

Clinical Preparedness for Social Work Practice with
Military Families
“To War Then Home”

The Sometimes Invisible Battle:
The VA’s Suicide Prevention Initiative

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History as Biography

- The case of US Army Reserve Capt. Donald B: December 2004
- The case of USMC Corporal Alex V: September 2006
- The case of Daniel C: October 2005



**IT
TAKES
THE
COURAGE AND STRENGTH
OF A WARRIOR
TO ASK FOR HELP.....**

**If you're in an emotional crisis
call 1-800-273-TALK "Press 1 for Veterans"**

www.suicidepreventionlifeline.org



Contents

- Suicide as a Patient Safety Problem.
- Suicide Prevention as a Patient Safety Goal.
- The Veterans' Healthcare Administration's Suicide Prevention Efforts.

http://www.mentalhealth.va.gov/suicide_prevention/Sinise_092008.aspx

[httpwww1.va.gov/health/Deborah_Norville_PSA.aspx](http://www1.va.gov/health/Deborah_Norville_PSA.aspx)

The VA's Suicide Prevention Initiative

- Education
- Research
- Clinical Intervention

Recent Data

- Over 33, 000 suicide fatalities/year.
- Fourth leading cause of death for 18-65 year olds: 27,321 in 2006.
- Four male fatalities for every female suicide fatality.
- 60% of elderly patients who die by suicide saw their PCP within a few months.
- Alcoholism is involved in 30 % of fatalities.

Suicide Prevention

- 83 % of suicides had contact with their physician within the year prior.
- 66 % had contact within the month prior.
- JJ. Mann, A current perspective on suicide and attempted suicide. *Ann. Internal Medicine*, 2002; 136:302-311

Recent Data

- 83 % of gun related deaths in homes are suicides.
- Firearms account for 50% of suicides.
- Out of 147,160,189 males:
 - 26,308 suicides
- Out of 151,594,819 females:
 - 6,992 suicides.

The Rand Corporation April 2008

"Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences and Services to Assist Recovery."

- Method Phone survey of 1,965 service personnel.
- 1.6 people have rotated through OIF/OEF.
 - PTSD and Depression at 18.5 %
 - 19 % may have had a TBI from PCS to severe penetrating injuries. 43 % have never been evaluated by a physician.
 - Of those who have had PTSD or Depression only 53 % of them have sought treatment.
- In summary
 - 300,000 psychological casualties
 - 320,000 brain injuries
 - 35,000 "normal" casualties
 - 101,000 Americans killed or wounded each year.

Suicide Prevention

- Avenues of Approach
 - Awareness and Education
 - Primary Care Physicians
 - Gatekeepers
 - Screening
 - Treatment Interventions
 - Means Restriction
 - Media

