UPSTREAM SUICIDE PREVENTION: NEW INNOVATIONS FROM THE TEXAS VETERANS COMMISSION

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VETERANS MENTAL HEALTH DEPARTMENT

- JUSTICE INVOLVED VETERAN PROGRAM
- COMMUNITY & FAITH-BASED PARTNER PROGRAM
- HOMELESS VETERAN INITIATIVE
- VETERAN PROVIDER PROGRAM
- MILITARY VETERAN PEER NETWORK
- SUICIDE PREVENTION
VETERANS MENTAL HEALTH DEPARTMENT

Across all programming, VMHD has the broadest definition of veteran. Regardless of:

- Discharge status
- Branch of services
- Length of service
- Active-duty status

The same broad definition applies to family.

All services provided across VMHD programming are offered freely.
OBJECTIVES

1. Introduce the Risk-Need-Responsivity (RNR) model

2. Describe how a modified RNR framework shapes VMHD program development and service implementation across Texas

3. Highlight how this ties into VMHD’s focus on reducing veteran suicide in Texas
1. Assess Actuarial Risk / Needs

2. Enhance Intrinsic Motivation

3. Target Interventions
   a. **Risk Principle**: Prioritize supervision and treatment resources for higher risk individuals
   b. **Need Principle**: Target interventions to criminogenic needs
   c. **Responsivity Principle**: Be responsive to temperament, learning style, motivation, culture, and gender when assigning programs
   d. **Dosage**: Structure 40-70% of high-risk offenders; time for 3-9 months
   e. **Treatment**: Integrate treatment into the full sentence/sanction requirements

4. Skill Train with Directed Practice (use Cognitive Behavioral treatment methods)

5. Increase Positive Reinforcement

6. Engage Ongoing Support in Natural Communities

7. Measure Relevant Processes / Practices

8. Provide Measurement Feedback
RISK-NEED-RESPONSIVITY MODEL
(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

RISK PRINCIPLE: Direct resources and more intensive services to higher risk individuals

NEED PRINCIPLE: Treatment / Intervention should target criminogenic needs (dynamic risk factors)

MODIFIED NEED PRINCIPLE: Programmatic Planning should target the changeable factors most relevant to the most important presenting problem

RESPONSIVITY PRINCIPLE: Treatment / Intervention should be provided in a style and mode that is responsive to the individual’s learning style and ability
RESPONSIVITY PRINCIPLE
(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

Responsivity:
- Factors that need to be considered in strategic intervention/program planning
- Focus on risk factors relevant to population/individual (i.e., trauma, TBI, presence of mental illness, access to lethal means, etc.)
- Protective factors can include strengths / protective factors such as employment, positive leisure activities / Interests, active and supportive family, faith, etc.
R-N-R: ASKING THE RIGHT QUESTIONS

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

Risk / Need focus helps answer:

- “Who needs treatment / intervention?”
- “What type and intensity of treatment / intervention is needed?”

Responsivity focus helps answer:

- “How would this population most benefit from intervention?”
- “What circumstances could present barriers to intervention?”
- “What steps can be taken to overcome these barriers?”
- “What strengths / protective factors and supports can be incorporated to bolster treatment / intervention?”
JUSTICE INVOLVED VETERAN PROGRAM

Risk/Need
- Continued involvement in CJ system
- Training for law enforcement to intervene & divert
- Veteran Treatment Courts
- Access to veteran services while incarcerated
- Reentry planning

Responsivity
- TA & Training is military cultural competency
- JIV info cards ("jailcards")
- Statewide Partnerships
- Leveraging local resources (e.g., MVPN)
COMMUNITY & FAITH BASED PARTNER PROGRAM

Risk / Need
- Identification of veteran status
- Access to services (distance, finances, etc.)
- Workforce Shortage
- Social Isolation
- Life Purpose

Responsivity
- Faith / Spirituality linked to resiliency
- Initial touchpoint / bridge to mental health services
- Faith & Allegiance (Military Cultural Competency)
- Leveraging community partners
- Especially rural and underserved areas
HOMELESS VETERAN INITIATIVE

Risk / Need
- Higher rates of trauma, mental health issues, justice involvement
- Gaps in the continuum of care
- Accessibility

Responsivity
- Definitions of “veteran” and “homeless”
- Coordinate across programs
- Services are identified at all levels: local, state, federal
- Provide trainings to direct service staff
- Strong interagency collaboration
VETERAN PROVIDER PROGRAM

Risk / Need
- **Trauma** is a pervasive problem among veterans
  - PTSD
  - Moral Injury
  - Military Sexual Trauma
  - Traumatic Brain injury
- Accessibility o Evidence-Based Practices

Responsivity
- Military Cultural Competency
- Military Informed Care
- Trauma-informed training & technical assistance
- Veteran counselor pilot program
EVIDENCE-BASED PRACTICES & RESEARCH SUPPORTED BEST PRACTICES

Cognitive-Behavioral Therapy (CBT)
Motivational Interviewing (MI)
Cognitive Processing Therapy (CPT)
Eye Movement Desensitization & Reprocessing (EMDR)
Prolonged Exposure (PE)
Peer Model
Columbia Protocol (C-SSRS)
Mental Health First Aid (MHFA)
Counseling on Access to Lethal Means (CALM)
Ask About Suicide to Save a Life (AS+K)
MILITARY VETERAN PEER NETWORK

Risk / Need
- Isolation and lack of connectivity / support
- Stigma
- Accessibility / waitlists
- Family engagement

Responsivity
- Statewide peer-to-peer network
- Trained peer volunteers
  - Direct peer-to-peer support
  - Training community stakeholders
  - Warm-handoffs to local resources and VA
SUICIDE PREVENTION

Priority A-1
- Gatekeeping: AS+K
- Lethal Means Restriction: CALM
- Mental Health First Aid
- Texas Suicide Prevention Collaborative
- Statewide Behavioral Health Coordinating Council (SBHCC)
- Statewide Planning (TCCVS, State Plan, Long-Term Action Plan, Short-Term Action Plan, Governor’s Challenge, Mayor’s Challenge)
- Collaboration with VA and national efforts
- Suicide Prevention Coordinator
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