared to 2019. We also know that young people reported in a CDC survey that they were, had considered suicide at a higher rate, about 25% of people ages 18 to 24 considered suicide. And 11% said they had seriously considered it in the past month.

And a lot of them were saying that they were turning to alcohol and street drugs to help themselves deal with pandemic-induced stress and anxiety. So what we, and we know this. There was all kinds of data that was coming out at the beginning of the pandemic that online alcohol sales went through the roof, right, and that we were seeing a lot of deaths of despair.

So even though, so we have suicide, and then we have, we have deaths of despair. Deaths of despair are things where, like, people who have accidental overdoses from overdosing on opioids, or benzodiazepines, or other substances. Deaths of despair can be fueled by a lack of availability of treatment options.

We know that a lot of facilities cut down the number of open beds that they had for mental health and substance use; and or some closed down altogether. So, we really were dealing with a tremendous amount of uncertainty, especially in those earlier days of the pandemic, and we're still feeling the repercussions from that.

So according to the National Institutes of Mental Health, the main risk factors for suicide are a prior suicide attempt, right; depression or another mental disorder; a substance use disorder; having a family history of mental health disorders, substance abuse or suicide. Being in prison or jail, being exposed to other suicidal behavior; a medical illness; and being 15 to 24, or over 60.

So, we have these two risky periods for people, adolescence and early adulthood seems to be one risky period; and then over 60 seems to be another. And we'll talk more about that specific to the Veteran population

later in this presentation.

But I mean, if you take a look at our, at this list of risk factors, when you think about a Veteran population, it's not surprising at all that they, that there's such a high overlap, and there's such a high incidence of suicide, either attempts or completion within this population.

So okay, come on, computer. There we go, so let's get down to talking about the specifics within the Veteran population. So, Veterans are about 50% more likely to complete suicide when compared with their non-Veteran peers. And the numbers vary depending on what study you look at, but somewhere around 20 Veterans complete suicide every day, which is just an incredibly high number.

And Veterans report that suicide or thinking about suicide is one of the biggest challenges that they face. And so, we also know that, again, just like in the previous slide, for the general population, that there are specific time periods that it, that are, sort of, critical periods for people where their likelihood to complete suicide increases. And that's that, the adolescence early adulthood, 18 to 34, right, and also from 55 to 74 for Veterans.

Interestingly, suicide rates do not increase if the Veteran is above 75. And we can talk about potential reasons for that later, but that's, sort of, an interesting, protective factor once you hit 75. In the Veteran population, males are three times more likely to complete suicide than females. When compared to the U.S. female population, female Veterans are two times more likely to complete suicide.

Male Veterans are more, 1.3 times more likely to complete suicide than their male peers in the civilian population. And we also, we don't have as much data on our LGBTQ Veterans, but we do know that their suicide rate is twice as high as cisgendered Veterans.

So, we know that being a Veteran and being a member of the LGBTQ population are both risk factors for suicide, but it, they, sort of, coalesce, and make it an even more stressful experience for people.

So, this data is really interesting. And if anybody cares for me to pontificate on it, I can later; but everyone would, kind of, assume, I think, that deployment would be related to an increased risk for suicide. And that's not necessarily the case.

So, when we compare to the general U.S. population, active duty Veterans have a general increased risk of suicide at 56%, increased risk. And then the post-9/11, and the Reserve, and National Guard Veterans had a 29% increased risk. However, non-deployed post-9/11 Veterans had a greater suicide risk than deployed post-9/11 Veterans.

That's right, the folks who were NOT deployed had a higher suicide rate. And I think there's a lot of things that could potentially explain that in terms of where people are putting their energy, and where, the assumptions we make about what should be traumatizing, or what should be a challenge in terms of reintegration.

So interestingly, in studies from the 1990s, Vietnam and Gulf War Veterans showed that their suicide rates were lower compared to the general U.S. population, which is not a fact that's often highlighted very much. So, something has really changed for Veterans of these newer conflicts. And we're still trying to figure out what it is.

Okay if we look at a study of Vietnam Veterans from 1996, Veterans with the greatest risk were white, had been wounded more than once, and were hospitalized for at least one of those wounds. So that makes sense in some level, that physical trauma would increase the risk of potential suicidal ideation, or action.

And when we looked at Veterans who were wounded and Veterans who were not wounded, the Veterans who were wounded had a higher accrued rate of suicide, but when we adjusted for demographic differences, this, the findings were no longer significant.

So, we really need to look at how physical injury affects somebody's likelihood of experiencing suicidal ideation or attempting to complete suicide. So that's still very much an area where we're looking for some clarity.

Here's what we do know; that an increase in suicide rate is consistent with an increase in mental health hospitalizations, and poor mental health. In other words, if we look at the data from the beginning of this century, we can see that if someone was depressed, and hospitalized for that depression, that increased their risk of suicidal, suicidality two-fold.

If they were abusing alcohol or dependent on alcohol, that increased their suicidality two-and-a-half-fold; substance use, five-fold; and PTSD or suicidal ideation increased the likelihood that they were experiencing problems at ten-fold.

Right, so we really want to know, at the bottom line, is we really want to know our Veterans' history. When they come into our courts, it's really important that our intake process does a good job of trying to understand what their history is with substances, with mental health, but also to understand what their history was like with the military.

Because it, depending on – we like to lump all Veterans together, I think,. "Well, they're a Veteran so they're like this." But the truth is that there's a, quite a bit of variability in in our Veteran populations, and sub-populations,

and we need to be paying attention to the factors that make them more unique, and therefore potentially more at risk.

