Precedence for Integration of Clinical Services in Public Health Initiatives

Reduction of suicide is widely recognized as a public health priority, and reports of elevated rates among veteran and military populations have received considerable attention. Clinical services, including effective management of behavioral disorders, psychotherapy, and the use of pharmaceutical agents, have been identified as important elements in a comprehensive approach to the prevention of suicide. Nonetheless, the proper role of clinical services in suicide prevention programs remains unclear, with a perceived tension between diagnosis- or symptom-driven clinical management and more universal approaches. However, such tension is more likely a function of the many challenges to implementing effective clinical services to address suicide risk, including the relative lack of evidence-based clinical therapies to prevent suicide deaths, stigma associated with behavioral disorders (e.g., mood disorders, substance use disorders), and low service utilization and adherence to treatment, than inconsistencies between the missions of clinical science and population health. We view such challenges as a call to create systems of care that are more inclusive and effective in meeting the needs of individuals vulnerable to suicide than a justification for divorcing clinical services from a comprehensive public health approach to suicide. Many of the major public health achievements of the 20th century, such as the eradication of smallpox and global reductions in the incidence and consequence of paralytic poliomyelitis (polio), relied on clinical services to identify and protect vulnerable populations. For example, the eradication of smallpox would not have been possible without safe and effective strategies for vaccine delivery, and reductions in polio (while similarly related to safe and effective vaccine administration) resulted from enhanced clinical and laboratory surveillance to identify vulnerable populations and pockets of vaccine resistance.

DEPARTMENT OF VETERANS AFFAIRS’ INTEGRATION OF CLINICAL SERVICES IN SUICIDE PREVENTION

The Department of Veterans Affairs (VA) provides an illustration of integrating clinical services in a multifaceted approach to reduce suicide. The approach includes an “enhanced care package” for veterans identified as high risk or potential risk, with use of evidence-based and promising interventions, including Safety Planning, the “caring letter program,” increased follow-up, and care monitoring and tracking by the Suicide Prevention Coordinators located at each site. The approach also features universal strategies to enhance access to services and availability of treatment of vulnerable veterans, such as the National Veterans Crisis Line and Chat Service. These and other clinically based initiatives demand rigorous study to document their effectiveness and to inform continuous improvement. Consistent with a public health framework, each of these initiatives addresses veterans’ suicidal thoughts and behaviors regardless of underlying disorders that may be contributing to risk. A public health perspective also demands attention to the primary methods leading to suicide fatalities, with firearms used in the majority of cases. In response, VA clinical training materials stress the importance of addressing means safety when working with suicidal patients, including in treatment planning. A public health perspective also requires that the settings where high-risk individuals are concentrated be targeted in preventive efforts. Along these lines, veterans discharged from inpatient psychiatric care after an attempt and those who receive treatment of a suicide attempt are routinely placed on the “high-risk list,” with their records flagged and the enhanced care package initiated.

RATIONALE FOR ADDRESSING BEHAVIORAL DISORDERS IN SUICIDE PREVENTION IN CLINICAL SETTINGS

A focus on addressing suicidal thoughts and behavior regardless of underlying disorders does not rule out parallel efforts to study and prevent suicide in diagnostic populations. Because of exposure to combat, stress of deployment, and other factors, military service members and veterans experience sleep disturbances, traumatic brain injury, posttraumatic stress disorder, substance use disorders, mood disorders, and other behavioral health difficulties at high rates during deployment to war zones and after return to home. Accordingly, clinically informed research on these and other correlates of suicide is needed to inform treatment development efforts. The need to integrate clinical services to treat behavioral disorders and to prevent suicide is underscored by the strong etiological link between behavioral disorders and suicide. A recent national cohort study of veterans who received Veterans Health Administration services reported that approximately half
suicide prevention. Although clinical care providers play in recognized the critical role that major US report on suicide has major behavioral disorders in suicide, each behavioral health disorders. Accordingly, sound delivery of evidence-based care for behavioral health conditions that confer risk for suicide in and of itself is an important element of a comprehensive suicide prevention strategy. In this regard, treatment of depression stands out as having an evidence base in suicide prevention, with a need to study the potential role of prevention in treatments for other conditions (e.g., substance use disorders).

Kenneth R. Conner, PsyD
Robert M. Bossarte, PhD

About the Authors
Kenneth R. Conner and Robert M. Bossarte are with the Veterans Integrated Services Network (VISN) 2 Center of Excellence for Suicide Prevention, Canandaigua, NY, and the Department of Psychiatry, University of Rochester, Rochester, NY. Correspondence should be sent to Kenneth Conner, PsyD, VISN 2 Center of Excellence for Suicide Prevention, 400 Fort Hill Ave, 3B, Canandaigua, NY (e-mail: KConner@va.gov). Reprints can be ordered at http://www.ajph.org by clicking the “Reprints/Eprints” link.

This editorial was accepted November 8, 2011.
doi:10.2105/AJPH.2011.300575

Contributors
K.R. Conner conceived and led development of the editorial. R.M. Bossarte contributed to the editorial.

Acknowledgments
We thank Janet Kemp, PhD, Peter Britton, PhD, and Wil Pigen, PhD, for their comments and edits.

References