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. Specific learning objectives to address potential learning gaps include:

- Discuss the epidemiology of suicidal behavior among veterans.
- Summarize the etiology, risk, and protective factors for suicide.
- Describe mental health issues related to suicide by military personnel.
- Discuss how clinicians can recognize suicide risk.
- Summarize the steps involved in assessing an at-risk individual.
- Discuss patient disposition according to level of risk.

Epidemiology

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 among U.S. Veterans and Active-Duty Military

The United States Department of Veterans Affairs reported that in 2017, 6,139 veterans died by suicide. In 2017, veterans constituted 7.9% of the U.S. adult population but accounted for 13.5% of all deaths by suicide among U.S. adults. Suicide rates per 100,000 population for veterans was 1-1/2 times the rate for nonveteran adults, and firearms were the most common method (70.7% of males and 43.2% of females).

From 2005 to 2017, there was a 43.6% increase in the number of suicide deaths in the general population and a 6.1% increase in the number of suicide deaths in the veteran population. An average of 16 veterans died by suicide each day during that same period, and in 2017 an average of 17 veterans died by suicide each day.

Between 2005 and 2017, the female veteran population increased by over 6%, and in 2017 the rate of suicide among female veterans was more than double the rate among nonveteran women. The 2017 rate of suicide among male veterans was nearly 1-1/2 times higher than the rate among nonveteran males.

In 2017, 58.7% of veterans who died by suicide had a mental disorder diagnosis (highest was bipolar disorder) or substance use disorder (highest was opioid use disorder).

Veterans ages 18 to 34 had the highest suicide rate in 2017, increasing 76% during the period from 2005 to 2017, and veterans ages 55 to 74 had the lowest rate. However, the absolute number of suicides was highest among veterans 55 to 74 years of age, accounting for 38% of all veteran deaths by suicide in 2017.

In 2018 the number of suicides among active-duty personnel was the highest in at least six years and roughly equal to the rates in the general U.S. population. Service members who died by suicide were primarily enlisted persons less than 30 years of age, the majority were male, and the primary method used was a firearm. The following are the number of suicides and the rate per 100,000 for each branch of the military:

- Army, 139 (29.5)
- Marine Corps, 58 (31.4)
- Navy, 68 (20.7)
- Air Force, 60 (18.5)
- Reserve members, 81 (22.9)
- National Guard, 135 (30.6)
(U.S. DOD, 2018; Kime, 2019a)
Suicide among Military Spouses and Dependents

In 2019 the Pentagon’s first-ever report on military family suicides reported that 123 spouses and 63 children took their own lives in 2017. Seven spouses were service members themselves. According to the report, the means of suicide in more than half the deaths of both spouses and dependents was a firearm—54% of spouses and 51% of dependents. Use of a weapon by female military spouses is a departure from behavior in the general population in that same year, which was 31.2% (Kime, 2019b).

Suicide among West Virginia Veterans

In 2017 the veteran suicide rate in West Virginia (41.5 per 100,000) was not significantly different from the national veterans’ suicide rate (31.0). However, it was significantly higher than the national population suicide rate (18.1) and the West Virginia population rate (26.9).

The U.S. Department of Veterans Affairs reported a total of 59 veteran suicides in West Virginia during 2017, the greatest number occurring in males. Of these veteran suicides, the highest number by age (23) were individuals between 35 and 54 years, and the highest percentage (79.7%) was related to firearms (VA, 2019a).

ETIOLOGY AND RISK FACTORS

The exact cause of suicidal behavior is unknown, but it is clear that the etiology is multifactorial (Zalsman, 2019). Studies done to date have found that suicide is most often caused by a collection of risk factors and underlying vulnerabilities. Genetic predisposition is a part of the explanation, but other biological, social, economic, lifestyle, and environmental factors also play important roles in the etiology of suicidal behavior. Mental illness is a major factor in the development of suicidal behavior (Strawbridge, 2019).

Biologic Factors

Biologic factors that contribute to suicide include:

- Genetic predisposition and personality traits
- Neurobiology
- Structural brain changes
- Immune system dysregulation
- Neuropsychology
- Psychopathology
Among psychopathological factors, psychiatric diseases account for a large majority of suicides and suicide attempts—at least 10 times as high as in the general population. Psychological autopsies (collected from family relatives, friends, and healthcare providers) from the middle of the previous century and onward have revealed that most (at least 90%) of those who have died by suicide were experiencing a mental disorder, the relevant risk factors being depression, substance use disorders, and psychosis. However, anxiety-, personality-, eating-, and trauma-related disorders, as well as organic mental disorders such as dementia or physical illness, also contribute to risk (Brådvik, 2018; Bachmann, 2018).