So the risk of suicide depends, for our – let me be specific. For our OEF and OIF Veterans, the risk of suicide depends on how, is, it's correlated with how long it's been since they've been out of the military. So the highest risk of suicide for this this group of Veterans is within that first year post-discharge.

And then there, it still remains high for about three years post-discharge. And so, the more time someone's given to be able to adjust, the risk of suicide goes down. But still we find that non-deployed Veterans had a higher suicide risk than deployed Veterans.

Okay so again, we have this bimodal distribution just like in a civilian population where we see those adolescents and early adults have a higher rate of suicide; and again, the, our older folks 55 to 74. So, there's a lot of reasons for this, potentially.

I think that early, 18 to 34, I think, we're seeing – the 18 to 25 is when the frontal lobes haven't fully developed yet. Your frontal lobes are the part of your brain that indicate when you are, that help you solve problems. It's in charge of something called executive functioning, which is really important for making good choices and decisions.

And so, this is why car companies don't, won't allow anybody under 25 to rent a car without an extra fee. Because they assume anybody under 25 doesn't have fully, fully formed frontal lobes., and that's why they are at increased risk of getting into an accident, right? So, you can see that this fragile period within human development falls neatly into this category of increased rate of suicide.

When we look at that slightly older population, my suspicion is that a lot of them have difficulty transitioning, which I'm going to talk about more later. And they're looking at their civilian peers who didn't serve. And in many ways, Veterans are told that serving in the military is going to further their opportunities in life.

And for many of our OEF and OIF Veterans when they transition back out of the military, the workforce was not ready for them. The workforce didn't have what needed, what it needed to be able to help them acclimate to the civilian world. And so, sort of, the bill of goods they were sold going in doesn't always match the experience they have coming out.

And then when we look at our older population, and I will talk more about this again later. You have, I have a lot of guys who cope with their trauma, and their mental health issues with a lot of physicality. Right, playing basketball, going for a run, what have you. And this is, and for many of them, it works quite well.

And so, then you had, I saw a lot of people come into our clinics because they were having trouble coping with their mental health for the first time in that age range, 55 to 74. And a lot of them, it was because they had blown out their knee, and had to have a knee replacement. Or they were starting to have cardiovascular problems and couldn't run anymore.

And so we see that the, that their coping strategies have changed or been eliminated in older age. And now, we need to help them regain a sense of control of their lives, and of their mental health.

We also know that gender plays a big role. Male Veterans are three times more likely to complete suicide than female Veterans. Again, we don't have exact numbers about our LGBTQ+ Veteran population, but we know that they're at an increased risk than their cisgendered peers, cisgendered straight peers.

So, Veterans who were deployed during their time of service, again, have a lower suicide rate, which is surprising. And then Veterans who were hospitalized, probably for a physical or a mental health issue, have a greater suicide risk; and again, that there's that risk period in the first year.

So why are these rates higher for Veterans? So obviously, if we look at just general mental health conditions, and rates within the suicide or within the Veteran population, we see that Veterans experience trauma-related and mood-related issues at a much higher rate than the general population.

And from our previous slide, which correlated risk, if you've got a mental health issue, you are more likely to experience suicidality or attempt suicide, right? So right off the bat, they have a higher risk, yeah, a risk, than the general population. Obviously, combat and deployment can create issues for them.

There's also a tremendous amount of isolation that Veterans feel when they come back from their time in the service. So especially, this was true. When we were, when World War II Veterans were coming back. They would come back on a boat, most often, and they had weeks or days to process what they had just been through with other Veterans.

Now, when you are taken out of the theater of combat, you can be back stateside, or at least in Europe in a safe zone within hours, if not days. And so, the ability to decompress is oftentimes nonexistent for them. In addition to that, we, in and Iraq and Afghanistan, we utilized National Guard, and Reserve folks at a much higher rate than we had in previous conflicts.

And so, these folks, as opposed to active duty units who are housed with, and live with, and know their fellow service members really well, because they all live together; our National Guard and Reserve folks have a less tight bond

in some ways than the active duty folks. And so, when they come back home, they're not going home to a base that's supportive, and going to help them decompress. They're going back to home, right away, to their civilian lives, and that can often create even more tension, and difficulty for them in transitioning.

We have issues with relation to military sexual trauma. We have traumatic brain injury, health issues. Grief, and moral injury, a lot of Veterans suffer with what they've done in the name of their service, and or need help coping with that afterwards.

And there's all kinds of other risk factors, including difficulties within their families when they come back, financial problems, legal problems. The military, in some ways is a very stabilizing force: You have food, you have shelter, you have clothing.

Like, there's, there's some constancy there. And when people eventually transition out of the military, a lot of the consistency that helped them cope with the world isn't there anymore, or is less available. And as a result, that can increase their susceptibility to, just to risk of suicide.

Let's talk more about what the research tells us. So, this is why – there are lots of models out there that try to capture what is happening in a population, specifically a Veteran population with respect to suicide. But I find this one particularly compelling.

So, the interpersonal-psychological theory of suicide says that suicide occurs when all three, when all three of these things are present, and only when all three of these things are present: A sense of high, a high sense of burdensomeness, feeling like a burden to your, to your community, or to your family. A low sense of belongingness, not sense, not feeling like you belong anywhere in your workplace, in your community, in your family. And having the ability to enact lethal self-harm, right?

So, we can intervene. When we look at this model, we can intervene at all of these different levels. And if we take one, two, or three of them out of commission, we have a higher likelihood of being successful in terms of decreasing that Veteran suicide completion rate. So we know that our modern Veterans are a very different population than our World War II Veterans.

