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Contact Hours: **2**

Suicide Risk and Prevention among Veterans for West Virginia Nurses

Mental Health Conditions Common to Veterans and their Family Members

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will demonstrate an understanding of the complex nature of suicide among veterans, how to assess and determine risk for suicide, prevention and management strategies for at-risk individuals, and appropriate treatment guidelines. Specific learning objectives include:

- Discuss the epidemiology of suicidal behavior among veterans.
- Summarize the etiology, risk, and protective factors for suicide.
- Describe the process of assessment and determination of risk for suicide.
- Outline the management of persons at risk for suicide.
- Discuss mental health issues related to suicide prevention efforts for military personnel.

EPIDEMIOLOGY

The data from the Department of Veterans Affairs and the Centers for Disease Control and Prevention tell us that suicide among military personnel has become a very serious problem. Since the wars began in Iraq and Afghanistan, military suicide rates have been increasing and have surpassed the rates for society as a whole.

The Department of Veterans Affairs has responded to this alarming increase by making suicide prevention a top priority. In order to reduce suicide risk, a climate must be created that encourages service members to seek out help, to reduce the access to lethal means, and to broaden the awareness about suicide risk and management among healthcare providers both in the military and in the private sector.

Suicide in the United States

Recent figures indicate that someone in the United States died by suicide every 12.3 minutes in 2014. Suicide is the tenth leading cause of death for all Americans and second leading cause of death for people ages 10 to 24 years. The suicide rate is close to four times higher among men than among women. Although men have a higher rate of dying by suicide, females attempt suicide three times more often (CDC, 2015a; AAS, 2015).

Suicide among U.S. Military Personnel

In 2012, more U.S. military personnel died by their own hands than in battle. Suicide was the number one cause of death among U.S. troops that year (Lee, 2013). The Veterans Health Administration reports that in 2014 an average of 20 veterans died by suicide each day. Veterans constituted 8.5% of the U.S. adult population over the age of 18 but accounted for 18% of all deaths by suicide. The risk for suicide was 21% higher among veterans when compared with U.S. civilian adults (VA, 2016a).

Tracking of military personnel suicides began in 1980, and the Afghanistan and Iraq wars have been associated with the highest suicide rates in the United States. A recent study done by the Department of Veterans Affairs revealed:

- Compared to the U.S. population, both deployed and nondeployed veterans had a higher risk of suicide (deployed veterans 41% higher, nondeployed veterans 61% higher).
- Deployed veterans had a lower rate of suicide compared to nondeployed veterans, a difference of 16%, possibly due to the fact that service members with psychological issues are held back from deployment and suicide prevention efforts are focused on those who were deployed.
- Female veteran suicide rate was about one third (11.2 per 100,000) the rate of male veterans (33.4 per 100,000).
- Regardless of deployment status, the risk of suicide was higher among younger male, white, unmarried, enlisted, and Army/Marine veterans.
- The predictors of suicide were similar for both male and female veterans.
- The increased risk of suicide among female veterans compared to the general U.S. female population was higher than the increased risk among male veterans compared to the general U.S. male population.

(VA, 2015)

A study of veterans following discharge showed the rate of suicide was found to be greatest within three years after leaving the military. For males, suicides decreased by 6.1% on average per year, but among females it varied, with a rate of 9.1 per 100,000 in the first year, 6.1 in the



second, 15.0 in the fourth year, and 9.9 in the seventh year. Early military separation (<4 years) and dishonorable discharge were suicide risk factors (VA, 2016b).

Suicide among West Virginia Veterans

In 2015 there were eight reported suicides among West Virginia Veterans (WVDVA, 2016). Nearly 1 in 10 West Virginia citizens have served in the U.S. Armed Forces. At the end of 2014, approximately 9% of West Virginians were military veterans, but veterans made up about 23% of state suicides from 2000 to 2013.

According to a Department of Veterans Affairs spokesperson, in 2011, the rate of suicide among veterans who obtained services through the Veterans Health Administration in West Virginia was 32 per 100,000. In that same year, the rate among the general population in the state was 17.4 per 100,000. These statistics support the fact that the risk for suicide is higher among West Virginia veterans when compared to the state's civilian adults (Allen et al, 2013; Beck, 2015; WVDVA, 2016).

ETIOLOGY AND RISK FACTORS

The exact cause of suicidal behavior is unknown, but it has been found that suicide is most often caused by a collection of risk factors and underlying vulnerabilities. Theories include biologic factors, psychopathology, psycho-sociocultural factors, and response to adverse life events.

Biologic factors include:

- Genetic predisposition
- Structural changes in the brain
- Neurobiological factors involving the serotonin system, the hypothalamic-pituitary-adrenal axis, and neuropsychological deficits (Kumar, 2014; Olvet et al., 2014; Goldney, 2013)

Psychopathologic factors include:

- Depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia
- Personality disorder
- Conduct disorder
- Substance abuse disorder
- Posttraumatic stress disorder (PTSD) (AFSP, 2015a)



Psycho-sociocultural factors include:

- Past experiences
- Living environment
- Relationships and support system
- Cultural norms
- Cognitive ability
- Intellect
- Personality
- Other psychological factors
(Geoffroy et al., 2014; Goldney, 2013)

Adverse life events include:

- Loss of a house, money, or employment
- Separation from children
- Serious or terminal physical illness or serious injuries resulting from an accident
- Chronic physical pain
- Intense emotional pain, hopelessness, and helplessness
- History of being victimized, such as by domestic violence, rape, or assault
- Loved one being victimized
- Physical, verbal, or sexual abuse or unresolved abuse from the past
- Feeling trapped in a perceived negative situation and that nothing can get better
- Being incarcerated or having serious legal problems
- Perceived humiliation or failure
- Combat exposure
- Psychiatric hospitalization or recent discharge from a psychiatric hospital
- Exposure to another person's suicide or to graphic or sensationalized accounts of suicide
- Poverty and low income along with few economic options or opportunities
(AFSP, 2015b; Soreff, 2015)



Suicide Protective Factors

Although there are many risk factors for suicide, there are also factors that protect people from making an attempt or completing suicide. These protective factors include:

- Access to effective clinical care for mental, physical, and substance abuse disorders
- Access to a variety of clinical interventions and support for seeking help
- Support from family and community (connectedness)
- Support resulting from ongoing medical and/or mental health relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Religious and/or cultural beliefs that discourage suicide and support the instinct for self-preservation
- Restricted access to guns
(CDC, 2015b)

Additional protective factors against suicide for military personnel have been found to include unit cohesion and mental health resilience. Social support involving leadership and soldier-to-soldier relations within a military unit may buffer against the harmful effects of stress, the development of PTSD and other psychiatric symptoms, as well as against suicidal behavior (Fisher, 2014). Resilience is defined by the American Psychological Association as a stable pattern of healthy adjustment following an adverse event, “the process of adapting well in the face of adversity, trauma, tragedy, threats, or other significant sources of stress.” It is the ability to “bounce back” (APA, 2017).

MENTAL HEALTH AND SUICIDE AMONG MILITARY SERVICE PERSONNEL

Among veterans, mental health conditions or substance use disorders have increased from approximately 27% in 2001 to more than 40% in 2014. Rates were highest among those diagnosed with severe depression.

In military culture, mental illness is often seen as a weakness and is highly stigmatized. Therefore active-duty members and veterans tend to not seek treatment. Often service members believe that having a mental illness would be detrimental to their careers, fearing that seeking help could result in discharged for being labeled incompetent or even dangerous (Beder, 2017). In one study of veterans who were asked about suicide at their last healthcare visit and who subsequently committed suicide (some within 7 days) 85% had denied having suicide ideation (Perkins, 2016).

The military branch with the greatest problem of suicide is the Army. One explanation is that it is due to an increase in poor mental health among Army personnel related to military experiences,



especially since the Afghanistan and Iraq wars. Hospitalizations among these soldiers have steadily been rising, doubling for depression alone. At the same time, active-duty soldiers have been hospitalized two and a half times more for alcohol abuse/dependence, five times more for drug abuse/dependence, and ten times more for PTSD (Castro & Kintzle, 2014).

It has been established that being in combat carries considerable risk to military personnel's psychological well-being, with higher depression and PTSD rates seen in those involved in combat when compared to those who were not. Evidence shows that the increase in military suicides is the result of an increase in mental health issues, driven in part, but not entirely, by combat and deployment involvement (Castro & Kintzle, 2014).

Suicide, however, is not only a problem among active-duty members, but also among those in the National Guard and Reserves. In one year, 2014, 166 died by suicide (Beder, 2017).

PTSD and Depression

Posttraumatic stress disorder has been found to be a risk factor for suicidal ideation. Among people who have had a diagnosis of PTSD at some point in their lifetime, approximately 27% have also attempted suicide (Tull, 2014). At least 20% of Iraq and Afghanistan veterans have PTSD and/or depression. It is the third most prevalent psychiatric diagnosis among veterans using the Veterans Affairs hospitals (Veterans and PTSD, 2015). PTSD and depression are conditions that often go hand in hand. It is estimated that nearly half of the veterans who had PTSD were also depressed, and up to 14% of service members experience depression after deployment (Kerr, 2016).

The presence of PTSD and other mental health disorders varies based on the particular war, the veteran population being studied (e.g., gender, branch of military), and when PTSD assessment is being performed (soon after return compared with years later) (Perkins, 2016). Among veterans returning from Iraq and Afghanistan, those with PTSD were three times more likely to report hopelessness or suicidal ideation than those without PTSD. Research done on this population estimates that 50% do not seek treatment (Hudenko et al., 2014).

Researchers have looked specifically at combat-related PTSD in Vietnam-era veterans and found that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt. In one study, close to 75% of veterans who had suicide ideation said they frequently experience guilt about having violated the precepts of their faith group, family, God, life, or the military (Kopacz et al., 2016).

In addition to PTSD, depression and anxiety disorders are also significantly associated with war and combat. Whereas 6.9% of Army soldiers returning from Afghanistan met screening criteria for depression, 7.9% met criteria after deployment to Iraq. A recent study found that over 25% of all female veterans reported being medically diagnosed with depression, and an additional 23% had symptoms of undiagnosed depression (Beder, 2017).

Depression is also a leading predictor of functional impairment and mortality, particularly in returning veterans with disability (Perkins, 2016).



Military Sexual Trauma (MST)

MST is defined as sexual harassment that is threatening in character or physical assault by another member of the military that occurred while the person was in the military. Estimates of the prevalence of MST range from 20% to 40% in women and 1% to 5% in men. However, since the military is approximately 85% male, the absolute number of victims is not markedly different between men and women (Perkins, 2016). In one study, 63% of female veterans reported experiences of physical sexual harassment during military service, and 43% reported rape or attempted rape (Udesky, 2017).

Men with a history of military sexual trauma are 70% more likely than fellow veterans without such experience to commit suicide, and women veterans with MST are more than twice as likely as other female veterans to do so. Those veterans who died by suicide were significantly more likely to be treated for mental health conditions that were related to their MST experience (Nelson, 2016).