One in four active-duty members of the U.S. military exhibit symptoms of mental illness, which are mostly the manifestation of posttraumatic stress disorder (PTSD), depression, traumatic brain injury, and/or stress related to transition back to civilian life. The lifetime prevalence of depression and PTSD is 5 to 15 times higher respectively when compared to civilians (Shirol & Current, 2019).

**Psycho-Sociocultural Factors**

Psycho-sociocultural factors are those that make someone respond to their environment in their own unique way. Such factors that may contribute to suicide risk include a person’s:

- Past experiences
- Environment in which a person lives
- Relationships with and support from others
- Cultural norms
- Cognitive abilities
- Intellect
- Personality
- Other psychological factors
  (Maniou et al., 2017)

**Adverse Life Events**

An extensive body of sociodemographic and psychological autopsy studies finds that almost all persons who died by suicide had experienced at least one stressful life event (usually more than one) within the year prior to death. Specific events that increase the risk of suicide include:

- Death of a family member
- Interpersonal conflicts (family or relationships with third parties)
- Separation/divorce
- Rejection
• Humiliation
• Physical illness
• Chronic physical pain
• Unemployment
• Problems at work
• Financial problems
• Serious injury or attack
• Sexual or physical abuse
• Rape
• Personal loss
• Domestic violence
• Problems with the law
• Change of residence/moving

(Maniou et al., 2017)

Suicide Risk among Military Personnel

Suicide is the second leading cause of death among active-duty U.S. military personnel (MSRC, 2019). Although suicide affects all groups of the population, the risk among military personnel differs in some ways.

Experiencing child abuse, being sexually victimized, and exhibiting suicidal behavior before enlistment are significant risk factors for service members and veterans, making them more vulnerable to suicidal behavior when coping with combat and multiple deployments.

Military personnel reporting child abuse as children have been found to be three to eight times more likely to report suicidal behavior. Sexual trauma of any type increases the risk for suicidal behavior. Men who have experienced sexual trauma are less likely to seek mental health care than females, as they may see it as a threat to their masculinity, a strong predictor of suicide attempts in military personnel. Service members who attempted suicide before joining the military are six times more likely to attempt suicide after joining the military (APA, 2019a).

A number of psycho-social factors are associated with suicide risk in the military, including relationship problems, administrative/legal issues, and workplace difficulties. Medical conditions that are associated with an increased risk for suicide among military personnel include traumatic brain injury, chronic pain, and sleep disorders (USUCDP, 2019).

Suicide among women in the military has increased at twice the rate of male service members. The primary reason is sexual trauma, particularly incidences of harassment and rape while stationed overseas. An estimated one in four military women are victims of sexual trauma. This
number, however, is believed to be low due to the stigma and possible consequences associated with reporting. Sexual trauma combined with combat stress can result in a higher risk of dying by suicide (Gorn, 2019).

There is strong evidence that among veterans who experienced combat trauma, the highest suicide risk has been observed in those who were wounded multiple times and/or were hospitalized as a result of being wounded (VA, 2019b).

Suicide Protective Factors

Although there are many risk factors for suicide, there are also factors that protect people from making an attempt or dying by suicide. These protective factors are both personal and environmental.

Personal protective factors include:

- Values, attitudes, and norms that prohibit suicide, such as strong beliefs about the meaning and value of life
- Strong problem-solving skills
- Social skills, including conflict resolution and nonviolent ways of handling disputes
- Good health and access to mental and physical healthcare
- Strong connections to friends and family as well as supportive significant others
- Cultural, religious, or spiritual beliefs that discourage suicide
- A healthy fear of risky behaviors and pain
- Optimism about the future and reasons for living
- Sobriety
- Medical compliance and a sense of the importance of health and wellness
- Good impulse control
- A strong sense of self-esteem or self-worth
- A sense of personal control or determination
- Strong coping skills and resiliency
- Being married or a parent
- Being pregnant (although pregnancy and motherhood has been studied as a protective factor, suicide remains a leading cause of maternal death in industrialized countries and vigilance in assessing for ante- and postpartum depression and anxiety must be strongly considered) (Weber et al., 2019)
External/environmental protective factors include:

- Opportunities to participate in and contribute to school or community projects and activities
- A reasonably safe and stable environment
- Financial security
- Responsibilities and duties to others
- Owning a pet
- Restricted access to lethal means
  (CDC, 2019; SPRC, 2019a; WMU, 2019)

In addition to the protective factors described above, veterans may possess unique protective factors related to their service, such as resilience and social connectedness through a strong sense of belonging to a unit (VA, 2018a). Resilience is defined by psychologists as the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. Resilience can also involve profound personal growth (APA, 2020a).