So, we know that that sense of shared military culture is really important, when, especially when people are returning to civilian life. And when you look at the population, about 50% of males, and 15% of women, which is really surprising – I, that always surprises me – of our World War II population, that's how, what percentage of the general population was participating in the war.

Right, and if we look at Iraq, and Afghanistan, about only 12% of the

population is male, and 3% female, have participated in some way. What that means is if you were coming back from World War II, everybody around you either served, themselves, or knew somebody who served.

And that's definitely not the case if, for our Iraq, Iraq, and Afghanistan Veterans. They come home to people, to civilians who are must, much less comfortable with the Veteran, or military culture, and are not as sensitive to the issues that that population is going to face.

When World War II ended, we had a very low rate of unemployment for our World War II Veterans. A lot of them returned back to the factory jobs that they had before they left. And in Iraq and Afghanistan, the rate of unemployment for those Veterans was about seven to 8%.

And when you look at the education populate, the education split, about less than half of our World War II Veterans graduated high school, and yet we have a more educated Iraq and Afghanistan Veteran population. So, what's the promise of education?

So many people enter the military to get their education paid for, and so they think, "Okay, well, I did better than my grandparents. I did better my parents; not only did I graduate high school, I graduated with a bachelor's degree." And now I'm unemployed? My grandfather had a job, I don't have a job.

Right, so again, a lot of the promises that they felt the military would afford them don't come to fruition, or didn't come to fruition in the sense that they thought they would. And as a result, sometimes Veterans are seen by civilians to have a sense of entitlement, like, "I should have these things." And that can create further tension between the Veteran and civilian culture as people are trying to reintegrate back into a civilian workplace.

So if you think about it, they're coming home. They feel less belonging, right, because the rest of the civilian population doesn't understand them, and doesn't, and doesn't even know somebody who might understand them. And they feel like a burden. They feel more like a burden because they have a greater sense of, or a greater rate of unemployment than groups of Veterans past.

Okay so more than 40% of Veterans say that they've experienced high levels of difficulty transitioning. Studies show that those individuals who are reporting difficulty transitioning have a five-time increased likelihood of experiencing suicidal ideation. And about 80% of Iraq and Afghanistan Veterans will tell you that they, the public doesn't understand their problems.

And more than 80% of civilian organizations have no Veteran specific recruiting programs, and more than 50% of them have a no onboarding or transitional support to, for Veteran hires. So, when you think about it, those programs are really essential to give people, to give Veterans a sense of

belongingness when they enter an organization.

I worked with a guy who is now incredibly successful. He's a, he's a major, he's an executive within a branch of government service. and he's, he's done a really great job, but he would be the first to tell you that the thing that helped him transition most was that when he got the government job he got, there was a group of Veterans willing to support each other through that hiring process.

And through that negotiating, like, how do I talk to my civilian boss versus how would I have talked to my military boss? There's, there's different ways of communicating here, and I don't know the script, right? And so those support organizations are really important.

So those who have combat experience report a higher degree of difficulty adjusting than those who did not have combat experience. And about 35% of that say they have a hard time paying their bills, right, within that first year of leaving the military.

And again, for a group of people who had their housing supplied, had their – I mean I realize, some people live off-base, and whatever, but for those who did have their housing supplied, their meals supplied, their clothing supplied, this is a big change in quality of life.

And about half of NCOs and enlisted folks would say that the military prepared them well for a transition to a civilian life. So, a lot of people feel hung out to dry after they get out of the military.

So, there are some specific Veteran, specific risk factors to look for in the Veteran population that increase that risk of suicide. So, substance abuse, and we know that military culture is one where drinking is a really big part of, of the culture. Binge drinking tends to be prevalent in the Veteran population or in the, and in the active-duty population.

And so those who have a substance use disorder of some kind are at twice the risk of suicide. And Veterans, female Veterans who have a substance use disorder are five times more likely to complete suicide, right? We've seen a tremendous uptake, uptick in the amount of deaths in our country related to opioid use.

Now, I know we've been talking about that for years now at this point, but just since the pandemic hit, the increased availability of fentanyl, and fentanyl being slipped into heroin, has gone way up. And we've had a significant amount of deaths as a result of that. Some of them may be intentional overdoses and some of them probably, very much unintentional overdoses.

So, we definitely want to be cautious when we understand that one of our

Veterans is using opioids. That really needs to be a focus of clinical attention for their safety.

We know that insomnia is a huge risk factor for Veterans. I have a civilian patient who is only ever suicidal when she wakes up in the middle of the night and can't get back to sleep. It's happened twice now, and so we're really, really cautious about keeping her medications far away from her, from her bedside because she doesn't need them nearby when she's, when she's getting triggered like that.

Insomnia makes it difficult to think clearly, right. Sleep has restorative functions for us, and when we don't sleep well our, our thinking is not as clear, and our ability to regulate our emotions goes way down. Right, so getting good sleep, this is, kind of, one of my soapbox things; like, this is for all you in the audience. This is for all of our patients. This is for all of our Veterans.

Sleep is precious, and we really have to work on getting good sleep because it's the building block for everything else. Okay. We also want to be looking at what kinds of medications our Veterans are using? So, things like benzodiazepines, pain medications, and that kind of thing can be a significant risk factor for suicide.

Sexual dysfunction is something that a lot of people don't want to talk about, but it is a huge risk factor for folks. You can think about, and I'm going to use male Veterans as a, as a particular example here; although women certainly experience sexual dysfunction at a high level. For a lot of men, their ability to perform sexually and engage with their partner sexually is a big part of their masculine identity and even just getting up the courage to ask a doctor about sexual dysfunction, and treatment for sexual dysfunction is a big, uncomfortable thing.