Traumatic Brain Injury (TBI)

TBI has been connected to increased risk of suicide, and those with mental health problems, such as PTSD or depression, are particularly at risk. Blast brain injury affects the whole brain. On a pathological level, the decompression injury causes ischemic lesions all through the brain. Emotional control becomes unstable and unpredictable. Cognitive-emotional effects can trigger suicide.

U.S. service members have been experiencing blast brain injuries at a high rate, and even one concussion is associated with an increased risk of depression and suicide. A physical blow to the head or loss of consciousness does not need to occur for TBI to result. Military members are typically exposed to repeated blasts. Every blast creates injury, and the sooner after one injury another occurs, the worse the cumulative effect (Black, 2014; Kennedy & Wang, 2016).

Grief

Military personnel and veterans who have been bereaved by another's suicide or the loss of comrades and friends to combat may themselves be at elevated risk for suicidal thoughts and behaviors. Many veterans describe their relationships with members of their unit as some of the closest they have formed in their lives. Attachment and bonding are essential for a military unit's cohesiveness, and experiencing multiple losses can lead to problems with bereavement. Factors that can influence bereavement include survivor guilt, feelings of powerlessness, anger at others, anger at self, fear of showing emotional vulnerability, inability to acknowledge death in the field, and feelings of vulnerability (Pivar, 2016).

Studies show that trauma from exposure to suicide can contribute to PTSD. In one study among veterans with PTSD, the majority of the participants (57.3%) reported knowing someone who had died by suicide, and of these individuals, most (53.1%) reported having lost a friend to suicide (Hom et al., 2017).



Pre-Enlistment Mental Health

Mental health issue rates have risen 65% among active-duty troops since 2000 (Kime, 2015). It has been found that nearly 85% of soldiers self-reported having had a mental disorder beginning prior to enlistment. The most common mental disorders reported by soldiers were panic disorder, attention deficit hyperactivity disorder (ADHD), and intermittent explosive disorder. An early onset of these disorders as well as substance use occurred more often in soldiers than civilians (NIMH, 2014; Naifeh et al., 2015).

In an all-Army study completed by the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), soldiers reported the following suicidal ideation or behavior prior to enlistment:

- 13.9% considered suicide at some point in the past.
- 5.3% had made a suicide plan.
- 2.4% had attempted suicide.

(Naifeh et al., 2015)

The study found that prior to enlistment, patterns of suicidal ideation and behavior were lower than in a matched civilian group, but once in the Army, these became more common.

Mental Health During Military Service

Approximately one third of post-enlistment suicide attempts are tied to pre-enlistment mental disorders, accounting for 60% of first suicide attempts in the Army (NIMH, 2014). Nearly two thirds of those who completed suicide had seen a doctor within the three months prior to taking their own lives, but less than half had a mental health diagnosis and less than a third gave any indication of planning to harm themselves (Kime, 2015).

A National Institutes of Mental Health study showed there was an increased risk of suicide in soldiers without at least a high school diploma or a GED certificate compared to soldiers with similar or higher degrees, and that demotions during enlistment increased the risk for suicide (NIMH, 2014).

Of particular concern is the fact that despite the military's attempt to remove barriers that are often associated with seeking care and to ensure soldiers that their careers will not be harmed by seeking care, the reality is that seeking care can impact career advancement. In addition, soldiers are encouraged to solve their own problems. In fact, they receive resilience training with the aim that they will not need to ask for help. This makes it easy to understand how a soldier may be diverted from getting the help needed (Castro & Kintzle, 2014).



Mental Health and Post-Active Duty

The transition from the military to civilian life involves moving away from the military culture to a civilian culture, which produces changes in relationships, assumptions, work context, and personal and social identity. Because certain factors may create a susceptibility to negative outcomes with this transition, veterans are particularly vulnerable to self-harm acts (Castro & Kintzle, 2014).

When the veterans of modern-day wars return to civilian life, they are rejoining a community that has had little direct experience with the military. This can lead to a sense of alienation and feelings of not belonging (Zottarelli, 2015). In addition, a veteran's sense of accomplishment at having served in the military during wartime is often not understood or appreciated by civilians. This, too, can lead to feelings of alienation and of not belonging (Castro & Kintzle, 2014).

Another problem for today's veterans is that of unemployment and competition for jobs within a highly educated workforce. The inability to find a job can cause the veteran to develop a sense of being a burden.

The veteran of today is also in many cases dealing with unresolved mental and physical health issues. Many have been wounded in action, and many have received a diagnosis of PTSD. They often leave service without adequately addressing these issues, and when transitioning to civilian life, this can result in significant barriers to occupational and social functioning. These issues can also inhibit the veteran's ability to form meaningful relationships, which can create within them a belief that they are a burden to their family and friends as well as the community as a whole.

For the older veteran, the move from middle life to later life can bring both physical and psychological deterioration, which may be related to war injuries (Castro & Kintzle, 2014).

SUICIDE WARNING SIGNS IN THE MILITARY

Warning signs that a military service member may be contemplating suicide include:

- Calling old friends, particularly military friends, to say goodbye
- Cleaning a weapon that they may have as a souvenir
- Visits to graveyards
- Obsession with news coverage of war or with military-related television programming
- Wearing the military uniform or part of the uniform (e.g., boots) when such dress is not indicated
- Talking about how honorable it is to be a soldier
- Becoming overprotective of children



- Standing guard over the house, perhaps while everyone is asleep; staying up to “watch over” the house; obsessively locking doors and windows
- Stopping and/or holding (temporarily skipping doses) medication
- Defensive speech, such as, “You wouldn’t understand”
- Stopping making eye contact or speaking with others

Source: DSPO, 2016.