MENTAL HEALTH AND SUICIDE AMONG MILITARY SERVICE PERSONNEL

The U.S. Department of Veterans Affairs reports that postmortem forensic reviews suggest that most persons who die by suicide have identifiable mental illness, yet only about one half had received a mental health diagnosis prior to their death. It has also been reported that 30% of active-duty and reserve military personnel deployed in Iraq and Afghanistan have a mental health problem requiring treatment, and of this 30%, only half of these returning vets in need receive any mental health treatment (VA, 2018a; Rappaport, 2018; NCBH, 2020).

Military culture has been found to contribute to this failure to receive mental health treatment. In this culture, there are multiple potential barriers that veterans face in seeking treatment for mental health issues, the first of which is that mental illness is often seen as a weakness and is highly stigmatized. Military socialization, command structure influences, and institutional attitudes (the ethos of “toughing it out”) reinforce the belief that help-seeking is a sign of failure.

Another barrier is the fear that disclosing a mental health issue increases the risk of losing one’s career. The same belief is not held when a problem is a general medical condition. Therefore, active-duty members and veterans tend to avoid seeking treatment (Cheney et al., 2018; Fischer & Weisner, 2019).

In a study done by the Military Suicide Research Consortium (MSRC, 2019) to determine the top reasons behind soldiers’ suicides, of 33 reasons they had to choose from, all of the soldiers included one in particular—the desire to end intense emotional distress.
There are three primary mental health concerns identified among military and veteran populations that are known to increase the risk of suicide. These include:

- Posttraumatic stress disorder
- Depression
- Traumatic brain injury

All of these involve emotional symptomatology and distress (NAMI, 2020).

**Posttraumatic Stress Disorder**

Posttraumatic stress disorder (PTSD) is a psychiatric disorder that can occur in persons who have experienced a traumatic event such as a natural disaster, a terrorist act, war and combat, rape, or other personal assault. A diagnosis of PTSD requires such exposure, but it could also result from indirect exposure to trauma experienced by others, such as a family member or a fellow soldier.

In the military during World War I, PTSD was referred to as *shell shock*, and following World War II, it was called *combat fatigue* (APA, 2020b). The rate of PTSD may be up to 15 times higher in active-duty service members compared to civilians (NAMI, 2020).

PTSD develops differently for each veteran, with both physical and psychological symptoms. However, there are four distinguishing clusters of symptoms, which include:

- Recurrent and intrusive reminders of the traumatic event
- Extreme avoidance of reminders of the event
- Being hypervigilant, emotionally reactive, or jumpy
- Feelings of guilt

Of these, the most significant predictor of both suicide attempts and preoccupation with thoughts of suicide is combat-related guilt about acts committed during times of war (VA, 2019b; Smith et al., 2019). PTSD is associated with difficulties in social and family life as well as occupational instability. It is often accompanied by depression, substance abuse, and problems of memory and cognition (Military Advantage, 2020).

**MILITARY SEXUAL TRAUMA**

*Military sexual trauma* (MST) refers to a service member’s experience with sexual assault or harassment. Both male and female veterans report experiencing MST; women are at greater risk, although nearly 40% of veterans who disclose MST are men. Sexual assault survivors show a higher lifetime rate of PTSD for both men and women. MST is also associated with depression and other mood disorders, as well as substance use disorders (DAV, 2020).
Depression

Depression very often occurs following trauma and frequently is comorbid with PTSD. It is nearly three to five times more likely in those with PTSD than those without it. Veterans returning from a war zone may have had traumatic experiences that can lead to depression as well as to PTSD. The rate of depression may be up to five times higher in active-duty service members compared to civilians, and with more severe depression, suicidal ideation may occur (VA, 2019c; NAMI, 2020).

