Transcript
Short Takes on Suicide Prevention Podcast
Episode 133
Homelessness, Veterans and Suicide Risk: Research Priorities
with Dr. Edgar Villarreal and Dr. Ryan Holliday

[00:00:00] **Announcer:** You're listening to Short Takes on Suicide Prevention, where experts talk to each other about how research is shaping suicide prevention. This podcast is brought to you by the VA Rocky Mountain MIRECC, and now onto today's conversation.

[00:00:24] **Edgar Villarreal:** Welcome to Short Takes on Suicide Prevention podcast. I'm your host, Dr. Edgar Villarreal. I'm the Director of Education and Training at the Rocky Mountain MIRECC for Suicide Prevention. And today we're going to talk to you about suicide prevention as it relates to Veterans that are experiencing homelessness.

We're going to be talking today with Dr. Ryan Holliday. Welcome Ryan.

[00:00:49] **Ryan Holliday:** Thanks so much for having me.

[00:00:51] **Edgar Villarreal:** And we're going to be focusing on Dr. Holliday's recent work on an article that he published titled Establishing a Research Agenda for Suicide Prevention Among Veterans Experiencing Homelessness. Dr. Holliday is a Clinical Research Psychologist at the MIRECC and an Assistant Professor at the University of Colorado, Anschutz Medical Campus. His clinical and research interests focus on understanding the intersection of trauma, psychosocial stressors, such as homelessness and justice involvement and mental health.

He is further interested in translating these findings into evidence-based practice. So, Ryan, really excited to start this conversation with you.

[00:01:35] **Ryan Holliday:** Oh, thanks so much. Definitely excited to talk about some of the work we have going on and how we can continue to improve how we connect to these Veterans to really important health and social services.

[00:01:45] **Edgar Villarreal:** Great. So just to kind of set up the conversation a little bit and help our listeners to understand why this topic of research is so important. I think it's important to just to acknowledge that suicide continues to be identified as a significant public health issue that spans the general population and specifically impacts our Veteran population.

Now your article sheds light on the fact that those experiencing housing instability and homelessness are at increased risk and that our Veterans really account for nearly 8% of those experiencing homelessness. Just curious to hear your thoughts on what are some of the challenges that individuals experiencing homelessness experience that uniquely puts them at risk for suicide.

[00:02:38] **Ryan Holliday:** You know I think it's, when we think about and talk about social determinants, like housing, instability and homelessness. I think what's so very difficult is, how do we label just one thing that's impacting this population? I think unfortunately the truth is it's more often than not an "and" versus an "or". We're talking about, factors such as psychiatric and health diagnoses that we know are associated with risk for suicide, things like serious mental illness and depression and PTSD, substance use disorders. And at the same time, we're also talking about individuals who are impacted in terms of their psychosocial functioning.

I'm sure anyone listening to this can take a step back and think about how difficult it would be to not only not have a place to sleep at night that they feel safe in, but also taking it to a larger level than that, thinking about factors such as un and underemployment, or the stigma of having housing instability, right? When we talk to not only health care providers, but people in the lay community, there's often this very negative stereotype that is associated with this population that's really difficult to escape.

[00:03:56] **Edgar Villarreal:** Thanks Ryan. And really one of the things, you know, as you were talking about, and as I was reading your article that really stood out to me was how complex suicide is an issue to study and to understand. And I'm hearing that there's a lot of unique factors about people that experience homelessness that makes this even more of a difficult topic to be able to kind of pin to one particular issue.

Now, Your article highlights, how complex suicide can be as an issue. And it really kind of struck me that you were kind of moving the conversation more to the direction of helping us really challenge the traditional way that we look at suicide prevention. Right? Often we look at suicide prevention as kInd of specifically focused on mental health or specifically focused on things like crisis intervention. Can you tell us a little bit about how this broadens our view of how we understand suicide prevention.

[00:05:00] **Ryan Holliday:** Yeah. And, and, you know, I, I definitely resonate in terms of the really great evidence-based treatments we have, right. We've been working to disseminate cognitive behavioral therapy, problem solving therapy, dialectical behavior therapy, in addition to things like safety planning to really prevent suicide among Veterans who are at elevated risk.

And at the same time, if we can't get someone into a mental health clinic, we can never provide those services. And I think that's such a resounding testament, when we're thinking about the fact that a lot of Veterans who are experiencing housing instability are likely prioritizing the thing that is most acutely impacting them.