SUICIDE SCREENING AND ASSESSMENT

Suicide screening and assessment of risk for suicide are important in any suicide prevention plan; however, it is very difficult to predict who will actually die from suicide.

Suicide prevention screening refers to a quick procedure in which a standardized instrument or tool is used to identify individuals who may be at risk for suicide and in need of assessment. It can be done independently or as part of a more comprehensive health or behavioral health screening. **Suicide assessment**, as opposed to screening, refers to a more comprehensive evaluation done by a clinician to confirm a suspected suicide risk, to estimate imminent danger, and to decide on a course of treatment.

Suicide Screening

Generally, screening takes 10 to 20 minutes and can be done by any qualified health service personnel using a standardized screening instrument. Such screening may be done orally by a person asking questions, with pencil and paper, or using a computer.

The **Patient Health Questionnaire-2** screening tool asks two questions about depression symptoms and can include an additional question about suicidal thoughts and feelings. If a patient answers yes to any of the questions, the **Patient Health Questionnaire-9** (PHQ-9) is administered. This asks nine questions about depression and suicidal ideation over the last two weeks, scored as: 1 (not at all), 2 (several days), 3 (more than half the days), or 4 (nearly every day). For any items with a positive response, the patient is asked to rate the degree of difficulty it causes at work and in getting along with other people (TJC, 2016).

Other screening tools include:

- ED-SAFE Patient Safety Screener
- Ask Suicide-Screening Questions (ASQ)

With the increase in suicides occurring among veterans, it is recommended by the American Medical Association that healthcare providers ask about military history when obtaining the



social history of a patient. This includes asking about military experience, branch of service, specific jobs performed, and how patients feel the military has affected them (Kime, 2016). The American Academy of Nursing offers a screening tool for healthcare professionals known as “Have you ever served in the military?” which has received the endorsement of the National Association of State Directors of Veterans Affairs (NASDVA). (See “Resources” at the end of this course.)

Suicide Assessment

Suicide assessment is done to determine risk and is not a prediction. The goals of suicide risk assessment are to:

- Identify factors that may increase or decrease a patient’s level of risk
- Estimate an overall level of suicide risk
- Develop a treatment plan that addresses the patient’s safety and modifiable contributors to suicide

Completing an accurate suicide risk assessment is a complex task. It is extremely important for healthcare professionals to use a systematic approach to conducting and documenting the possibility that a patient will die by suicide (Harris et al., 2015).

An evidence-based approach remains difficult mainly because suicidal behavior involves so many different factors. At this time, there is no tool or scale that is specific or sensitive enough to predict to any useful degree whether a person will die by suicide. It is, therefore, important that the assessment process involve both a standardized tool and a detailed clinical interview that is repeated over time (Harris et al., 2015; Lotito & Cook, 2015).

ESTABLISHING RAPPORT

Being skilled at establishing rapport quickly is essential for all clinicians. It is imperative that the person be given privacy, be shown courtesy and respect, and be made aware that the clinician wants to understand what has happened or is happening to him or her.

Basic Attending Skills

Basic attending and listening skills are valuable in establishing rapport and a therapeutic alliance in order to obtain information, set the foundation for the treatment plan, and assist in determining interventions. These skills range from nondirective listening behaviors to more active and complex ones.

Positive attending behaviors are nonverbal and include:

- **Eye contact.** Cultures vary in what is considered appropriate. Asian and Native Americans, for example, may view eye contact as aggressive. Most patients are



comfortable with more eye contact when the interviewer is talking and less when they are talking.

- **Body language.** Usually leaning slightly toward the patient and maintaining a relaxed but attentive posture is effective. This may also include mirroring, which involves matching the patient's facial expression and body posture.
- **Vocal qualities.** These include tone and inflections of the interviewer's voice. Tonal quality may move toward "pacing," which is matching the patient's vocal qualities.
- **Verbal tracking.** This involves using words to demonstrate that the interviewer has an accurate following of what the patient is saying, such as restating or summarizing what the patient has said.

Negative attending behaviors include:

- Turning away from the patient
- Making infrequent eye contact
- Leaning back from the waist up
- Crossing the legs away from the patient
- Folding the arms across the chest

Listening Skills and Action Responses

Effective interviewing also requires nondirective and directive listening as well as directive action responses.

Nondirective listening responses include:

- **Silence** is a skill requiring practice to be comfortable with. It is very nondirective, and if used appropriately, it can be very comforting for the patient.
- **Paraphrasing** or reflection is a verbal tracking skill that involves restating or rewording what the patient has said. There are three types of paraphrasing that can be utilized:
 - Simple paraphrasing gives direction but involves rephrasing the core meaning of what the patient has said.
 - Sensory-based paraphrasing involves the interviewer using the patient's sensory words in the paraphrase (visual, auditory, kinesthetic, etc.).
 - Metaphorical paraphrasing involves making an analogy or metaphor to summarize the patient's core message.



- **Intentionally directive paraphrasing** is solution-focused and attempts to lead the patient toward more positive interpretations of reality. It involves selecting positive parts of the patient's statement and can also include adding to or "twisting" what has been said.
- **Summarization** is an informal summary of what the patient has said. It should be interactive, encouraging, and supportive, and include positives or strengths that may help the patient cope.