Depression symptoms can range from mild to severe and may include:

- Persistent sadness, anxiety, or depressed mood
- Feelings of hopelessness or pessimism
- Irritability
- Feelings of guilt, worthlessness, or hopelessness
- Loss of interest or pleasure in activities
- Decreased energy or fatigue
- Slowed movements
- Restlessness
- Difficulty concentrating, remembering, making decisions
- Difficulty sleeping, early-morning awakening, oversleeping
- Appetite and/or weight changes unrelated to dieting
- Physical complaints with no clear physical cause
- Thoughts of suicide, suicide attempts

(NIMH, 2018)

Traumatic Brain Injury

Traumatic brain injury (TBI) is usually the result of a significant blow to the head and can occur even when there is no direct contact to the head. TBI may happen when a person experiences any trauma where the brain is shaken within the skull and the damage causes bleeding between brain tissue and bone. Active-duty and reserve service members are at increased risk for TBI related to operational and training activities. TBIs can be classified as mild, moderate, severe, or penetrating. The most common form of TBI in the military is mild, often called a concussion. In the military, the leading cases of TBI for both deployed and nondeployed personnel are:

- Blasts (the most common in the deployed setting; affects the whole brain)
- Bullets
- Fragments
• Falls
• Motor vehicle crashes and rollovers
• Sports
• Assaults

The effects of moderate to severe TBI can be long-lasting and may result in permanent physical or mental disability. Cognitive fatigue is the hallmark of TBI, and everything becomes more challenging. Depression is the most common psychiatric diagnosis after a brain injury, with a rate of close to 50% (BrainLine, 2019).

**TBI symptoms** can include:

• Headaches
• Emotional instability
• Unpredictability
• Irritability
• Sleep disorders
• Memory lapses
• Slowed thinking
• Depression

TBI has been connected to increased risk of suicide, and those with coexisting mental health problems, such as PTSD or depression, are particularly at risk. Iraq and Afghanistan veterans with multiple TBIs are almost twice as likely to consider suicide compared to those with only one or none (Shura et al., 2019).

Researchers have found that certain specific cognitive deficits often occur in TBI and concluded that slowed processing speed and/or memory difficulties may make it challenging to access and use past experiences to solve current problems and imagine future outcomes. This may then lead to an increase in hopelessness and suicidal ideation (Richman, 2018).

**RECOGNIZING THOSE AT RISK FOR SUICIDE**

**Suicide Screening**

*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.
There is debate about the benefits of screening all patients (universal screening) for suicide risk factors and whether screening actually reduces suicide deaths. Instead of universal screening, some guidelines recommend that screening be done for those presenting with known risk factors (selective or targeted screening). Despite this lack of uniform guidance, health systems are implementing suicide screening protocols, and screening tools are already widely used in primary care settings (Durkin, 2019; O’Rourke et al., 2019).

**U.S. DEPARTMENT OF VETERANS AFFAIRS SCREENING RECOMMENDATIONS**

The U.S. Department of Veterans Affairs began universal screening for suicide risk in all primary care settings in October of 2018, and since then more than 3.8 million veterans have been screened for suicide. The screening and evaluation protocol has three parts:

1. A primary screening for suicide risk is done by a registered nurse in the primary care setting using the Patient Health Questionnaire-9 (PHQ-9).

2. If that screening is positive, the nurse will then provide a referral to the primary care provider or to a licensed independent practitioner to conduct a secondary screening using the Columbia-Suicide Severity Rating Scale (C-SSRS).

3. If the secondary screening is positive, the primary-care provider can conduct a comprehensive suicide risk evaluation or may facilitate a referral to other mental health staff working in the primary care clinic to conduct the evaluation.

(VA, 2019d)

**SCREENING TOOLS**

The following are validated, evidence-based screening tools:

*Ask Suicide-Screening Questions (ASQ)*

This is a four-item suicide screening tool designed to be used for patients ages 10 to 24 in emergency departments, inpatient units, and primary care facilities. The tool takes two minutes to administer and asks the following four questions:

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? If yes, how?

(NIMH, 2019)
Columbia-Suicide Severity Rating Scale (C-SSRS) Screening Version

This tool is to be used in general healthcare settings for all ages and includes questions that address:

- Whether and when the patient has thought about suicide
- What actions they have taken, and when, to prepare for suicide
- Whether and when they have attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition (TJC, 2018)

Patient Health Questionnaire-9 (PHQ-9)

This nine-item tool is used to diagnose and monitor the severity of depression in those ages 12 and older in all primary care and behavioral healthcare settings. Question #9 screens for the presence and duration of suicide ideation (TJC, 2018).

Suicide Behavior Questionnaire-Revised (SBQ-R)

This four-item self-report questionnaire is for use in ages 13 to 18. It asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones and includes a question about lifetime suicidal ideation, plans to die by suicide, and actual attempts (TJC, 2018).