I'll never forget when I had a Veteran come into my office, and he was in his late 30s, I think. And he, it was causing a lot of problems, sexual dysfunction was causing problems in his marriage with his wife. And he went to, he had the guts, bless him, to go to his primary care doctor, and say, "I'm here really struggling with this, can we talk about an issue? Maybe some medicine to help me?"

And she said to him, "You have way bigger things to worry about in your life than this," and refuse to talk to him any further about sexual dysfunction. And I think that is a crime. This man had enough courage to say, "I want to be able to be close to my wife, I want to be able to have sex with her." And this doctor completely dismissed his need. You can bet, he probably didn't go back and ask again. And so, we really need to take those conversations seriously when someone says that that's a problem for them.

I don't know why low cholesterol is on the list, if I'm being completely

transparent; I really don't. But it's there, it's, and remember, this is correlational data, and correlation isn't causation.

So, my, if I had to guess, I imagine, it has something to do with diet, is the real culprit. But the thing that it's correlating with is cholesterol; I would be on the lookout.

So obviously, we talked about before, mental health conditions, including brain injury, right. We know a lot of our Veterans come back with mild traumatic brain injury or some type of post-concussive syndrome.

And then there are a lot of social determinants of health. So, whether or not the Veteran is coming back to a violent community or a violent household? Whether they have stable housing, they're having financial or employment problems, legal problems, familial or social problems, lack of access to health care, and transportation, and other, sort of, psychosocial needs that we haven't listed here.

Alright, this is the big one, right? And if you remember way back to that first slide, about 50% of suicides are completed with a firearm. And we know that this population are very, very fond of their firearms, right, and they have a lot of fears about getting mental health treatment. Because they're afraid that their firearms are going to be taken away.

And so, it's actually a very rare thing for any clinician to make an attempt to remove somebody's, legally restrict somebody's access to a firearm. More often than not what we attempt to do when someone is feeling suicidal is negotiate with them to temporarily give the firearm to a trusted other, so that they temporarily don't have access.

So that's, sort of, a myth that I think is really important to address with this population, and I've had to address it over, and over again: I'm not here for your firearm. I'm here to keep you safe, I'm not going to take your legal right away. I just want to talk to you about how to decrease the risk. Okay.

Suicides are about two to ten times more likely in a home that has a firearm. And we do see some variation based on the age of the population, and how people store their firearms. When I used to work at the VA, we would hand out gun locks like they were lollipops. And I think that was a great program that we had.

So, the problem is that, there's not just an increased risk to the gun owner, but anyone living in that household, of suicide. In addition, I'll never forget a Veteran who told me a story about, he had pretty significant PTSD. And he was divorced so his kids split time at his house and his ex-wife's house.

And his college-age daughter decided she was going to come home to his house late at night, didn't tell him she was coming. And he got triggered, and

thought somebody was breaking into his house, and he pointed a gun at his daughter, and almost shot her. Right, so there are increased risks of firearms in the home, period, when we've got a Veteran population. And so, we want to navigate that carefully, but we also want to present them with that reality in a straightforward way.

Okay so we talked about that first transition period, right, which was that early adolescence, and again, brains aren't fully developed, that, and then there's so much pressure financially to transition back. And that's probably why that 18 to 35, or 18 to 34-year-old population is at increased risk. But that's also true for our older Veterans, right?

So they call this the Hemingway effect, after Ernest Hemingway. And he was an American writer, and a Veteran, and he died at, of suicide at 61. And when we look at the things that he was, the risk factors that he had, it actually makes a lot of sense.

So, he had, he was never in the military. Okay, my notes, he was never in the military, but he served extensively in combat experiences. He had a high genetic loading for suicide because his dad, brother, and sister all completed suicide. He had a lot of back pain from two separate plane crashes.

These are things I didn't know about Ernest Hemingway until this this presentation. It's, kind of, crazy to think all, that life was so full. He was a heavy drinker, and he had cirrhosis of the liver because of that. He had access to firearms. It's well-documented that he had some pretty severe mental health problems.

And when you – and he was estranged from his social support network in more ways than one. So, when we put that all together, he had a decreased sense of belongingness, right, if we go back to that, that diagram with the three bubbles, right. He had a decreased sense of belongingness because he was isolated from his family and his community. He had an increased sense of burdensomeness because his health was failing, and he was in chronic pain. And he had the means, right, he had the means to harm himself.

So, and when we look at this in a more broad sense for older Veterans, we often see a lot of the same things, right. Their family members and friends are passing away because everyone is ageing. They feel isolated. They may or may not be able to leave their homes anymore with ease. Their health conditions are isolating them and preventing them from working. And their military experiences in and of themselves put them at higher risk.

Okay so let's talk about some of the strategies, and initiatives that the VA has put in place to try and help Vets be safer and decrease the risk of suicide. So, there's the REACH VET program, which started in April of 2017. And basically, what they did was – we're just going to go through; I mean, the VA has a lot, quite a powerful electronic medical record system. And it's

probably the biggest and most functional electronic medical record system across the whole country.

And so, one of the things they did was every month, they generated a list of the most at-risk Veterans and they base that on all those risk factors that I talked before: age, marital status, diagnoses, and their prescriptions. That's what they were specifically looking at, and that population they culled when they did that search, they estimated that their increased risk of suicide was 40 times that of the average person.