Points of Intervention to Prevent Suicide

Population Prevention

Public Health Measures



Mass Screening



Individualized Risk Assessment



Safety Planning and Disposition



Treatment Engagement



**Individual Treatment:
Inpatient vs. Outpatient treatment**

Basic Assumption of Suicide Prevention in the VA

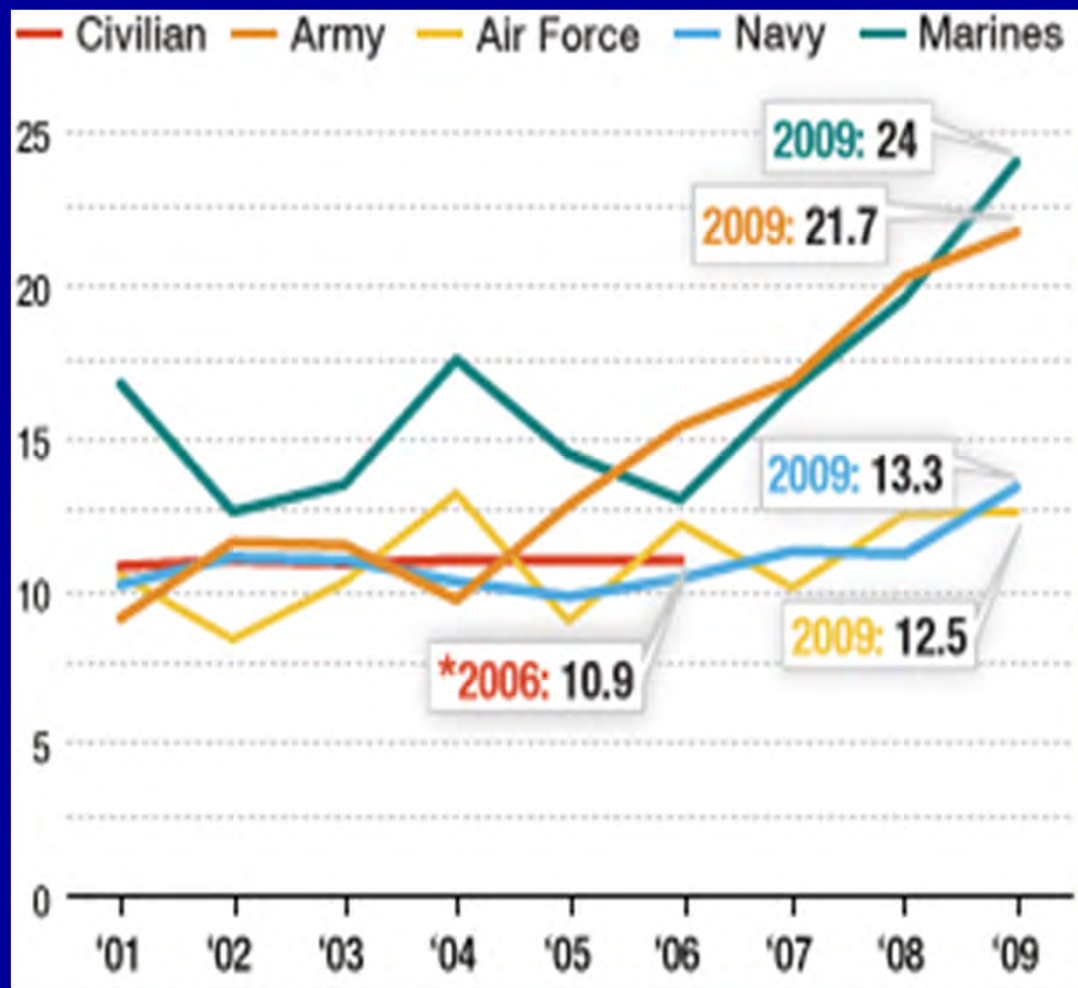
- Basic assumption
 - Suicide prevention requires access to a high quality mental health care system and activities that specifically target suicide directly
- Strategy
 - Overall enhancements of Mental Health programs
 - Specific actions
 - National priority led by centers of excellence
 - Suicide prevention hotline in Canandaigua
 - Appointment of suicide prevention coordinators in VAMCs
 - Evolving programs and activities

VA's Strategy for Suicide Prevention

- Universal
 - For everyone
 - Destigmatizing mental illness
 - Screening
 - Improving capacity & access for MH services
- Targeted
 - For those at increased risk
 - Promoting high quality MH treatment
 - Integrating MH & Primary Care
 - Focusing on recovery, rehabilitation MH specialty care
 - Implementing evidence-based care
- Indicated
 - For those at high risk
 - Promoting case identification
 - Increased monitoring, intensifying care

“Let’s not talk about it”: Suicide Inquiry in PC

- 152 PC physicians from 4 sites in Northern CA and Rochester NY
- Using Actors/Confederates as patients
- PCPs inquire about suicide in less than half the time



Suicide Rate By Military Branch

The rates per 100,000 people of suicide among active-duty personnel in the Army, Marines, Navy and Air Force. The statistics show an increase in suicide rates since 2001, compared with the relatively steady rate of suicide among the U.S. civilian population.