So if someone's about to be evicted, they're more likely than not going to be talking to a case manager versus some social worker or a psychologist specific to their depression or substance use. And I think what this really indicates to us in the health service delivery field is we really have to expand our lens and really seek to work with Veterans in the services they are accessing.

And so it's not to say that mental health care isn't important, but rather how do we engage someone in the services they can and do need as well as are accessing in order to ensure that we can eventually get them into these evidence-based treatments.

[00:06:21] **Edgar Villarreal:** Yeah, that's really interesting. I think you really kind of highlighted the importance of expanding our lens in order to make sure that we're engaging Veterans. Now, you know, moving into how this article came to be, you specifically kind of talked about the VA convening, Health Services Research and Development and Suicide Prevention and that in order to enhance our understanding of how to engage Veterans, that really we needed to kind of come together in some way to be able to develop a research agenda. So can you talk to us a little bit about how this meeting came to be? What, you know, what was really the goal? What were you all looking to get out of meeting together and establishing this research agenda?

[00:07:19] **Ryan Holliday:** Definitely. You know, as you mentioned earlier, preventing suicide and even to a degree, understanding suicide remains this really complex challenge for us. And I think unfortunately what often ends up happening when it comes to programming and research is we can sometimes get really siloed and focus on that one thing that we're doing well.

And while that can be really informative and important to do, it's also similarly important to recognize that there's so much that occurs outside of what we know and what we do. And this meeting really was born out of that, recognizing that, we in suicide prevention, do a really good job of recognizing mental health and psychiatric diagnoses.

However, our expertise isn't always specific to some of these social determinants. And on the flip side, you know, partnering with individuals who are in the Homeless Programs Office, as well as conducting research at the national center, they have such an amazing expertise in some of those domains, but maybe don't study specifically some of those more nuanced factors when it comes to suicide prevention.

And so what we were really just hoping to do with the initial first step of the meeting was bringing all these individuals together, across all these different levels, to just start a conversation of how do we collaborate and synergize our efforts to really help this patient population that we fairly well established is at elevated risk for suicide.

[00:08:45] **Edgar Villarreal:** Great. And, you know, one of the things that stood out to me as you're kind of talking about bringing everybody to the table and really kind of breaking down those silos was that you all, you know, took a very intentional approach and decided to include Veterans as part of that conversation. Can you tell us a little bit more about how you did that?

[00:09:08] **Ryan Holliday:** So, you know, I think sometimes again, going back to that silo discussion, we can get really stuck in our thoughts of like, oh, this is what's going to work because it's what the data says. And one of the major facets that we're

noticing more and more is we can have the, you know, best idea, but if people don't want to do it or aren't interested in accessing it, then it really isn't beneficial to the patient population.

So one thing we worked to do was to engage Peer Support Specialists with lived experiences in these conversations to kind of share their experiences and discuss these different aspects, to really inform not only their perceptions as an individual with lived experience, but also how they might be interested in integrating and implementing some of these facets into the work they currently do.

[00:09:59] **Edgar Villarreal:** Great. And I think that's definitely an important point to highlight that by, you know, really integrating people with lived experience and providing them that voice, that you can ensure that the recommendations and the conversations really center around the people that this really is going to impact, which is our Veterans.

So that's really great to hear .Now, Ryan I was wondering if you could kind of give us a sense of how you were approaching trying to get consensus. I can imagine that trying to come up with a research agenda, that's going to drive this work for the field, can feel like an insurmountable task.

So how did you go about approaching this meeting and what were your thoughts about how you were going to try to really come to a consensus about what that research agenda would look like?

[00:10:50] **Ryan Holliday:** So I'm definitely more than happy to discuss all the nerdy facets of the, quote, unquote, Delphi process that we did for this, but I think that could be its own conversation and unfortunately might not be the most interesting to everyone. But I think one of the big takeaways that I think is really important to highlight is the Delphi process really thinks about how do we bring a lot of really, Integrated individuals in the field with different expertise in different lenses, into a discussion and then really uses multiple rounds of actively discussing things to identify a priority or a ranking system for the things that we view as the most important.

And so that included active discussions as well as a ranking system for thinking about, what are the really important things for us to think about within the VA, as well as in our collaborations with the community, for prioritizing suicide prevention among homeless Veterans, as well as next steps on that same vein or in that same vein?

[00:11:59] **Edgar Villarreal:** Yeah, and thank you for trying to, you know, boil it down to really kind of the core always there. You know, you kind of mentioned that the process really is meant to take the conversation and develop a ranking system. Now, the things that you identify, it sounds like out of those conversations, you were able to identify nine core research domains here.