So, this is the highest risk of the highest risk population. And so, they created a dashboard that allowed them to track these folks as they went along. In the first year of the project, they identified 30,000 Veterans, and the early data on this program indicates that it's been pretty successful. They've had these folks increase attendance at their health and mental health appointments.

They missed their fewer, they miss fewer appointments, and there have been fewer inpatient mental health admissions for that population. And the doctors and the providers who are, who are participating in this program indicate that it's been really helpful in helping Veterans who would have otherwise been overlooked. So sometimes big data can be really helpful in this fight against suicide.

So, another piece of this is that they're attempting to put an intervention in place where there typically wasn't one before. So traditionally, if you came into the VA system and or in an Emergency Department at a VA, the the first thing they do is a risk assessment; and then depending on your level of risk, they either admit you, observe you, or refer you.

Okay there's no intervention; and simply by putting, doing the usual suicide risk assessment in the Emergency Room, they insert a brief intervention, which I'm going to talk about later. And then they'll do the traditional thing, either admit you, observe you, or refer you, and then have you follow-up until you're engaged in care.

So, there are two, two interventions, really; there's the brief intervention at the time they come in, and then there's the follow-up until they're engaged in care. And this has significantly improved access and continuity in terms of care for patients. So, the safety planning intervention, some of you who are clinicians or work in the field have probably seen this.

It's very simple. I, pretty much, have this whole thing memorized having done it over, and over again. And most patients are actually really okay with going through this; and I explain it to them like this: When you're feeling suicidal, you're not in a place where you can think from your best mind, and from your best place.

And as a result, we're going to try to do some good thinking now, and we're

going to write it down, so that when you get to a point where you're feeling activated, you're feeling under threat, you're feeling suicidal, your best thinking is documented. And you have it someplace else to look at.

So, the first step is identifying the warning signs, like, how do I know when I need to use my safety plan? Patients will say, "When I can't stop crying. When I can't get out of bed. When I'm having thoughts about hurting myself. When, when I don't want to talk to anyone." So, they have to identify what their personal warning signs are, and they're very different from person to person.

And first we identify internal coping strategies that could be employed without the assistance of another person. So, this varies widely from person to person. Sometimes it's watching television, taking a walk, taking a shower, or taking a nap, eating something, playing with their pet. Whatever it is, something that doesn't rely on another person.

That's the first level of intervention, right? The second level of intervention is having them have people or social settings that could serve as a distraction. And this is where the pandemic really, really messed us up. Okay, because I'm gonna tell you; my favorite thing was, like, go to Target, and walk around, or go to a coffee shop, and give yourself a cup of coffee, and just sit amongst other people.

And I'll tell you, once the pandemic hit, there were a lot of people who were not willing to engage in those behaviors for obvious reasons. And so, we had to get real creative. Have a Zoom call with your best friend, like, it got interesting there for a while. Then we asked the person, if they, who they would reach out to for help?

That might be somebody they would be willing to say they were suicidal to, and it might be somebody that they just think will serve as a good distraction, right. And so, we document that person, those people, and their phone numbers. And one of the things that I do at that stage is I also ask the person, "Is there anybody from this list of close and trusted individuals that you'd like me to call personally to explain this safety plan to them?"

Because what I don't think we should do, is put this person, or these people on the list, and then not give your support people the resources they need to be helpful to you in the moment when things are really bad. And I go to tell you, 80 to 90% of my patients, and my Veterans were, like, "Yeah, please, please call my spouse and tell her what she needs to do. Please call my parents and let them know what they should do."

It all, one, it serves to break the ice around talking about suicide with that person because it's; I've already done it for them. And the second piece is, it's so important for those family members, and friends to know what to do in that situation, and know when to reach out to this, to the Suicide Prevention

Lifeline or to the person's clinicians. And if they don't know those resources are there, they're a less effective resource, right?

So, we also put down the information, my information, or their therapist, or their psychiatrist, or their caseworker, or anybody else who's a professional who can help them through that. And then we do whatever we can to make the environment safer: limiting access to harmful medications, limiting access to firearms, or other kinds of weapons, that kind of thing.

So, it's not, it takes 15 minutes, maybe 20, if somebody's really got a lot going on, to go through a safety plan. And but it's incredibly effective in terms of just giving people or documenting people's best thinking.

Okay so that was the end, that's the intervention that's been done after they do a suicide risk assessment in the ER, in the, in the, in VA ERs. And then we also do follow-up, which is we will call them, and we will assess their suicide risk. We will review and revise their safety plan. We'll tell them about their upcoming appointments.

We help them problem solve any barriers to getting care, especially transportation. And then we will provide any, any additional referrals, or if a, and if a rescue is needed, we will do that. So, calls were typically made 72 hours following discharge, and then weekly until the Veteran was engaged with a care provider.

Okay so let's talk about in our last 13 minutes or so, some of the warning signs, and tips for talking about suicide with patients who are suicidal. So, warning signs, pretty clearly, are talking about suicide; talking about or obtaining the means of completing suicide, so buying a gun, getting pills, withdrawing from social contact, severe mood swings, preoccupation with death, dying, or violence, feeling trapped, or hopeless, increased use of substances.

And for our Veteran population, I can't emphasize enough how much this next one is a factor: Doing reckless things, that could be using drugs, riding their motorcycles too fast. I had people who car surfed. I don't know if you know what car surfing is, but it's when two cars drive down next to each other, and people will jump back and forth, driving recklessly that, kind of, thing.

Because they are so used to situations in the military that, that are adrenaline inducing, they will often, when they're feeling suicidal engage in reckless behavior that's going to stimulate that same adrenaline rush. Giving away, giving away personal belongings, or getting their affairs in order can also be a sign.