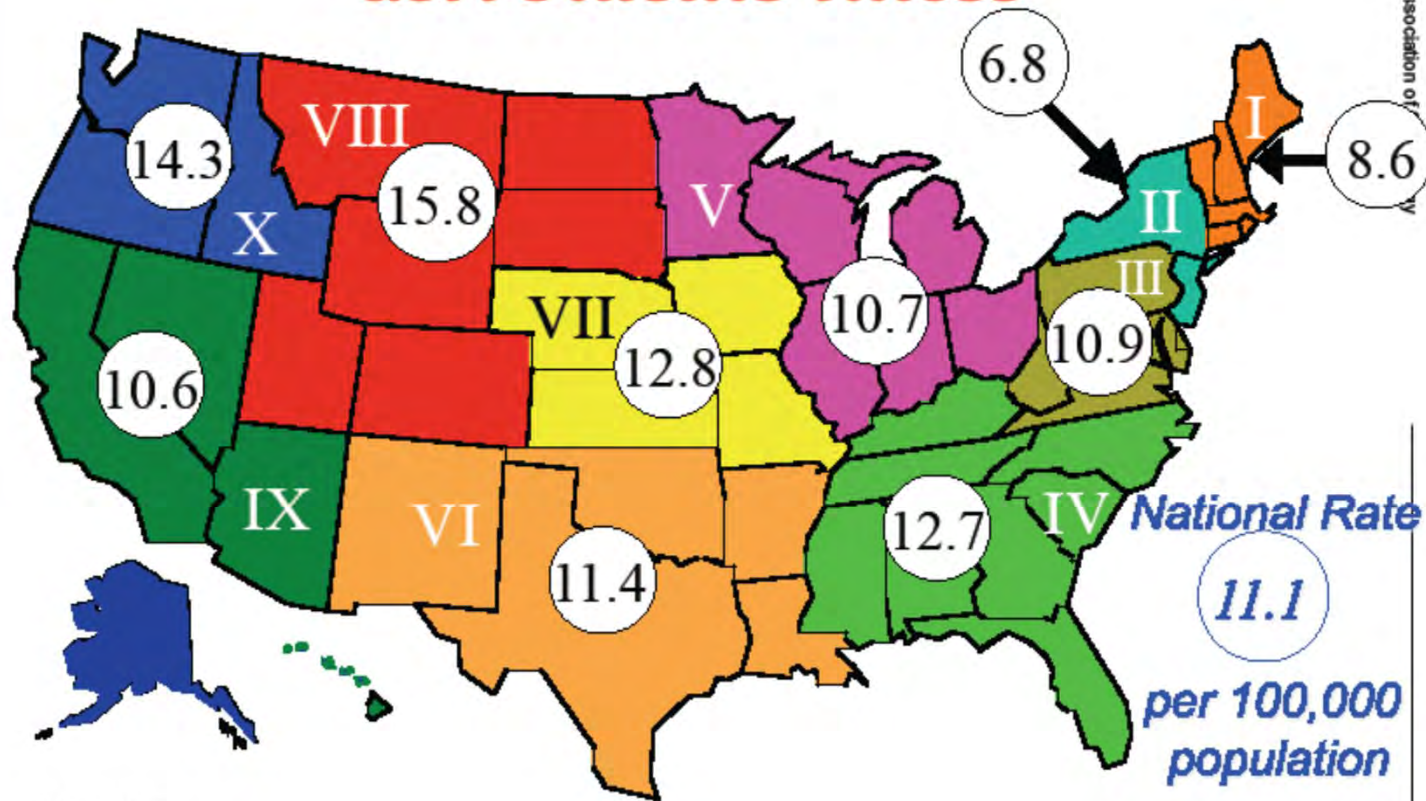
The Suicide Hotline

- National Total Hotline Calls: 626,648
- Veteran Callers: 372,744
- Family/Friend Callers 45,886
- Referrals to SPC 95,803
- Rescues 25,534
- Warm transfers 16,316
- Active Duty Callers 8,240

