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Contact Hours: **2**

Suicide Risk Assessment and Prevention among Veterans

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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 knowledge 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

Despite increasing awareness that suicide is preventable, suicide continues to be a major health problem in the United States and around the world. In recent years, more military members have died by suicide than in combat, partly the result of rising suicides, but also because of decreased combat deaths due to the withdrawal of military personnel from Iraq and Afghanistan (DOD, 2022).

Suicide among Active-Duty Military and U.S. Veterans

The U.S. Department of Defense's annual report for 2021 on suicide in the military found that 519 active service members died by suicide, with young enlisted male service members being at greatest risk and with firearms being the main mechanism. Suicide is now the second leading cause of death among military personnel (DOD, 2022).

Data from 2020 shows an overall downward trend in veteran suicides. The U.S. Department of Veterans Affairs (VA) reported that the number of veteran suicides was the lowest since 2006, with 6,146 veteran suicides, a rate of 31.7 suicide deaths per 100,000, making suicide the 13th leading cause of death among veterans overall.

The suicide rate for female veterans in 2020 was the lowest since 2013, and for men it was the lowest since 2016. Veteran suicide rates by race showed decreases from 2019 to 2020 for all groups (VA, 2022a).

Suicide among Military Spouses and Dependents

In 2020, the Department of Defense reports that 202 dependents died by suicide, including 133 spouses and 69 other dependents (minor and non-minor), and that firearms were the primary method of suicide death. Among military spouses, 51% were female, and 79% were under 40 years of age. Among dependents, 72% were male, and 62% were under 18 years of age (DOD, 2022).

ETIOLOGY, RISK, AND PROTECTIVE FACTORS

Suicide etiology is complex and includes family history, genetics, epigenetics, neurobiology, medication use, and gender.

- **Genetics:** Four genes have been identified as heightening the risk of suicidal thoughts and actions.
- **Epigenetics:** The resulting impact of environmental influences on gene activity and expression has been associated with suicidal behavior.
- **Neurobiology:** Inflammatory mediators have been found to play a critical role in the pathophysiology of suicide.
- **Medications:** Certain antidepressants and anticonvulsant drugs can increase the risk for suicide.
- **Gender:** The rate of completed suicide in men is higher than in women; however, attempted suicide is more common among women than men.

Suicide Risk Factors

Risk factors for suicide may include:

- Family history of suicide or neuropsychiatric conditions
- Previous suicide attempt(s)
- Having a mental health disorder (e.g., depression, substance use disorder, PTSD, traumatic brain injury)
- Being a divorced or widowed female
- Socioeconomic factors (especially for men), including occupation, education, income
- Personality factors (e.g., paranoid personality features, obsessive-compulsive features)
- Developmental factors (e.g., behavioral disinhibition, negative emotional states)
- Life experiences, including history of trauma or abuse
- Impulsive/aggressive tendencies
- Cultural and religious factors
- Barriers to accessing mental health care
- Lack of or poor supportive social networks
(NV DPBH, 2021)

Suicide Risk Factors among Military Personnel

Risk factors for suicide among the military population include:

Life circumstances

- Being a young, enlisted male service member
- Difficulty readjusting following deployment
- Lack of advancement or having a sense of a loss of honor due to a disciplinary action
- Access to lethal means of self-harm, such as firearms or medications
- Loss from death and/or suicide among family or community
- Loss of, or problems within, a close relationship
- Financial and/or legal challenges
- Experience with firearms
- Deployment-related physical and/or mental health problems
- Transition from military to civilian life

Psychological issues

- History of abuse, family violence, neglect, or trauma
- Medical or mental health challenges such as depression, posttraumatic stress disorder, and traumatic brain injury
- Prior suicide attempt
- Family history of suicide
- Impulsiveness, aggressiveness
- Alcohol and substance misuse
- Severe or prolonged stress or combat-related psychological injuries
- Overwhelming grief from a loss (death of a loved one, divorce, disabling injury, etc.)

Cultural issues

- Limited access to healthcare
- Religious beliefs that support suicide as a solution; negative attitudes toward getting help
- Limited social and familial support
  (Military OneSource, 2021)

Military personnel are more likely to make a suicide attempt or die by suicide if they are experiencing intense emotional distress, which can result from depression and posttraumatic stress. Risk for suicide increases when the individual experiences these together.

Combat exposure can increase the risk and intensity of psychological and behavioral disorders such as posttraumatic stress disorder, depression, and substance abuse. Although these conditions increase the risk for suicide, less than half of military personnel who have died by suicide have even been deployed or been in combat, meaning that combat and deployment were not a contributor to the majority of military suicides.