Saying goodbye to people like they're never going to be seeing them again; and then big changes in their personality. If they're normally a calm, funny,

engaging person, and they're suddenly, suddenly withdrawn, and irritated, and snippy, these are all things that we want to be paying attention to as potential warning signs.

So, there's a lot of myths around this, and that make people anxious in terms of approaching folks when they're concerned about them. Talking about suicide does not cause an increased suicidation, a suicidal ideation or risk. There's no statistical significant, statistically significant data that says that talking about suicide leads to suicidal ideation or action. In fact, talking about suicide decreases the stigma around getting help; more likely than not reduces suicidal ideation, and improves mental health in those who are treatment seeking for their mental health.

So suicidal ideation is not a permanent situation. These people are suffering, they're not well, and they need treatment. If depending on your role, you may be a treatment provider in this discussion today, in which case you are charged with treating that.

But for many of our treatment core professionals, your job is just to be supportive, and get them hooked up with services. Don't feel hopeless, don't feel like you have to take the burden on yourself. Your team should have the resources and the connections to be able to help you segway these folks into treatment.

You want to be sensitive, but you also want to be direct. Don't beat around the bush, ask questions directly. And if you think the person is in immediate risk, don't leave them alone, and make sure you call 9-11.

So here are some ways that you can directly ask about suicide: How are you coping with what's been happening in your life? Do you feel like just giving up? Are you thinking about dying? Are you thinking about hurting yourself? Are you thinking about suicide? Do you have access to weapons? What's making you feel so bad? What do you think would make you feel better?

Direct questions, don't be afraid of the word, 'suicide,' don't be afraid of the word, 'hurting,' the words, 'hurting yourself,' or 'killing yourself.' These are really important, direct questions to ask somebody. So, there's a variety of things you can do to support them.

You can offer them the National Suicide Prevention Lifeline. If you press one, that directs them to the branch of the Suicide Prevention Lifeline, that's for Veterans, specifically. You can encourage them to seek treatment from a professional. And there may be things that you can do.

One of the assessment tools that I use in a clinical practice, not as a screening tool, but in clinical practice is called the CAMS, which is for the Collaborative Assessment of Suicide. And it's – one of the questions is, asks, if there was just one thing that could change in your life that would decrease

the desire to complete suicide, what would it be?

And sometimes they're very practical things like, "Gee, if I didn't have to worry about food, or access?" Or if I didn't have to worry about transportation; or if I had some, some resources, then I think I could manage. So, asking directly, how you can be helpful, means a lot to this population. You want to encourage them to continue talking to you.

But you also, again, if you're not the treatment provider, you want to encourage them to seek the help elsewhere as well. You really want to be respectful, tone is so, so important in this situation. It's important not to be patronizing or judgmental. And if, if it's a possible or appropriate, trying to remove dangerous items from the person's home; like, if they're going home, and they have a firearm, or they have access to a lot of medication, talking to a support person in their life about getting those objects either locked away, or removed from the home.

Some, some do, some, some no-no's on the list of dealing with folks who are suicidal is promising to keep their suicidal thoughts a secret; you can't do that, and you shouldn't. You don't want to dismiss their feelings. The other thing I often see is people trying to talk people out of their feelings, "You shouldn't feel that way. You have so much to live for, things could be worse."

Those are not helpful to somebody who's feeling suicidal because it makes them feel like you don't understand or that they should feel shame for feeling suicidal. You also don't want to act shocked to the best of their ability – to the best of your ability. As calm as you can be, that's the most helpful thing you can do for that person in that moment.

So, I think it's sometimes helpful to just talk through what actually happens for a person who is calling the Suicide Prevention Lifeline. First you hear a message that says you've reached the hotline, then there'll be a, some hold music until they can connect you, and then there's a trained crisis worker on the end of the line.

And then the result might be a rescue call. The result might be a referral. The result might be just somebody talking to you until you feel better because you already have all those resources in place, but it's 2:00 in the morning, and you can't call your best friend, and you just need to talk to somebody. Right, so there's a lot of possible outcomes.

Okay there are also some other organizations. Obviously, the VA, the VA is a huge source of – the VA, and Vet Centers are a huge source of support for folks who are dealing with suicidal ideation who are former military. But there's also organizations that are outside of the VA like Stop Soldier Suicide.

The rest of this presentation is a bunch of resources for folks who are struggling. Like I said, the pandemic has, sort of, magnified a significant

amount of the problems that our Veterans are facing that are, are practical problems.

And one of the things, I realize that this is not a talk on medication assisted treatment, but I want to make my plug. Because I like to make my plug as often as I can for medication assisted treatment. So, we know that medication assisted treatment works. And in addition to trying to stop suicide by firearm and all kinds of other things, we really as a community, as a treatment for community need to be paying attention to these deaths of desperation, these overdoses, and acts, intentional, and accidental overdoses that are happening in our community.

And the best way we can do that is by getting effective treatment for substance use disorders, and that includes medication assisted treatment. We know that MAT increases people's treatment retention, it decreases their substance use. It increases their ability to gain and maintain employment. It improves birth outcomes for pregnant women who are struggling with opioid use or other types of substance use.

It decreases the risk of contracting HIV and hepatitis C by decreasing the potential for relapse, right. So, this is a public health concern, too, beyond the individual in the family. Like, where MAT helps decrease the spread of communicable disease, right. And it's cost effective, and provides more mental health benefits than treatment without medication.