Directive listening skills include:

- **Validating feelings** involves acknowledgement and approval of the patient's emotional state. It can help patients accept their feelings as normal or natural and can enhance rapport.
- **Interpretive reflection of feeling**, also referred to as advanced empathy, seeks to uncover deeper, underlying feelings, which can bring about strong emotional insights or defensiveness.
- **Interpretation** can be a classic psychoanalytic technique that produces patient insight, or a solution-focused way to help patients view their problems from a new and different perspective, known as reframing.
- **Confrontation** involves pointing out discrepancies to help the patient see reality more clearly. It works best when excellent rapport has been established, and it can be either gentle or harsh.
(Sommers-Flanagan & Sommers-Flanagan, 2014)

The individual who is suicidal should be encouraged and given the opportunity to express thoughts and feelings and allowed to discharge pent-up and repressed emotions. This can best be achieved by asking **open-ended questions** such as: "What are your feelings about living and dying?" Such questions allow an expression of the ambivalent feelings most often experienced by persons who are suicidal. Direct questions such as "Do you really want to kill yourself?" do not allow such an expression.

It is also important to avoid "why" questions, which tend to make people defensive. Asking "who," "what," "where," "when," and "how" questions allows for more detailed information to be obtained for consideration (IASP, 2015).

ASSESSING SUICIDAL INTENT

Once an individual is suspected of thinking about dying by suicide, specific and direct questions should be asked, such as:

- Have you ever felt that life is not worth living?
- Have you been thinking about death recently?



- Did you ever think about suicide?
- Have you ever attempted suicide?
- Do you have a plan for suicide?
- What is your plan for suicide?

Assessment Tools

There are many tools available to assist healthcare professionals in determining suicidal intent. These assessment tools are used to assess a person's intent to carry through. They are often used following positive results done with one of the screening tools mentioned above.

Columbia-Suicide Severity Rating Scale (C-SSRS) is currently the most favored assessment tool. In 2012, the U.S. Food and Drug Administration conferred "gold standard" status on this scale, which is used extensively in primary care, clinical practice, surveillance, research, and institutional settings worldwide. It is exceptionally useful in initial screening, and no mental health training is required to administer it (CUMC, 2015; Giddens et al., 2014).

The C-SSRS consists of two sections: suicidal ideation and suicidal behavior. The scale provides definitions and standardized questions for each category. The suicidal behavior section assesses for four suicidal behaviors: 1) an actual attempt, 2) an interrupted attempt, 3) an aborted attempt, and 4) preparatory behavior. This is then followed by questions regarding the intensity of the ideation (CUMC, 2015).

Other effective assessment tools include:

- Beck Depression Inventory-II
- Beck Hopelessness Scale
- Beck Scale for Suicidal Ideation
- Linehan's Reasons for Living Scale
- Firestone Assessment for Self-Destructive Thoughts

Structured Interview

Although assessment tools are helpful, the best approach in determining risk for suicide is through an integration of a history with a structured interview that includes the following components:

- Exploring suicide risk factors
- Assessing depression



- Direct questioning regarding suicidal ideation
- Determining the presence of a suicide plan
- Determining suicide intent by assessing the patient's reasons for living
- Judging the patient's self-control
- Exploring military history
(Sommers-Flanagan & Sommers-Flanagan, 2015)

The **Chronological Assessment of Suicide Events (CASE)** approach is a structured interviewing technique that allows the healthcare provider to get a detailed account of suicidal thoughts, any preparations and attempts, and current psychiatric symptoms that may require treatment. It is an easily learned interviewing strategy designed for use by frontline clinicians in both mental health and primary care settings and can be completed in 5 to 10 minutes (Lotito & Cook, 2015; Peterson, 2014; TISA, 2015).

This flexible interviewing strategy is used to sensitively uncover suicidal ideation, planning, behaviors, and intent by gathering important information in four time frames:

1. Exploring the **present** problem from beginning to end (past 48 hours)
2. Exploring **recent** suicidal events and determining extent and lethality of suicidal planning (previous 2 months)
3. Gathering **past** history of suicidal ideation or behaviors (prior to 2 months ago)
4. Determining the **immediate and future** suicidal ideations (during the interview itself)
(Lotito & Cook, 2015)

ASSESSING THE PLAN, LETHALITY, AND RISK

When assessing lethality of a plan, it is important to learn all the details about the plan, the method chosen, and the availability of means. People with definite plans for a time, place, and means are at high risk for suicide. Someone who is considering suicide without making a plan is at lower risk.

Methods of Suicide and Lethality

The desire for a painless method of suicide often leads individuals to choose a method that tends to be less lethal. This results in failed attempts. For every successful attempt, there are 33 unsuccessful ones, and for drug overdoses, the ratio is around 40 to 1.

The most common means for suicide among veterans is firearms, with approximately 41% of female and 68% of male veteran suicide deaths resulting from a firearm injury in 2014. Poison (overdosing on medications, drugs, or alcohol) is the second most common



means of suicide for female veterans, at 32%. Among male suicide decedents, suffocation in the second most common cause of death, at 17% (VA, 2016a; Villatte et al., 2015).

Level of Risk

Low risk. Patients who have had recent suicidal ideation or thoughts but no specific plans or intent to die by suicide, who are able to control the impulse to act, and who have no history of suicidal behaviors are considered low risk and should have outpatient follow-up recommended. Follow-up should always be offered if there are inadequate social supports available.

Moderate risk. A patient who has current suicidal ideation or thoughts, has a plan but with no intent to act, is able to control the impulse, and has no recent suicidal behavior is at moderate risk. The patient and family should be educated on risk and treatment options. A safety plan should be established and access to lethal means should be limited. Referral should be made for outpatient psychiatric evaluation and treatment.