Suicide Warning Signs

Besides screening for risk factors for suicide, it is important for clinicians to be able to recognize behaviors that indicate an individual is at immediate risk for suicide. These are referred to as proximal factors, or warning signs, and are grounds for immediate action. Such warning signs include:

- Talking about or writing about death, dying, or dying by suicide
- Threatening to hurt or kill oneself
- Looking for ways to kill oneself, such as searching online for lethal methods or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped, like there is no way out
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Withdrawing from friends, family, or social activities
• Changes in eating and/or sleeping habits
• Showing rage, anger, or talking about seeking revenge
• Acting anxious or agitated
• Displaying significant changes in mood, especially suddenly changing from very sad to very calm or happy
• Taking risks that could lead to death, such as driving extremely fast
• Losing interest in school, work, or hobbies
• Losing interest in personal appearance
• Visiting or calling people to say goodbye
• Giving away important possessions
• Preparing for death by writing a will and making final arrangements
  (APA, 2019b)

 SUICIDE WARNING SIGNS SPECIFIC TO THE MILITARY

Warning signs that a military service member or veteran in particular 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
• Sleeping more (sometimes the decision to commit suicide brings a sense of peace of mind, and they sleep more to withdraw)
• 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 or holding medication (temporarily skipping doses)
• Hoarding medication or alcohol
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- Defensive speech, such as, “You wouldn’t understand!”
- Stopping making eye contact or speaking with others (NJDMVA, 2020)

“HAVE YOU SERVED IN THE MILITARY?”

Samplings of primary care providers had found that patients are seldom asked about their military history (19%). Many providers are able to identify PTSD, depression, and anxiety as common problems among this population, but very few identified substance or traumatic brain injury as top concerns despite their prevalence among this population (Vest et al., 2018).

Veterans are at high risk for many negative health conditions related to deployment, combat, and the challenges of reintegration, including higher rates of suicide. It is important for healthcare providers to screen patients for veteran status and to become familiar with the health impacts of military service. The American Academy of Nursing offers a screening tool named “Have you ever served in the military?” that begins by asking:

- Have you ever served in the military?
- Do you have a close family member or partner who has served in the military?

These questions are followed by others that lead to a better understanding of the person’s branch of service, rank, role, deployment and combat experience, as well as common military health risks.

(See also “Resources” at the end of this course.)

ASSESSING PATIENTS WHO ARE AT RISK FOR SUICIDE

Communicating with Patients with Suicidal Ideation

The most effective evaluation of the patient who has screened positive for suicidal ideation begins with the establishment of a therapeutic relationship. It is important to note that often suicidal persons have recently perceived rejection, and a considerable amount of expertise may be required in order to establish rapport (IASP, 2019).

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 them.
**Basic Attending Skills**

Basic attending and listening skills are valuable in establishing rapport and a therapeutic alliance in order to obtain information 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 comprehension of what the patient is saying, such as restating or summarizing what the patient has said.

**Negative** attending behaviors include:

- Overuse of positive attending behaviors, which can become negative or annoying

- 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

  (Grieve, n.d.)

**Listening Skills and Action Responses**

Effective communication 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:
  
  o Simple paraphrasing gives direction but involves rephrasing the core meaning of what the patient has said.
  
  o Sensory-based paraphrasing involves the interviewer using the patient’s sensory words in the paraphrase (visual, auditory, kinesthetic, etc.).
  
  o 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.
  
  (Sommers-Flanagan & Sommers-Flanagan, 2016)

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, also 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, 2016)
When attempting to elicit information from suicidal persons, it should be remembered that challenging or direct questions which could be interpreted as critical will rarely be of benefit. 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 (IASP, 2019).

Assessing Suicidal Intent

Once it is determined that suicidal ideations are present, the next step is to determine whether the patient has active (thoughts of taking action) or passive (wish or hope to die) intent.

Suicidal intent can be determined best by considering the degree of planning, the knowledge of the lethality of the intended suicidal act, and the degree of isolation of the person. At this point, specific and direct questions should be asked to gather specific information, such as:

- Did you ever think about suicide?
- Have you ever practiced or attempted suicide?
- Do you have a plan for suicide?
- What is your plan for suicide?
- Do you have your chosen means for suicide available or readily accessible?

Red flags to consider may include a sense of hopelessness, a feeling of entrapment, well-formed plans, a perception of no social support, distressing psychotic phenomena, and significant pain or chronic illness (Harding, 2019; Schreiber & Culpepper, 2019).