Okay. So opioid use with or without methadone; you can see with methadone, we have a significant decrease in the opioid use, the same thing with buprenorphine. One of the things I want to point out is, if you – I realize that a lot of your folks are engaging in treatment courts, and one of the goals is eventually abstinence. And depending on the model you're using, we're shooting for abstinence eventually, but it may not be the initial goal of treatment.

And so, in the approach to that, we also want to be thinking about harm reduction methods to make sure that as they're seeking treatment, and working toward abstinence, that they're decreasing the risk of spreading viral hepatitis, and HIV, different forms of hepatitis A, and B. And that, and syringe exchange, exchange programs have a, are a huge part of harm reduction, and keeping people safe when they're in our programs as they're moving toward abstinence.

And we really, also want to make sure that our, everyone in our programs, whether that's a mental health or a court related program, has access to naloxone, and has access to it, and knows how to administer it. Right, because even as our folks are on their way toward abstinence, relapse can happen, overdose can happen. And it can happen in our courtrooms, right, so we really want to prevent those deaths of despair.

Okay this is a; this is a program where you can look up the syringe service program within your neighborhoods. And I'm going to stop right there. We're a couple minutes towards, noon, and transition back to the question, and answer portion. I have just a bunch of slides after this, which are just giving people access to resources in your community that might be helpful. But you can read that on your own, if you'd like. And I'd like to spend the rest of the time addressing questions.

Scott Tirocchi: Dr. Marshall, thank you very much. That was fantastic. I know, I'm just not speaking for myself, I'm speaking on behalf of all these folks: a lot of positive comments; a lot of negative ones, no, only kidding, all positive.

Dr. Christa Marshall: You had me sweating there, Scott.

Scott Tirocchi: Real, a real tough topic –

Dr. Christa Marshall: Yeah.

Scott Tirocchi: – Absolutely recognized. One of the questions was, is a particular person, a caregiver residing in the state of Connecticut, and they're looking for assistance for someone that's struggling with these issues. And where would, where could they turn, perhaps first level?

Dr. Christa Marshall: So, the first thing, it depends on who this person is, and what level of services or engagement they're already in. So, if they are a Veteran, and they are already engaged in VA healthcare, the VA is a great resource.

Now, Veterans have a variety of different feelings about the VA, and willingness to participate in VA programs, and resources. But as someone who's worked at three different VAs across the country, I can tell you, there are some really great providers, and some really great programs.

So, you might start by going to a primary care visit with your loved one, if they will allow you to, and talking to the primary care doctor at that visit who can then provide referrals onto mental health, substance use programs within the VA. If there's, if there's issues around homelessness, or jobs, or anything like that, VA has, it is, kind of, a one stop shop for those kinds of things.

If you have a Veteran in your life who's not willing to engage in VA healthcare, but thankfully has access to health insurance in the private sector, one of the things you might do is same thing, go to a primary care doctor in the civilian world, go to the appointment with them, talk about what's going on, and see what resources are available in the community.

If you're looking for immediate mental health services, you can call the VA directly, and try to get in through mental health without going through primary care sometimes. You can also contact therapists directly in the community who will do an evaluation. If you're, the person in your life

doesn't have health insurance? I also just really want to encourage folks to get familiar with how to apply for Medicaid. Because that, that is the gateway to all the services that are necessary.

And if that person is struggling financially, and or doesn't have a job, it's much, much easier to apply for and get Medicaid than it even, ever has been in the past. And I believe there are some slides later in this presentation that can, that can go that way.

Also, if your Veteran is perhaps a bit prickly, and not interested, or as you're having a difficult time getting them engaged in their care, which can be an issue for a lot of loved ones and caregivers, there is a program at the VA called Coaching Into Care. And it's actually meant for the family members, the family members can call, and talk to a health psychologist, or a health provider about ideas specifically tailored to your Veteran about how to get them engaged with their healthcare if they're struggling.

So, I don't think I have that number in this presentation, but again, it's called Coaching Into Care, through the VA. And I'm pretty sure if you did a Google search, you could find that phone number.

Scott Tirocchi: That, that sounds like a critical resource as caregivers, family members. When it was challenging is when you, when you were working with someone as a family member, but yeah,

Dr. Christa Marshall: But they're not engaged, or they're saying, "I don't need that," or they're scared to engage, right. And so, that resource can be really helpful to give loved one's ideas.

Scott Tirocchi: Can you talk a little bit about the Vet Center model, and what that is, and how that works?

Dr. Christa Marshall: Absolutely, so the VA is obviously funded by the government, and is the, there's three branches of VA. There's Veterans Benefits Administration, there's Veteran Health Administration, and Veterans…. Help me out, Scott.

Scott Tirocchi: The internment, right?

Dr. Christa Marshall: Yes, the cemetery, it's not Veteran cemetery services, but essentially, dealing with death benefits. Right?

Scott Tirocchi: I'm glad I don't know the name of that one right now.

Dr. Christa Marshall: No, I don't, I don't, I don't want to know the name of that one. But yes, so the VA is the, the VA hospitals are the branch of the Veterans Health Administration, which is separate from the Benefits Administration, which handles compensation, and pension. Right?

So, after the Vietnam War, because the Vietnam War was so controversial, one of the things we have to remember in the context of VA centric healthcare is, we know that trauma has been a part of the Veteran experience back to World War I and World War II, right? We, shell shock was a term we had going on at that point in time. But posttraumatic stress disorder in its current iteration, in the Diagnostic and Statistical Manual of Mental Disorders, wasn't added in until 1985.

