Reproductive Health Care Settings: A Novel Approach to Enhancing Suicide Prevention for Women Veterans

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Background

- Women Veterans (WV) of childbearing age (18-44) are fastest growing subgroup of Veterans[1]
- Suicide rate among WV is rising: 60.5% from 2005-2017[2]
- Reproductive health care (RHC) is one of the most frequent reasons women in this age group seek medical treatment[3]
- Reproductive health and related life events (i.e., childbirth) are associated with increased vulnerability to depression and anxiety, conditions known to increase suicide risk[4]
- Suicide is believed to be a leading cause of pregnancy-associated mortality in the US[5]
- Among WV using health care services provided by the Department of Veterans Affairs (VA), mental health conditions frequently co-occur with reproductive health diagnoses[6]
- Prevalence of suicide ideation (SI) and S-SDV among WV using RHC services is unknown.

Define the Problem: Surveillance

Primary Aim 1 – Estimate rates of suicide, SI & non-fatal S-SDV in women using RHC services

Identify Risk & Protective Factors:

Secondary Aim – Estimate the prevalence of S-SDV risk factors

Exploratory Aim – Estimate association with Veteran suicide risk.

Implement Interventions:

Results from this and future studies have the potential to influence VA policy and ultimately save lives.

Develop & Test Interventions:

Primary Aim 2 – Describe Veterans' beliefs, attitudes, and preferences regarding suicide risk assessment and prevention within RHC settings

Future research – integrating upstream suicide prevention strategies within VA RHC settings.

Aims

Public Health Approach to Suicide Prevention

Methods

- **National Survey of WV using VA RHC Services in FY18 (n = 352)**
  - Separated from military service 10/1/09 – 9/30/18 at 18-44 years of age
    - Years since separation: <2 (n=63, 18%); 2-5 (n=114, 32%); 5+ years (n=175, 50%)
  - Random sample of eligible cohort, direct mailed invitation
  - Online (n=289) and paper (n=63) survey modes
  - Domains: demographics, military history, health care use, general, mental and reproductive health, family & relationships, self-harm history, lifetime adverse experiences
- **Qualitative Interviews with a subset of survey participants (n = 21)**
  - Semi-structured interview guide, telephone interviews, single interviewer
  - Analysis was inductive and utilized a thematic analysis framework

Results

Demographics & Military History	n	%[1]
Age		
18-29	98	28.1
30-39	182	52.1
40+	69	19.8
Race		
Caucasian	233	66.4
African American	55	15.7
Other	63	17.9
Hispanic Ethnicity		
Yes	53	15.1
Sexual Orientation		
Heterosexual	284	80.9
Bisexual	40	11.4
Other	28	7.7
Current Relationship Status		
Married or in a relationship	254	72.4
Not in a relationship	97	2.8
Employment		
Employed	218	61.9
Unemployed, seeking	49	13.9
Unemployed not seeking, Retired	85	24.1
Last Branch of Service		
Army	164	46.9
Air Force	86	24.6
Navy, Coast Guard	69	19.7
Marines	38	10.9
Deployed during Military Service		
Ever	229	67.0
Millitary Sexual Trauma		
Harrassment	236	67.2
Assault	149	42.4

Mental Health & Suicidality	n	%[1]
Current MH Problems		
Yes (self-report)	273	77.8
Satisfaction with MH		
Very/Somewhat Dissastisfied	178	50.7
Neither Satisfied nor Dissatisfied	66	18.8
Somewhat/Very Satistfied	107	30.5
Depression (PHQ-8)		
Mild to Moderate	175	50.0
Moderately Severe to Severe	91	26.0
PTSD (PCL-5)		
Provisional Diagnosis	157	44.7
Alcohol Use Problem (AUDIT-C)		
Positive Screen	112	31.9
Drug Use Problem (DAST)		
Positive Screen - low	56	16.0
Positive Screen - moderate/high	19	5.4
Active Suicide Ideation (C-SSRS)		
Lifetime	148	42.4
Past Month	39	11.2
Suicide Attempt History (C-SSRS)		
Lifetime	82	23.4
Past Year	17	4.9

[1]Missing data: age (n=3), race (n=1), relationship status (n=1), branch of service (n=2), deployment (n=10), MST harassment (n=1), MST assault (n=1), MH problems (n=1), MH satisfaction (n=1), PHQ-8 (n=2), PCL-5 (n=1), AUDIT (n=1), DAST (n=3), SI (n=3), SA (n=3)

- Most women reported using VHA RHC for preventive care, pregnancy and STI screening, and contraception services
- 60% reported receiving RHC services in primary care, 55% in women's health clinics

Interview Themes & Illustrative Quotes

Establishing positive patient-provider relationships in RHC settings is key

"He came in, and he was like, I know you haven't met me before, and we're supposed to do your pap smear. But if you're uncomfortable, we can just meet today and talk and get to know each other"

Some WV prefer female providers in RHC and for suicide risk screening

"…sometimes I feel, you know, a woman doctor understands more womanly stuff than a male doctor."

"Again, probably male. Because one of the experiences regarding wanting to harm myself or kill myself was male caused. So I would prefer talking to a female…I would tell them [male provider] that I have had them [suicidal thoughts]. But I might not go into detail as much as I would with a female."

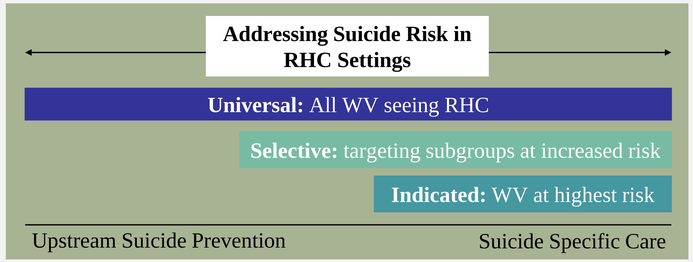
Suicide risk screening and prevention in RHC settings: desired, acceptable, unmet opportunity

"I think it's a great idea. There are a lot of women will open up more to their GYN, and so they maybe more apt to. So just, obviously it's a more intimate exam so they may feel more apt to opening up about that. I think any opportunity that someone has to open about mental health issues is another opportunity."

"I think that, like I, think most mental health providers get it. But also think that like reproductive doctors get more of like the hormonal and like, the hormonal part and like the chemical part of like emotions. Because it's related, you know, like when you're pregnant you have different hormones, and when you're on your period, you get different hormones. And like, get that part of it."

Conclusions

- **Survey findings** suggest a need for integrating suicide prevention with VA RHC; WV using RHC services experience high levels of MH problems and suicidality
- **Qualitative interviews** indicate that suicide risk screening and prevention in RHC settings are welcomed by WV, especially when rapport/trust has been established between the WV and RHC provider



- **Enhancing suicide prevention in VA RHC settings is promising:** developing effective upstream suicide prevention programs requires identifying care settings frequented by the population of interest, in which such activities could be implemented in a feasible, cost-effective, and acceptable manner.

Future Directions

- **Findings presented here are preliminary**, analysis of survey data is ongoing and will be complemented by an analysis of administrative and clinical records for all WV separating from military service between FY10-FY17 who were 18-44 years of age at separation and who used VHA services at any point following separation. Suicide rates will be computed for this population overall and within RHC service- and diagnosis-defined subgroups.
- **Future research** seeking to understand provider perspectives is warranted
- **Future research** aiming to implement upstream suicide prevention initiatives in RHC settings will be driven by findings from this study and the subsequent provider study

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