I wanted to kind of focus our discussion on maybe the top two that you all identified. Can you tell us a little bit more about how those conversations came to kind of rank

these as the two top priorities for research. And just to kind of remind you of the first one, the first priority that you all had identified in those conversations was [00:13:00] examining barriers and facilitators to suicide, risk assessment and emergency interventions in the community with homeless Veterans, by obtaining both provider and Veteran perspectives.

So let's start with that one.

[00:13:06] **Ryan Holliday:** Yeah. So, you know, what was surprisingly easy about this process was, especially with these ones that kind of rose to the top, and it's not to minimize the other factors that were identified, but there was just a couple that were so salient and really there was a fairly large consensus. And I think with this first one, I think it resonates so much for anyone who's ever worked, either in emergency service settings, or in settings where an individual might be working with Veterans at risk or currently experiencing homelessness, which is really this cycle that we unfortunately see with this patient population of kind of starting to kind of get back on their feet and then all of these things impacting them. And then the patient at times accessing an emergency intervention either because they're experiencing a ton of acute distress or rather to manage mental health or physical health conditions that are relatively difficult to do because they might not be able to access them on an outpatient basis. And so, one thing that we were really thinking is how do we break this down and start to think about this cycle that's so very common in this population to really inform, not only their health service delivery, but also how do we identify when someone is at that elevated risk and in that setting versus utilizing it to manage their health care or social services in other ways?

[00:14:41] **Edgar Villarreal:** And then the second one that you had identified was. Identifying the complex relationship between periods of risk and then subgroups at elevated risk. Also looking at, you know, nonclinical drivers of that risk. What can you tell us about that second priority area?

[00:15:01] **Ryan Holliday:** So this was a relatively interesting one when we were kind of doing our brainstorming, because I think the more we discussed things as a group, the more we notice that often we group individuals together as this very homogenous group of Veterans experiencing homelessness or at risk for homelessness, but there's so many additional contextual factors that can really change up the clinical presentation.

For example, we know that women Veterans who are experiencing or at risk for homelessness, are more likely to engage into different forms of housing instability. Right? So we might see more couch surfing. Or, we might also see that some women Veterans are able to access certain shelters or have to access certain shelters because women Veterans are more likely to get relegated to have childcare duties versus men Veterans who are experiencing homelessness.

Additionally, things that we were talking about were factors such as morality. You know, sometimes we might think of individuals who are experiencing homelessness as a very urban issue. And while there is definitely something to be said about that,

you know, when we're thinking about things such as Los Angeles and Skid Row, we also know that Veterans experiencing housing instability in rural areas have very different needs.

And some of the things that we're thinking about and doing in the VA, which are amazing, might be a little more difficult for that patient population. Right? Veterans in rural areas might have a more difficult time keeping an iPad or a phone charged for telehealth services versus an individual in an urban area who might be able to do that within settings that are a little more open to individuals experiencing homelessness, such as shelters or bus stations, things like that.

And so I think what we thought about, and really we came to consensus fairly quickly with this priority, was how do we also think about the subgroups within this patient population who are differing in different ways and may need more tailored approaches or augments to their care that we aren't currently thinking about because they make up a smaller subset of the population.

[00:17:13] **Edgar Villarreal:** Yeah. And that makes a lot of sense, you know, as you were kind of talking you were really kind of mapping it out for us in terms of how there may be very different approaches depending on the subpopulations. You often use the word upstream in the article to describe some of the priorities and even some of the recommendations.

Can you tell us a little bit about what that means for our listeners that may not necessarily know what upstream means and the terms of research and suicide prevention?

[00:17:43] **Ryan Holliday:** Yeah. And, you know, in the VA we've taken this really awesome approach to suicide prevention called the public health approach. And there's so many different facets to that. But I think one which really kind of resonates with this upstream idea is, what sort of things can we do before someone is in that acute crisis?

What sort of services might we be able to offer or engage an individual into to bolster their resilience? You know, one thing I often think about in a clinical capacity when I'm doing suicide prevention care and services is that, unfortunately, when it comes to suicide prevention, that people who are coming to either myself or providers I'm working with are often in a very, very severe state.

And it's so much harder for us to engage an individual in our really great effective programs when they're already experiencing those multitude of problems and stressors, versus if we can start to think, what sort of things could we do early? What sort of things might be really helpful to take something off their plate that might help engage [00:19:00] them in something like dialectical behavior therapy or vocational rehabilitation to really kind of shift that trajectory?