High risk. Patients with persistent thoughts of suicide; those with a plan and/or intent to die by suicide; and those presenting with significant agitation, impulsivity, psychosis, or a recent suicide attempt are considered high risk. In this situation, clinicians should ensure that the patient is under constant observation and monitoring while arrangements are made for immediate transfer with escort to emergency care for psychiatric evaluation and possibly hospitalization (IASP, 2015; Goldney, 2013; VA, 2015).

After a patient has been stabilized and there is improvement in suicidal ideation, risk for suicide still remains. Those who attempt suicide have a risk of death during the following year that is 100 times greater than that of the rest of the population (Norris & Clark, 2012).

Impulsiveness and Access to Means

The evidence is heavily weighted to support the claim that suicide is rarely if ever an impulsive and unplanned behavior. The actual suicide act occurs, as would any behavior, in a brief span of time, but the suicidal ideation and ambivalence that precedes it waxes and wanes.

During a short-term crisis, suicide attempts can be made impulsively. Twenty-five percent of individuals aged 13 to 34 who attempted suicide and survived said that less than five minutes passed from the time they decided to kill themselves and the actual attempt to do so (SAMHSA, 2014).

Documentation

Accurate, sufficiently detailed, and concise records of a patient's treatment allows for quality care and communication among providers (APA, 2016).



Since suicide risk assessment is not a one-time, isolated event, a standardized form is recommended to gather essential information on risk and protective factors as well as collateral information and to make it readily accessible to other clinicians. The use of such a form ensures that all important facets of the assessment are included and allows the clinician as accurately as possible to make a clinical judgment about level of risk and the treatment plan that coincides with this level (APA, 2016).

SUICIDE RISK ASSESSMENT DOCUMENTATION ELEMENTS

The following elements are considered essential in the accurate documentation of a suicide assessment:

- Events preceding the person's current suicidal ideation or behavior
- The frequency, duration, and intensity of suicidal thoughts
- Preparations made, such as giving away possessions, putting affairs in order, stockpiling pills
- The stated or inferred desire to die and the intent to act
- The reasons for wanting to die
- Past suicide attempts, including the outcome and aftermath
- Any protective factors that could reduce the risk of suicide
- The person's view of the risk factors for suicide
- The clinician's view of the person's risk factors
- The plan or methods considered and the means to carry out the plan
- Inquiries about firearms and other lethal means available to the person
- Efforts made to have lethal means removed from the patient's environment
- Consultations or collaboration sought from significant others, such as spouse or parents, as well as what they said
- Consultations with other providers (including phone, face-to-face, email)
- Categorization of level of risk (low, medium, high, imminent), including rationale
- Steps that were put in place, considering the combination of risk and protective factors unique to the patient
- Rationale for treatment decisions, including rationale for actions not taken
- Creation of a crisis plan
(MacDonald, 2015; Freedenthal, 2015)



Any information that does not fit on the standardized assessment form should be documented on separate sheets of paper that are individually signed, dated, and attached to the assessment form.

This record may become a legal document if the person goes on to attempt suicide or die by suicide. If notes are subpoenaed, they should never be edited (MacDonald, 2015; Freedenthal, 2015).

MANAGEMENT OF THE PATIENT AT RISK FOR SUICIDE

Following medical stabilization of a patient in the event of a suicide attempt or in patients identified as at risk for suicide, a safe environment should be the first consideration.

Patients with suicide ideation but with no plans or means in place, who also have good social support, may be treated as **outpatients**. With the consent of the adult patient, family or friends should be enlisted to ensure the patient's safety and adherence to follow-up. If the patient is considered safe to go home with later follow-up from behavioral health, the patient's contact information is obtained and passed on (Russ & Russ, 2016).

Inpatient admission should be offered for patients with a specific plan and means in place (Bolster et al., 2015).

Making a Referral

Initial contact providers can prevent suicides by connecting patients to appropriate behavioral health services. The Suicide Prevention Resource Center offers guidance to assist in identifying those needing referral (Dehay et al., 2013). (*See "Resources" at the end of this course.*)

- Because of the urgency, an **emergency assessment** (preferably within seven days) should be requested.
- Patients who are initially assessed to be at moderate or high risk and who have symptoms of a psychiatric disorder should be referred to a **psychiatrist** for medication evaluation.
- Patients with alcohol or substance use/abuse issues should be referred for **alcohol/drug assessment** and treatment.
- Patients in any category of risk experiencing significant thoughts of suicide or death should be referred for **individual or family therapy**.
- All patients at risk should be provided information in writing about the **National Suicide Prevention Lifelines**. Counselors at these crisis centers are skilled in suicide crisis management and can provide information about local resources.

Close follow-up with a patient who has the potential for suicide is very important. Even a very simple follow-up contact (e.g., phone call) has been shown in studies to reduce the risk for



additional suicide attempts and completed suicide. The provider should use each follow-up contact as an opportunity to assess for recurrent or increase in suicidal ideation or behavior.

For ED patients, if the number of days following discharge from the ED until the follow-up appointment exceeds the recommended seven days, the following should be considered, if available, while awaiting longer-term treatment:

- A transition clinic for short-term outpatient crisis management
- Partial hospitalization or day treatment program
- Crisis residential placement for 24-hour crisis stabilization (SPRC, 2013)

TREATMENT MODALITIES FOR PATIENTS AT RISK FOR SUICIDE

Patients who are suicidal warrant some form of emotional support or psychotherapy with a focus on learning more adaptive ways of coping in the future. They may also warrant medications for treatment of specific mental disorders such as major depression. Treatment modalities include:

- Cognitive behavioral therapy (CBT)
- Dialectical behavior therapy (DBT)
- Interpersonal therapy (IPT)
- Problem-solving therapy
- Milieu therapy
- Group therapy
- Creative arts therapy
- Occupational therapy
- Antidepressant medications

Discharge Following a Suicide Attempt

When an individual is being discharged following a suicide attempt:

- Provide the patient and family with information regarding risk and protective factors, warning signs of worsening condition, treatment options, home care, and follow-up recommendations.
- When possible, schedule the first follow-up appointment before the patient is discharged, preferably within 24 to 72 hours and within a maximum of seven days after discharge.