Assessing Lethality and Risk

When suicide risk screening results in the positive identification of an individual at risk for suicide, it is vitally important that the healthcare provider further assess the patient’s level of suicide risk and lethality of plan to determine if a referral for a mental health evaluation is warranted or to directly refer the individual for a mental health evaluation and suicide risk assessment.

When assessing lethality and risk, it is important to learn 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. Suicidal deaths are more likely to occur when persons use highly damaging, fast-acting, and irreversible methods and do so when rescue is fruitless. 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 attempted suicides that do not end in death. For every 25 attempts, there is one death. For drug overdoses, the ratio is around 40 to 1. The following are methods of suicide and the likelihood that they will result in death:

- Firearms: 82.5%
- Drowning/submersion: 65.9%
- Suffocation/hanging: 61.4%
- Gas poisoning: 41.5%
- Jump: 34.5%
- Drug/poison: 1.5%
- Cut/pierce: 1.2%
- Other: 8.0%

(HSPH, 2020)

Factors that influence the lethality of a chosen method include:

- **Intrinsic deadliness.** A gun is intrinsically more lethal than a bottle of pills.
- **Ease of use.** If a method requires technical knowledge, for example, it is less accessible than one that does not.
- **Accessibility.** Given the brief duration of some suicidal crises, a gun in the cabinet in the hall is a greater risk than a very high building 10 miles away.
- **Ability to abort mid-attempt.** More people start and stop mid-attempt than carry through. It is easier to interrupt a hanging or to call 911 after overdosing than if jumping off a bridge or using a gun.
- **Acceptability to the individual.** Must be a method that does not cause too much pain or suffering. For example, fire is readily accessible, but it is seldom ever used in the United States.

(HSPH, 2020)

Research indicates that having a gun in the home triples a person’s overall risk of suicide, and nearly half of all veterans own firearms. One in three veteran gun owners store at least one of their firearms loaded and unlocked. Storing a loaded gun at home or carrying one has been found to be associated with a fourfold increase in the odds of suicide death among soldiers (Kime, 2019c).
LEVEL OF RISK

A clinical judgment that is based on all the information obtained during evaluation should help to assign a level of risk for suicide and determine the setting of care.

Patients who are low risk of suicide:

- Have thoughts of death only
- Have no suicide plan
- Have no clear intent
- Have easily identifiable and multiple protective factors
- Have no history of suicidal behaviors
- Have evidence of self-control
- Are willing to talk about stressors or depression
- Have supportive family members or significant others
- Are willing to comply with treatment recommendations
- Have a high degree of ambivalence

Most people who are suicidal do not necessarily want to die; they just do not want to continue living in an intolerable situation or state of mind. This ambivalence is one of the most important tools for working with suicidal persons. Almost everyone who is suicidal is ambivalent about dying, leaning toward suicide at one moment in time, and then leaning toward living the next. The healthcare professional can use this ambivalence to help focus the person on the reasons why they should live.

Patients who are at moderate risk:

- Have suicide ideation
- Have no clear plan for suicide
- Have limited intent to act
- Have some identifiable protective factors
- Exhibit fair/good judgment
- Have no recent suicidal behavior
- Have supportive family or significant others
- Are willing to comply with treatment recommendations
- Have a high degree of ambivalence
- Have no access to lethal means
Patients who are at **high/severe/imminent risk:**

- Have a specific suicide plan
- Have access to lethal means
- Have minimal protective factors
- Have impaired judgment
- Have poor self-control either at baseline or due to substance use
- Have a poor social support network
- Have severe psychiatric symptoms and/or an acute precipitating event
- Have a history of prior suicide attempt

(Yasgur, 2016; WICHE MHP & SPRC, 2017)

**Assessing Impulsiveness and Access to Lethal Means**

Research has found that when people make a decision to attempt suicide, nearly half will attempt it within 20 minutes (Meinert, 2018). To define impulsivity in relation to suicide, however, is difficult. Some consider the duration from first suicidal ideation to actual attempt, and others define it as an absence of planning or preparation. Regardless of this uncertainty, it is common for suicide attempts to be considered impulsive acts, and there is evidence that strongly links the two.