[00:18:59] **Edgar Villarreal:** Yeah, thank you. And I think it really kind of highlights that, like you said, that shift that VA has made to really take more of a proactive

approach in suicide prevention, not waiting for that crisis to brew up and really kind of look at suicide prevention from different levels of prevention. And just wondering, you know, how do you think, you know, some of these research priority areas that you've identified or some of these upstream approaches, how do you think that that's going to translate to some of the research?

Or what do you hope that that does to the research?

[00:19:40] **Ryan Holliday:** You know, I think one thing that I really hope is that we can start to think about supporting these Veterans and the providers working with them within the capacity that expands beyond just mental health. And we talked about that earlier. You know, and I know both you and myself and a psychologists, we care so much about mental health and we know that suicide prevention, isn't just that.

And so I think one thing that I continue to hope is that we can think about things in a bi-directional capacity. Not only how can I get these Veterans into a mental health clinic, but also thinking about it on the flip side, how can we get Veterans who are in primary care? How can we get Veterans who are in a residential PTSD treatment facility, into a setting in which they're also accessing some of these social services, in addition to things that might be related to acquiring housing that can really help these individuals across their life course? Whether it has to do with employment or other factors.

[00:20:47] **Edgar Villarreal:** Great. So that really kind of highlighting that point, that needing to move our understanding and our supports and out interventions beyond, kind of our traditional understanding of suicide prevention, which really just focuses on mental health. You know, there's a lot here that we can spend so much time talking about, I wonder if you could talk to us a little bit about some of the recommendations that came out of the discussions that the group had.

[00:21:17] **Ryan Holliday:** You know, I think one of the things that really was resounding that came out of a lot of these discussions, is just the continued importance of collaboration between VA and the community. When we're talking about Veterans who are at risk for, or experiencing homelessness, they're often what we call multi-user of care.

You know, versus some of the other individuals who are Veterans or aren't Veterans who might just go to one health care center or one hospital for their services. We're often talking about a population who might be accessing care at tons of different hospitals and social service organizations. And one of the major difficulties that this carries is not only the heterogeneity in care and services provided, especially if the organization doesn't have mental health or suicide prevention aspects, but also that these organizations don't often talk well to one another.

Maybe they're using different health care systems or maybe they don't have a release of information. And so I think it just continues to speak to a lot of really great efforts that VA is doing as well as community based organizations to really change

that and shift, how can we really establish a continuity of care because that's going to be so important, especially if a Veteran is going into a community-based hospital and discussing suicide risk factors and we aren't hearing about that in the VA.

[00:22:45] **Edgar Villarreal:** Got it. And you know, one of the things as you were kind of talking about that integration piece, that stood out to me in the article was that, that there may have been a need to maybe get more non VA participants involved. Could you maybe help us understand, you know, what role do you feel the community and those community partners can play moving forward and implementing this research agenda?

[00:23:15] **Ryan Holliday:** I think that community partners are integral. We know that a huge portion of Veterans don't come to the VA regularly. And so I think we have so many great efforts in terms of mental health and housing instability prevention and things along those lines, that we really have put tons of effort into researching and doing program development around.

And so continuing to work to spread some of those outside the VA into community based organizations is, in my opinion, paramount. I almost kind of think about it like, why reinvent the wheel, right? If someone in the community is doing something great, we'd love to hear about it in the VA and vice versa. I know that, we have some really great individuals in both, Office of Mental Health and Suicide Prevention as well as Homeless Program Office.

For example, as part of this meeting, we established a work group and I think it just kind of speaks to that this is the first step of hopefully many to come, that we just continue to grow this collaboration, to increase the reach and spread of our programming, as well as our understanding of the service needs of this population.

[00:24:26] **Edgar Villarreal:** Well, Ryan, I, you know, I think you really kind of set us up in a really good way with that call to action, to be able to kind of wrap up our episode for today. But before we leave, you know, just wanted to, again, thank Dr. Holliday for spending. This time today with us and sharing his expertise and experience with the rest of us.

And of course we would like to thank our listeners for joining today's conversation.

[00:24:55] **Ryan Holliday:** Thanks for having me.

[00:24:57] **Edgar Villarreal:** Thank you Ryan.

[00:25:02] **Announcer:** That's it for this episode, you can find more Short Takes on your favorite podcasting app. And if you like what you hear, subscribe to the show and give us a review. Until next time you can follow us on Twitter at R MIRECC. We'll see you then, take care. Short Takes on Suicide Prevention is an informational podcast and not a substitute for mental health care.

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