Totals from 2007 to Date



Health Regions & USA Suicide Rates



2006 Data

<u>Rank</u>	<u>State [Division]</u>	<u>(2005 rank)</u>	<u>Deaths</u>	<u>Rate</u>
1	Wyoming [M]	(4T)	116	22.5
2	Alaska [P]	(3)	135	20.1
3	Montana [M]	(1)	189	20.0
4	Nevada [M]	(2)	486	19.5
5	New Mexico [M]	(4T)	352	18.0
6	South Dakota [WNC]	(9)	125	16.0
7	Arizona [M]	(8)	979	15.9
8	Oregon [P]	(10)	579	15.6
9	Colorado [M]	(6)	730	15.4
10	Idaho [M]	(7)	222	15.1
11	Oklahoma [WSC]	(11)	537	15.0
12	Kentucky [ESC]	(17)	622	14.8
12	West Virginia [SA]	(16)	269	14.8
14	Tennessee [ESC]	(13T)	874	14.5
15	North Dakota [WNC]	(12)	90	14.2
15	Utah [M]	(15)	362	14.2
17	Kansas [WNC]	(18T)	379	13.7
17	Missouri [WNC]	(22T)	799	13.7
19	Florida [SA]	(18T)	2,440	13.5
20	Arkansas [WSC]	(13T)	376	13.4
21	Indiana [ENC]	(27)	824	13.1
22	Vermont [NE]	(22T)	81	13.0
23	Alabama [ESC]	(28T)	580	12.6
23	Washington [P]	(21)	809	12.6
25	North Carolina [SA]	(30T)	1,106	12.5
26	South Carolina [SA]	(26)	524	12.1

26 Wisconsin [ENC] (30T).	670.	12.1
28 Maine [NE] (18T).	158.	12.0
29 Louisiana [WSC] (34T).	492.	11.5
29 New Hampshire [NE] (24T).	151.	11.5
29 Ohio [ENC] (28T)	1,325	11.5
29 Virginia [SA] (33).	876.	11.5
33 Nebraska [WNC] (38T).	202.	11.4
34 Michigan [ENC] (36).	1,139.	11.3
35 Iowa [WNC] (34T).	334.	11.2
35 Mississippi [ESC] (24T)	325	11.2
35 Pennsylvania [MA] (32).	1,396.	11.2
United States - Total.	33,300.	11.1
38 Delaware [SA] (41)	91	10.7
38 Minnesota [WNC] (37).	554.	10.7
40 Texas [WSC] (38T).	2,347.	10.0
41 Georgia [SA] (40).	923.	9.9
42 Hawaii [P] (44T).	120.	9.3
43 California [P] (42).	3,334.	9.1
44 Maryland [SA] (44T).	495.	8.8
45 Rhode Island [NE] (48).	90.	8.4
46 Connecticut [NE] (44T).	292.	8.3
47 Illinois [ENC] (43).	1,010.	7.9
48 Massachusetts [NE] (47).	450.	7.0
49 New York [MA] (49).	1,326.	6.9
50 New Jersey [MA] (50)	585	6.7
51 District of Columbia [SA] (51). ...	30.	5.2

Proposed DSM-V: Suicide Risk

- Rationale: Though suicide is not predictable in individual patients, it is considered standard of care for a clinician to assess suicide risk factors in patients with mood disorders and other severe psychiatric disorders (e.g. schizophrenia, eating disorders, borderline personality disorders, substance abuse disorders) The suggested risk factor groups progress from chronic risk factors to more immediate risk factors based on current clinical features.
- The proposed suicide assessment scale will allow a clinician to make this assessment explicit, when a diagnosis is made, and allow classification of the patient into estimated suicide risk groups from low to high. This should aid in the management of the patient. Each item may not be of similar importance in assessing risk. At this point we are not aware of literature assessing the relative weight of each factor. The point is to focus and assist the clinician make a thorough suicide assessment of the patient's membership in a risk group for suicide using the best knowledge and evidence we have.