- Provide written educational materials, such as the “After an Attempt” guide, copies of which can be downloaded from the National Suicide Prevention Lifeline website. (*See “Resources” at the end of this course.*)
- Provide military personnel with contact information for the Veterans Crisis Line. (*See “Resources” at the end of this course.*)
- Provide instructions for obtaining resources and supports in the community.
- Advise about reducing the hazards of another suicide attempt by removing lethal means, especially firearms.
- Develop a personalized suicide prevention plan that includes a written list of safety considerations, coping strategies, and sources of support the person can use during or before suicidal crises.
- Review discharge arrangements with patients verbally, along with a written document, and encourage adherence to the discharge plan.
 (SPRC, 2013)

Outpatient Management

It is important that the patient’s social support system be enlisted to assist with outpatient management. The patient should have frequent contact with his or her primary care provider and access to mental health and behavioral specialists as well as community programs that provide crisis counseling.

Appropriate psychopharmacotherapy, psychotherapy, or sociotherapy should be initiated for the patient who is being managed on an outpatient basis, and any medications prescribed for the patient should be given in limited amounts (e.g., 3- to 5-day supply with no refill). The intensity of outpatient treatment should vary in accordance with risk indicators and might mean more frequent appointments, telephone contacts, and concurrent individual and group treatment.

Inpatient Management

Admission to a psychiatric hospital or unit generally is necessary for those at high risk for suicide in order to keep them safe. The greatest majority of such admissions are voluntary, which means the person freely agrees to be admitted for treatment. Anytime someone attempts suicide and refuses treatment, however, the person most likely will be involuntarily committed for treatment.



INVOLUNTARY COMMITMENT

Involuntary commitment means placing a person in a psychiatric hospital or unit without their consent. According to West Virginia Code §27-5-4, an adult person can make an application for involuntary hospitalization of another person if it is believed the person is likely to cause serious harm to self or others **due to what the applicant believes are symptoms of mental illness or addiction**. The court may detain this person for a probable cause hearing to be held within 24 hours, during which time a mental health examination is ordered and the court will appoint legal counsel.

During the hearing, the person can remain silent but has the right to confront witnesses and testimonies against him/her and to present evidence and witnesses of their own.

If the court determines there is probable cause based upon the examining physician's determination that the person is a threat to self or others, a final commitment hearing must be instituted within 15 days.

West Virginia case law says that justification for commitment will end when the person is found to no longer be a threat to harm self or others.

Source: West Virginia Legislature, 2016.

SUICIDE PREVENTION STRATEGIES

A U.S. Surgeon General's public service announcement (2015) stated, "We all have a role to play in preventing suicide." A public health approach to suicide prevention employs strategies that:

- Identify people at risk
 - Increase help-seeking behavior
 - Provide access to mental health services
 - Establish crisis management and postvention procedures
 - Restrict access to lethal means
 - Enhance life skills
 - Promote social networks and connectedness
- (SPRC, 2015)

Within the Department of Veterans Affairs, the Veterans Health Administration's approach to suicide prevention is based on a public health framework that focuses on intervention within populations rather than a clinical approach that intervenes with individuals. This approach allows for consideration of the broader problem of suicide among all veterans, including those not



currently being cared for by the VHA. This framework has three elements: 1) surveillance, 2) risk and protective factors, and 3) interventions.

Surveillance

The agency is involved in the systematic collection of data about suicide rates and identification of characteristics associated with higher or lower suicide risk. No nationwide surveillance system exists for suicide among all veterans; therefore, surveillance requires gathering information from other sources such as the Department of Defense, which standardizes suicide surveillance efforts across all the branches of the armed services (Air Force, Marine Corps, Army, and Navy) (National Center for Telehealth & Technology, 2015; Bagalman, 2016).

Risk and Protective Factors

Risk and protective factors are gleaned from the data collected from surveillance and are then used to develop interventions that reduce risk factors and/or increase protective factors. Risk factors are used in identifying at-risk groups or individuals so that interventions can be developed and delivered to them.

Veteran-specific research on risk and protective factors is required because the veteran population differs from the nonveteran population in ways that may be associated with suicide risk. Veterans who are enrolled in the VHA may also differ from nonenrolled veterans.

Interventions

The development of intervention strategies addresses all veterans, at-risk subgroups, and high-risk individuals. VHA's suicide prevention interventions include:

- Easy access to care
- Screening and treatment
- Suicide prevention coordinators
- Suicide hotline
- Education and outreach
- Limiting access to lethal means

In order to facilitate access to care, the Veterans Access, Choice, and Accountability Act of 2014 requires the VHA to authorize reimbursement for non-VHA care under certain circumstances, and the Clay Hunt Suicide Prevention for American Veterans (SAV) Act of 2015 included a one-year extension of the existing five-year postdischarge period of enhanced enrollment in VHA healthcare for certain veterans.



Each VA medical center has at least one suicide prevention coordinator who tracks patients identified as high risk for suicide. A safety plan is developed for them; it is a written document created by both patient and clinicians that identifies strategies for coping in a crisis.

The VHA has a gun safety program that includes free gun locks and the dissemination of gun safety information. VHA also is conducting research on blister packaging medication in an effort to reduce medication overdoses.