Right, so when you think about that generation of people who were coming back from Vietnam who were undoubtedly, many of them experiencing PTSD, they would go to VA, and they'd be told, "There's nothing wrong with you." They would be having all kinds of symptoms, they would be having all kinds of issues, and they would be dismissed. They might be over medicated in a lot of ways.

And so, this group, this, there became this, and significant level of distrust between that that Vet, and the Vietnam era population, and the VA itself, right. And so, as a result to that, the government started to fund something called Vet Centers, which are standalone facilities, they are, they are open to anybody, I believe, who is, who served in a combat capacity in a, in a conflict, and also their direct family members, I believe.

And the records, and the notes are kept completely separate from the government file that might be held at the VA. So, there's a lot more privacy afforded to the Vet Centers. They're almost never a part of the VA facility. They're standalone facilities, which some people feel a lot more comfortable going to.

And so, and again, they're, they're primarily providing counseling, not any, kind of, additional health related services. So, the Vet Centers can be a really important resource for people who are wary of the VA, or just, kind of, need to feel a little bit of distance from the government in one way or another.

Scott Tirocchi: Thank you, thank you very much. A comment just came into the box about how critical mentors could actually play a very informal role in this process –

Dr. Christa Marshall: Yeah.

Scott Tirocchi: – And peer support recovery.

Dr. Christa Marshall: Absolutely, so when I was working at the VA about ten years ago, that was just when those peer support models were starting to come out. And I got to tell you, I had one, a female peer mentor that I worked with for a couple of years, and she was awesome. She was in the groups I would work with.

So, I would be running these groups for other women, and sometimes the women were just, like, they didn't want to hear it from me. But when my co-facilitator who was also a Veteran who had been through her own recovery

process, kind of, would pipe up, they listened. And so, she was really, oftentimes the connector that allowed people to eventually get more detailed, or more in-depth treatment.

And so, I think that the mentor model is really important, an important one, and can, and can be helpful with those Veterans. And that's, so that's another thing that that person from Connecticut might want to look into, is if their VA has any peer support models, and if their person would be more comfortable talking to a peer support, at least initially, when getting hooked up into care.

Scott Tirocchi: Thank you. Another comment, when you were chatting, I typed in the crisis line information. And one of the questions that came out of that was, although the primary purpose is for a person in a crisis, can you actually be diverted to set up a medical appointment, if you needed to?

Dr. Christa Marshall: I don't believe so; but that's a great question. I don't believe so. You, if you need medical support or assistance, I'm assuming they might be able to look up, especially if you, if you go into…. So, to back up, that crisis line is a national program. But the, when you press one, and you go to Veterans, right, there's actually a hotline.

I think it's right here in Canandaigua, New York, at, there's a hotline that is staffed by VA clinicians, crisis clinicians. And they have the ability to tag or communicate with VA providers across the country. I don't know that they would be able to schedule an appointment, but I do think that they can leave messages, and contact providers in your home VA to initiate care.

But probably your best bet is to call your local VA directly to make an appointment. But again, if you, if you go to that national hotline number, and you press one, you are getting into a VA connected system.

Scott Tirocchi: Thank you very much, and yeah, that, that's, kind of, a plug for My Health, right, My VA Health. I connected to that, and boy, once you call your regular VA Center, then you connect to the website, you can track all your medical appointments. You can track your blood work, everything,

Dr. Christa Marshall: And you can communicate with your providers directly. So, one of the things –

Scott Tirocchi: That's right.

Dr. Christa Marshall: – That's really nice is, that some of us might be familiar with this in the civilian world, that I can get onto my doctor, or my website here in Rochester. And if I want to ask my doctor a question about my medicine, I just do it directly, and I get a response. I'm not diverted by phone to the nurse or whatever else; I get to talk to my direct, my doctor directly when they're able to get back to me, right.

And so, the VA has worked really hard to create a system where through that, My HealtheVet portal, you can go on, and look at your appointments, look at your meds, and send your provider a direct message without having to go through, like, three levels of secretaries to figure out how to get to them. So, it's a great tool, and a great advance in the last probably decade – decade and a half.

Scott Tirocchi: I also, I also noticed that there's, that there is a lot more questions upon your routine medical examination around symptoms of depression, and how you're feeling today. And it's worded differently, but asked multiple times, which –

Dr. Christa Marshall: Yes.

Scott Tirocchi: – That's a big help.

Dr. Christa Marshall: So, screening has become a massive part of VA's initiative to help with mental health. So, you will notice, probably every time you have an interaction with a VA provider, especially your PCP, that they're going to ask you about questions related to depression, and also PTSD.

So that's huge. And that also is another layer of protection in that it relies on you as the Veteran to be honest, and to be open, and say directly what's going on. But they're gonna meet you halfway, and at least ask you the question. Right?

Scott Tirocchi: That's fantastic. Well, Doctor, thank you very much. I think that's all we have. Really, you gave so much information. And yes, folks, these slides will be available. Give us about two weeks though, we'll have them on the website. It will be in PDF format. This whole presentation was recorded, that will also be available to view. Dr. Christa Marshall, thank you very much, again, we appreciate it.

Dr. Christa Marshall: You're welcome, yeah.

Scott Tirocchi: We look forward to seeing you again, and –

Dr. Christa Marshall: Yeah.

Scott Tirocchi: – Hopefully, you can join us in Nashville July 25 to 28, shameless plug. If you are around? For RISE22.

Dr. Christa Marshall: Love it. Thanks so much.

Scott Tirocchi: Thank you – also want to thank Cindy League in background for all the technical support. Thank you folks, and have a nice day.