DSM-V

- Suicide risk factor groups:
 - Any history of a suicide attempt
 - Long-standing tendency to lose temper or become aggressive with little provocation.
 - Living alone, chronic severe pain, or recent (within 3 months) significant loss.
 - Recent psychiatric admission/discharge or first diagnosis of MDD. bipolar disorder or schizophrenia.
 - Recent increase in alcohol abuse or worsening of depressive symptoms
 - Current (within last week) preoccupation with, or plans for suicide.
 - Current psychomotor agitation, marked anxiety or prominent feelings of hopelessness.

DSM-V

- Level of concern about potential suicidal behavior :
- (sum of items coded as present)

- 0 – Lowest concern
- 1-2 Some concern
- 3-4 Increased concern
- 5-7 High concern

Suicide Prevention

Suicide Risk Factors

- Factors that may *INCREASE* risk
 - Current ideation, intent, plan, access to means
 - Previous suicide attempt or attempts
 - Alcohol/Substance abuse
 - Previous history of psychiatric diagnosis
 - Impulsivity and poor self control
 - Hopelessness-presence, duration, severity
 - Recent losses-physical, financial, personal
 - Recent discharge from an inpatient unit
 - Family history of suicide
 - History of abuse (physical, sexual or emotional)
 - Co-morbid health problems, especially a newly diagnosed problem or worsening symptoms
 - Age, gender, race (elderly or young adult, unmarried, white, male, living alone)
 - Same-sex sexual orientation