The VA established the Veterans Crisis Line in 2007, and it has since answered over two million calls and initiated emergency service dispatch over 56,000 times. In 2009, the anonymous online chat service was added and has been involved in over 267,000 chats. In 2011, the Veterans Crisis Line began a text-messaging service, which has since responded to more than 48,000 texts. The VA is also coordinating with communities and partner groups across the country (VA, 2016c).

CONCLUSION

On average, 20 U.S. veterans die by suicide each day. The Department of Veterans Affairs has made suicide prevention a top priority and seeks to create a climate that encourages veteran help-seeking behaviors, reduces access to lethal means, and ensures that healthcare providers in both the military and the private sector are aware of suicide risk and management among this population. Having knowledge of risk factors, protective factors, issues of mental health among veterans, and obtaining a military history are the most important steps in the process of assessing for risk of suicide and providing suicide prevention interventions.



RESOURCES

American Foundation for Suicide Prevention
<https://afsp.org>

Ask Suicide-Screening Questions (ASQ)
<https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials>

Columbia-Suicide Severity Rating Scale (C-SSRS)
<http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english>

“Have you ever served in the military?” screening tool (American Academy of Nursing)
<http://www.haveyoueverserved.com/intake-questions.html>



National Suicide Prevention Lifeline
<http://www.suicidepreventionlifeline.org>
800-273-TALK (8255)
866-833-6546 (teen link)
741741 (crisis text line)

Suicide Prevention (National Institute of Mental Health)
<http://www.nimh.nih.gov/health/topics/suicide-prevention/>

Suicide Prevention Resource Center
<http://www.sprc.org/>

Veterans Crisis Line
<http://www.VeteransCrisisLine.net/chat>
800-273-8255, press 1
838255 (text line)

Veterans Self-Check Quiz
<https://www.vetselfcheck.org/welcome.cfm>

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TEST

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1. Suicide in the United States is:
 - a. Four times higher in women than men.
 - b. The tenth leading cause of death.
 - c. The first leading cause of death in people ages 60 to 80.
 - d. Attempted by men more often than women.

2. A recent study regarding suicide rates among veterans found that:
 - a. Nondeployed veterans had a lower suicide rate than deployed veterans.
 - b. Female veterans had a higher suicide rate than male veterans.
 - c. Both deployed and nondeployed veterans had a higher suicide rate than the general U.S. population.
 - d. Male and female veterans had different predictors of suicide.

3. A biologic risk factor for suicide is:
 - a. Depression.
 - b. Cognitive ability.
 - c. Genetic predisposition.
 - d. Posttraumatic stress disorder.

4. A protective factor against suicide unique to military personnel includes:
 - a. Unit cohesion.
 - b. Ongoing medical support.
 - c. Combat exposure.
 - d. Problem-solving skills.

5. Among which group in particular is depression a leading predictor of functional impairment and mortality?
 - a. Navy personnel
 - b. Vietnam War veterans
 - c. Returning veterans with a disability
 - d. Deployed male Marines



6. Which is a **true** statement regarding suicide during military service:
- a. Over 90% of suicides were completed by officers.
 - b. Approximately one third of suicide attempts are tied to pre-enlistment mental disorders.
 - c. Suicide rates are lowest among soldiers who are divorced or separated.
 - d. The majority of service members who attempt suicide give advance indications they plan to harm themselves.
7. Which is a suicide warning sign characteristic of military personnel in particular?
- a. Giving away personal possessions
 - b. Refusing to watch any news coverage of wars or military activity
 - c. Refusing to visit graveyards
 - d. Standing guard over the house
8. During a clinical suicide assessment interview, the nondirective listening response that involves restating or rewording what the patient has said is called:
- a. Summarization.
 - b. Paraphrasing.
 - c. Validating feelings.
 - d. Confrontation.
9. Which suicide assessment tool is labeled by the U.S. Food and Drug Administration as the “gold standard”?
- a. Beck Scale for Suicidal Ideation (SSI)
 - b. Chronological Assessment of Suicide Events (CASE)
 - c. Beck Hopelessness Scale (BHS)
 - d. Columbia-Suicide Severity Rating Scale (C-SSRS)
10. The **best** approach for determining an individual’s risk for suicide is:
- a. Integrating a patient history with a structured interview.
 - b. Taking a patient history and administering a depression screening tool.
 - c. Using a suicide assessment scale while establishing patient rapport.
 - d. Conducting an unstructured interview and psychiatric evaluation.



- 11.** Which patient is at **highest** risk for suicide completion?
- A woman talking about suffocation by hanging
 - A man with a suicide plan who possesses a firearm
 - An adolescent planning to take a handful of pills
 - A young woman with a history of depression
- 12.** Which is a **correct** statement about the essential elements in documenting suicide assessment?
- Include the rationale for actions not taken.
 - Avoid the use of a standardized form.
 - Do not include the clinician's view of the patient's risk factors.
 - It is not necessary to document a past suicide attempt outcome or aftermath.
- 13.** In West Virginia, when is involuntary commitment to a hospital appropriate management for a patient at risk for suicide?
- The patient has made a plan for suicide but has had no recent suicidal behavior.
 - The patient makes a serious suicide attempt.
 - The applicant is aware the patient has access to a high-risk method of suicide.
 - The applicant believes the patient has symptoms of mental illness or addiction.
- 14.** Each VA medical center has at least one suicide prevention coordinator whose role is to:
- Restrict veterans' access to lethal means.
 - Track patients identified as high risk for suicide.
 - Standardize suicide surveillance efforts across all branches of the armed services.
 - Create a written safety plan for patients at high risk for suicide.