Studies done among those who have attempted suicide have found that when compared to those who were nonimpulsive suicide attempters, impulsive suicide attempters:

- Have less severe and intensive suicide ideations, suggesting they progress from vague suicide ideation directly to a suicide attempt
- Have significantly lower intent
- Use significantly less lethal methods
- Are relatively younger
- Rarely have significant risk factors such as being older; living alone; or being widowed, divorced, or separated
- Have psychiatric symptoms as the main reason for a suicide attempt

Impulsivity is considered a possible phenotype underlying self-harm and suicidal behaviors, and there is evidence that different facets of impulsivity follow different neurodevelopmental trajectories, with some factors more strongly associated with such behaviors than others (Lim et al., 2016; Chaudhury et al., 2016).
Documenting Risk Assessment

Good documentation is basic to clinical practice. Accurate, sufficiently detailed, and concise records of a patient’s treatment allow for quality care and communication among providers. 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 (APA, 2016).

SUICIDE RISK ASSESSMENT DOCUMENTATION ELEMENTS

The goal of documentation is to explain the clinical reasoning and decision-making behind the suicide assessment and the treatment plan that follows the assessment. The following elements should be included in the documentation:

- What prompted the suicide assessment (includes direct quotes as well as more subtle indications)
- Summary of the presenting complaints, including a detailed assessment of suicidal ideation
- Record of past suicide attempts and outcomes
- Evaluation of current risk factors, protective factors, and warning signs
- Presence or absence of firearms
- Listing of individuals who participated in the evaluation, including the patient’s family, friends, and any collaborative consultants
- Summary of treatment options discussed with the patient, including any suggestions and/or recommendations for hospitalization, if applicable
- Review of the treatment plan agreed upon with the patient, including why this plan provides the safest treatment in the least restrictive environment. Treatment plan may include:
  - Starting medications and/or therapy
  - Means restriction, and, if possible, verification from the patient’s support system that it will be completed
  - Substance use reduction or formal treatment
  - Safety or crisis plan creation (a copy of which is placed in the medical record)
  - Referral to a mental health provider
  - Hospitalization
- Follow-up plan (appointment, phone calls, etc.)
(Weber et al., 2018)
DETERMINING PRIORITY FOR ACTION AND REFERRAL

Once an assessment of the patient’s level of risk, lethality, and access to means have been completed, the next step is to determine the priority for action and where intervention can best be achieved. Disposition is determined according to level of risk:

- **High risk:** Patients who have a psychiatric diagnosis with severe symptoms or an acute precipitating event, have made a potentially lethal suicide attempt or have persistent ideation with strong intent or suicide rehearsal generally should be managed with suicide precautions and admitted to a hospital for management.

- **Moderate risk:** Patients with multiple risk factors and few protective factors, who have suicidal ideation with a plan but no intent or behavior, may require referral for a more in-depth evaluation or hospital admission. If not admitted, a crisis plan should be developed and the patient should be given emergency/crisis numbers.

- **Low risk:** Patients with modifiable risk factors and strong protective factors who have thoughts of death, no plan, intent, or behavior should be referred for outpatient management and be provided with emergency/crisis numbers. (SAMHSA, 2020)

Clinicians who are the initial contact for patients who are at risk or who have made a suicide attempt most often refer them to one of the available treatment options, depending upon degree of risk.

A patient who is in acute suicidal crisis should be kept in a safe healthcare environment under one-to-one observation while arranging for immediate transfer to an emergency department. In certain instances where a patient is not willing to comply with disposition recommendations or is unwilling to provide informed consent for treatment, it then becomes the responsibility of the clinician to protect the patient by contacting legal authorities for assistance (TJC, 2016).

Other patients who are not in suicidal crisis may require a referral for further evaluation and treatment. This requires a smooth and uninterrupted transition of care from one setting to another. In order to ensure that the patient is linked to appropriate care, the referring clinician follows these steps:

- Refer the patient to an outpatient provider for an urgent appointment for a date within a week of discharge.

- If unable to schedule the first follow-up appointment for a date within a week of discharge, refer for follow-up with a primary care provider and contact the primary care giver to discuss the patient’s condition and reason for referral.

- Institute or revise a patient’s safety plan before discharge or referral.
• Ensure that the patient has spoken by phone with the new provider.

• Send patient records several days in advance of the appointment to the new treatment provider and call to go over patient information prior to the first appointment.

• Troubleshoot the patient’s access-to-care barriers (e.g., lack of health insurance, transportation needs) using information from the community resources list.

• Contact the patient within 24 to 48 hours after they have transitioned to the next care provider and document the contact.
  (SPRC, 2019b)

VETERANS HEALTH ADMINISTRATION PREVENTION FRAMEWORK

Within the Department of Veterans Affairs (VA), 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 public health perspective considers questions such as:

• Where does the problem begin?
• How can we prevent it from occurring in the first place?