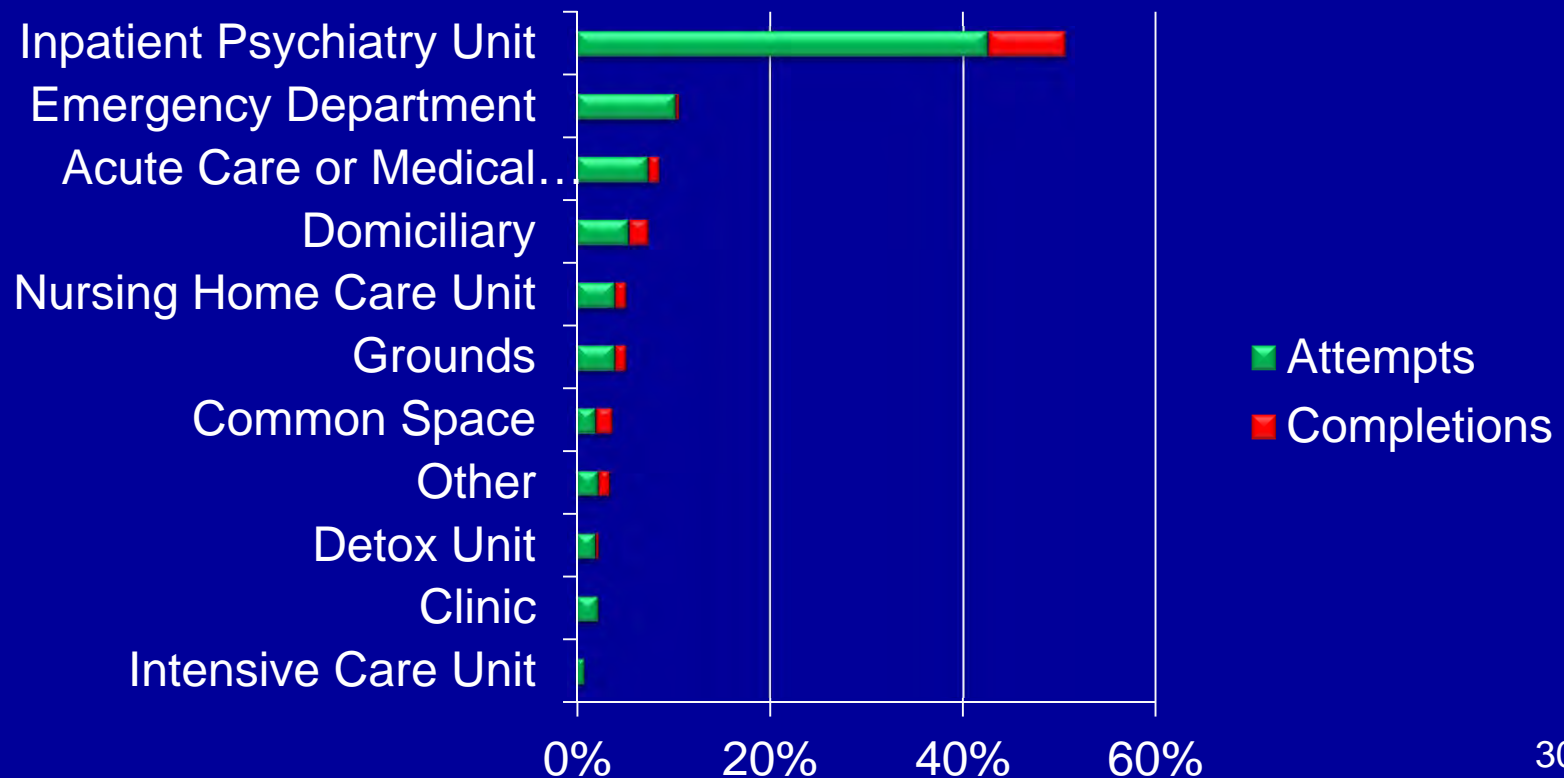
Suicide Prevention

Environmental Risk Factors

- 1500 inpatient suicides per year in the U.S.
- Inpatient suicide rates estimated to be 5-80 per 100,000 psychiatric admissions in U.S.
- Second most common JC sentinel event
- Physical environment a root cause in 84% of JC sentinel event inpatient suicides.
- Hanging is the most common method reported in JC (75%) literature and in the VA (30.8%).
- 50% of suicide by hanging were NOT fully suspended – using anchor points below the head.

Suicide Prevention Environmental Risk Factors

Location of Inpatient Suicide Attempts and Completions (N = 350)



Suicide Prevention

Reducing Environmental Risk Factors

- Eliminate structures that are capable of supporting a hanging object
 - Plumbing, ductwork, fire sprinkler heads, curtain or clothing rods, hooks, shower heads and controls, doors, hinges, door handles, light fixtures
- Include structures close to the floor
 - Towel bars, grab bars, toilet/sink plumbing & faucets, projections and side-rails on beds
- Reduce strangulation devices
 - Drapery cords, belts, shoe laces, ties, kerchiefs, bathrobe sashes, drawstring pants, coat hangers, call cords, privacy curtains, trash can liners. Very hard to eliminate all of these e.g. sheets.

Suicide Prevention

Reducing Environmental Risk Factors

- Reduce access to dangerous objects
 - Contraband check, medications, objects provided by roommates and visitors, cleaning supplies, electrical outlets, stoves, breakable furniture
- Reduce access to sharps
 - Any breakable glass or tiles, razors, flatware, light bulbs, wires or springs, dishes, scissors
- Reduce opportunities to jump
 - Windows, balconies, walkways, roofs

Suicide Prevention

Signs of suicidal thinking

Acute Warning Signs and Symptoms:

- Threatening to hurt or kill self
- Looking for ways to kill self
- Seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide

Suicide Prevention

Signs of suicidal thinking

Additional Important Warning Signs:

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities
- Feeling trapped
- Increasing drug or alcohol abuse

Suicide Prevention

Signs of suicidal thinking

Additional Important Warning Signs:

- Withdrawing from friends, family and society
- Anxiety, agitation
- Dramatic changes in mood
- Feeling there is no reason for living, no sense of purpose in life
- Difficulty sleeping or sleeping all the time
- Giving away possessions

Post-Traumatic Stress Disorder

Symptom Clusters
and Available Treatments

PTSD Symptom Clusters

- Re-experiencing
- Avoidance
- Hyperarousal

Re-experiencing

- Frequently having upsetting thoughts or memories about a traumatic event.
- Having recurrent nightmares.
- Acting or feeling as though the traumatic event were happening again, sometimes called a "flashback."
- Having strong feelings of distress when reminded of the traumatic event.
- Being physically responsive, such as experiencing a surge in your heart rate or sweating, to reminders of the traumatic event.

Avoidance

- Making an effort to avoid thoughts, feelings, or conversations about the traumatic event.
- Making an effort to avoid places or people that remind you of the traumatic event.
- Having a difficult time remembering important parts of the traumatic event.
- A loss of interest in important, once positive, activities.
- Feeling distant from others.
- Experiencing difficulties having positive feelings, such as happiness or love.
- Feeling as though your life may be cut short.

Hyper-arousal

- Having a difficult time falling or staying asleep.
- Feeling more irritable or having outbursts of anger.
- Having difficulty concentrating.
- Feeling constantly "on guard" or like danger is lurking around every corner.
- Being "jumpy" or easily startled.

PTSD

- 60 % of men and 50% of women will experience a traumatic event in their lifetime.
- Some post event symptoms are expected.
- When the symptoms persist then PTSD may have emerged.
- 6.8 % of Americans
 - Women 9.7%
 - Men 3.6%

PTSD

- Symptoms must be present for one month and cause some impairment in functioning.
- Re-experiencing: thoughts, memories, flashbacks.
- Avoidance and numbing
- Arousal: sleep, anger, irritability, vigilance, startles, concentration deficits.

Other Problems

- Depression
- Anxiety
- Substance Abuse

- Social Problems: unemployment, separation, divorce, domestic abuse

- Medical problems: alteration in the central and autonomic nervous systems.

Treatments for PTSD

- Residential Programs
- Outpatient Treatments
- Medications
- Individual and Group Therapies
 - Prolonged Exposure Therapy
 - Cognitive Processing Therapy
 - Anger Management
 - EMDR
 - Sleep Hygiene Training
 - Virtual Reality Therapy (offered in certain circumstances)

Traumatic Brain Injury

Mild

Mild TBI

- Alteration of Consciousness:
 - Glasgow Coma Scale Scores
 - Severe 3-8
 - Moderate 9-12
 - Mild 13-25
- Blow to head with Loss of Consciousness:
Duration < 30 minutes
- Post-traumatic amnesia: Duration < 24 hours

Glasgow Coma Scale (GCS)

- **EYE OPENING RESPONSE**
 - SPONTANEOUS--OPEN WITH BLINKING AT BASELINE 4 POINTS
 - TO VERBAL STIMULI, COMMAND, SPEECH 3 POINTS
 - TO PAIN ONLY (NOT APPLIED TO FACE) 2 POINTS
 - NO RESPONSE 1 POINT
- **VERBAL RESPONSE**
 - ORIENTED 5 POINTS
 - CONFUSED CONVERSATION, BUT ABLE TO ANSWER QUESTIONS 4 POINTS
 - INAPPROPRIATE WORDS 3 POINTS
 - INCOMPREHENSIBLE SPEECH 2 POINTS
 - NO RESPONSE 1 POINT
- **MOTOR RESPONSE**
 - OBEYS COMMANDS FOR MOVEMENT 6 POINTS
 - PURPOSEFUL MOVEMENT TO PAINFUL STIMULUS 5 POINTS
 - WITHDRAWS IN RESPONSE TO PAIN 4 POINTS
 - FLEXION IN RESPONSE TO PAIN 3 POINTS
 - EXTENSION RESPONSE IN RESPONSE TO PAIN 2 POINTS
 - NO RESPONSE 1 POINT

Mild TBI

- Etiology: Diffuse Axonal Injury (DAI), caused by intense acceleration, and shearing forces. Also neurochemical cascade including glutamate, neurotoxic free radicals and oxidants, arachidonic acid and increased calcium.
- Tests of divided attention and working memory (concentration) maybe abnormal for several weeks post event.
- Initial complaints include neck pain, head ache, fatigue, dizziness.