The VA follows this systematic approach:

1. Define the problem by collecting data to determine the who, what, where, when, and how of suicide deaths.
2. Identify and explore risk and protective factors using scientific research methods.
3. Develop and test prevention strategies.
4. Assure widespread adoption of strategies shown to be successful.

Resources available for veterans and their families include:

• **Suicide Prevention Coordinator** available at each VA medical center who provides veterans with the counseling and services they require. As appropriate, callers to the Veterans Crisis Line are referred to their local coordinator.

• **Coaching Into Care** is a national telephone service for family members and friends seeking care or services for a veteran. Licensed psychologists and social workers help each caller find appropriate services at a local VA facility or elsewhere in the community.
Suicide prevention resources also available for former Guard and Reserve members include:

- **Veteran’s Crisis Line**
- **A Suicide Safety Plan** app
- **inTransition**, a free, confidential program offering coaching the specialized assistance over the phone for active-duty service members, Guard and Reserve members, and veterans who need access to mental health care
- **Make the Connection**, an online resource that connects veterans, family members, friends, and other supports with information and solutions to issues affecting their lives
- **Vet Centers’ readjustment counseling services**
  (VA, 2018)

**CONCLUSION**

Suicide—the deliberate ending of one’s own life—is an important public health concern around the world. Many complex factors contribute to a person’s decision to die by suicide. One important thing to consider is that most people are ambivalent about dying by suicide. They are caught in a situation from which they see no way out but to end their lives. This ambivalence is important, as it is the starting point at which an effective intervention can occur.

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, mental health issues among veterans, and obtaining a military history are the most important steps in the process of assessing for risk of suicide and ensuring the patient receives appropriate intervention.

**RESOURCES**

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

Ask Suicide-Screening Questions (ASQ)

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

Help4WV (Behavioral health call center)
https://www.help4wv.com/
844-HELP4WV
844-435-7498 (text)

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. Recent data regarding suicide among veterans and active-duty military found that:
   a. Rates for veterans were lower than for nonveterans.
   b. Female veterans had a lower suicide rate than female nonveterans.
   c. In 2018 active-duty military had the highest number of suicides in at least six years.
   d. Male and female veterans had the same rates of suicide.

2. Which is a psycho-sociocultural factor that contributes to suicide risk?
   a. Cognitive abilities
   b. Psychiatric disease
   c. Mental disorders
   d. Problems with the law

3. Which is a true statement regarding suicide among military personnel?
   a. Service members who attempt suicide prior to enlistment do not have an increased risk for suicide.
   b. For females in the military, sexual trauma is the primary cause for the increased rates of suicide.
   c. Medical conditions have no association with increased suicide risk.
   d. A veteran who was wounded in combat does not have an increased risk for suicide.

4. Which is a protective factor against suicide that is unique to military personnel?
   a. Resilience
   b. Ongoing medical support
   c. Combat exposure
   d. Problem-solving skills

5. The most significant predictor of both suicide attempts and preoccupation with thoughts of suicide among those in the military is:
   a. Having flashbacks.
   b. Withdrawal from others.
   c. Combat-related guilt.
   d. Hypervigilance.
6. The most common cause of TBI in deployed military personnel is:
   a. Falls.
   b. Assaults.
   c. Blasts.
   d. Motor vehicle rollovers.

7. The U.S. Department of Veterans Affairs screening protocol calls for:
   a. Only a primary screening by a registered nurse.
   b. A referral for treatment after a positive primary screening.
   c. Both a primary and secondary screening by a registered nurse.
   d. A referral for a secondary screening after a positive primary screening.

8. 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. Cleaning a souvenir weapon

9. A nondirective listening response that involves rephrasing or restating what the patient has said is called:
   a. Summarization.
   b. Paraphrasing.
   c. Validating feelings.
   d. Confrontation.

10. When assessing lethality and risk, which factor increases fourfold the odds of suicide death among soldiers?
    a. Ease of use of chosen method
    b. Storing a loaded gun at home
    c. Inability to abort mid-attempt
    d. Acceptability of method

11. Which patient is at highest risk for suicide?
    a. A woman talking about suffocation by hanging
    b. A man with a suicide plan who possesses a firearm
    c. An adolescent planning to take a handful of pills
    d. A young woman with a history of depression
12. When determining priority for action and disposition, a person who is at moderate risk:
   a. Has no plan and does not require a referral.
   b. Has rehearsed suicide and has strong intent.
   c. May require more in-depth evaluation.
   d. Does not require hospitalization.