Manifestations of Mild TBI

- Hard Studies are negative: MRI and CT of the brain.
 - In most cases, symptoms remit by 3 months post injury. But persistent problems for a sub-set of patients (7-8%) including those with prior head injury.
 - Memory
 - Irritability
 - Depression
 - Poor Concentration
 - Restlessness

VA: Medical Record Tools in the Suicide Prevention Efforts

- 1. The Suicide Risk Assessment
- 2. The Suicide Safety Plan
- 3. The Suicide Behavior Report
- 4. The Category II Patient Record Flag for High Risk for Suicide
- 5. The retraction note for the Patient Record Flag (used after the 90 day window for the Flag has passed)

Suicide Attempt

- Those who succeed on the first try.
- Those who refuse follow up care.

Emergency Departments

- Some patients who come to ED after a suicide attempt, refuse referrals for follow up care.

Background

- Suicidal patients are very difficult to engage in treatment
(Rudd et al., 1996)
- 11% to 50% of attempters refuse outpatient treatment or drop out of outpatient therapy quickly
(Kurz & Moller, 1984)
- Up to 60% of suicide attempters do not even attend more than one week of treatment post-discharge from the ED
(O'Brien et al., 1987; Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995; Trautman et al., 1993; Spirito et al., 1989; Taylor & Stansfield, 1984; Kurz & Moller, 1984; Litt et al., 1983)

Background

- Of those who do attend treatment, 3 months after hospitalization for an attempt, 38% have stopped outpatient treatment

(Monti et al., 2003)

- After a year, 73% of attempters will no longer be in any treatment

(Kruee & Hales 1988)

The implications.....

- Most suicidal individuals who go to the ED for help attend very few outpatient treatment sessions
- Many do not attend even one session
- Therefore, it's important to intervene whenever they are accessible

Typical Strategy for Crisis Intervention

But, given the limited success of referrals, alternative strategies that include immediate intervention ought to be considered

Crisis contact may be the **ONLY** contact the suicidal individual has with the mental health system

May be able to increase its “therapeutic” capacity
Assess imminent danger then refer for treatment

Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with family members or others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means (firearms)

The Letter Writing Campaign

- Motto, J., & Bostron, A. (2001) “A Randomized Controlled Trial of Post Crisis Suicide Prevention,” *Psychiatric Services*, Jun Vol.52, No 6, pp. 828-833.
- Carter, G., Clover, K., Whyte, I., Dawson, A., D’Este, C., (2005) “Postcards from the Edge project: randomized controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self-poisoning.” *British Medical Journal* 2005 , Sept.

The Motto Study (2001)

- Total sample of 3,005 patients
- 843 Refused follow up after hospitalization
- These were randomized to “letters” or “no letters.”
- Letters were sent 4 times a year for 5 years.
- Follow-up up for the 5 years and then for the subsequent 10 years (Total 15)
- Significant lower rates for the first 2 years. No differences by year 14.

Postcards from the Edge (BMJ, 2005)

- 772 patients with self-poisoning
- Treatment or Treatment and post-cards.
- 57 in the intervention group poisoned again
- 68 in the usual treatment group did so.
- No statistical difference.
- However, repeats episodes was 192 in the control and 101 in the intervention.
- This was significant.

Final Thoughts

- Suicide and Suicide risk will be a challenge in these stressful times for Veterans and non-Veterans alike.
- Healthcare Clinicians are on the front lines of identification and are avenues of access to care.
- Commitment to research will reveal patterns to aid prevention efforts as yet not well understood.