Military personnel who have been deployed and who also have posttraumatic stress disorder and depression are more likely to be suicidal, especially if they feel isolated or disconnected from others. Combat veterans who feel as if they do not "belong" or "fit in" with others are at greater risk for suicide (ABCT, 2023).

(See also "Mental Health and Suicide" below.)

SEXUAL TRAUMA IN THE MILITARY

Military sexual trauma (MST) refers to service members' (both male and female) experience with sexual assault or harassment. It is important to note that by percentage women are at greater risk, but nearly 40% of veterans who disclose MST to the VA are men (VA, 2023a).

Suicide among women in the military has increased at twice the rate of male service members. A primary contributor is **sexual trauma**, particularly incidents of harassment and rape while stationed overseas. An estimated 1 in 3 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. Women in the military report a "blanket of ugliness" pervading military culture, an antagonistic bias against women in the military, and being sneered at and called names by male service members daily (Gorn, 2023a).

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

- 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
- Strong sense of cultural identity
- 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

External/environmental protective factors

- Opportunities to participate in and contribute to school or community projects and activities
- Strong relationships, particularly with family members
- A reasonably safe and stable environment
- Availability of consistent and high-quality physical and behavioral healthcare
- Financial security
- Responsibilities and duties to others
- Cultural, religious, or moral objections to suicide
- Owning a pet
- Restricted access to lethal means
  (WMU, 2023; CDC, 2022b)

In addition to the protective factors described above, veterans may possess unique protective factors related to their service, such as resilience, a sense of belonging and purpose through military service, access to VA mental health care and care for substance use disorders, and positive coping skills learned in high-stress settings. Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands (APA, 2022; The Resilient Veteran, 2023).

MENTAL HEALTH AND SUICIDE AMONG MILITARY SERVICE PERSONNEL

The rate of mental health problems has risen 65% in the military since 2000, with nearly one million troops diagnosed with at least one mental health issue. Reasons for the increase may include high exposure to trauma, stress and burnout, isolation, loneliness, and difficulties integrating into civilian life (DeAngelis, 2022).

Mental health includes emotional, psychological, and social well-being, affecting how a person thinks, feels, and acts, and nearly 1 in 4 active-duty members show signs of a mental health condition. A recent study asked a group of active-duty soldiers why they tried to kill themselves, and out of the 33 reasons they had to choose from, all of them included a desire to end intense emotional distress (NAMI, 2023a; ABCT, 2023).

Combat exposure can increase the risk and intensity of psychological and behavioral disorders such as posttraumatic stress disorder (PTSD), depression, and substance abuse. Risk for suicide increases when military personnel experience both depression and posttraumatic stress together (DeAngelis, 2022).

Active-duty females have higher rates of PTSD, are almost twice as likely to have adjustment disorders (stress-related conditions), and have experienced higher rates of sexual harassment or assault even prior to joining the miliary, predisposing them to the development of a mental health disorder (Gorn, 2023b).

The Department of Veterans Affairs notes that 43% of female veterans who receive care through the VA have been found to be diagnosed with mental health issues, compared to 26% of male veterans (Walsh, 2021).

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, 2023a).

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder has been known by different names in the past, such as “shell shock” during the World War I years and “combat fatigue” after World War II. This disorder is highly related to traumatic experiences, such as military combat, assault, disasters, or sexual assault, and can have long-lasting negative effects. PTSD can also result from being indirectly exposed to the trauma experienced by others, perhaps a family member or a fellow soldier. The rate of PTSD among military personnel has been found to be 15 times higher than among civilians (NAMI, 2023b; APA, 2022).

Individuals experiencing PTSD experience a wide array of symptoms, including:

- Recurring involuntary intrusive thoughts about the traumatic event, flashbacks, or distressing dreams
- Avoidance symptoms that involve reminders of the event, such as people, places, activities, objects, and situations
- Cognitive and mood symptoms, including difficulty recalling the events and negative self-thinking leading to ongoing distorted beliefs about oneself or others
- Feeling detached from others or being unable to experience positive emotions
- Alterations in arousal and reactivity, which may include irritability, angry outbursts, reckless behavior, hypervigilance, being easily startled, or having problems concentrating or sleeping
(APA, 2022)

Depression

Depression very often occurs following trauma and frequently is comorbid with PTSD. Depression remains one of the leading mental health conditions in the military. Studies show that up to 9% of all appointments in the ambulatory military health network are related to depression. The military environment can act as a catalyst for the development and progression of depression (Inoue et al., 2022).

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

- Persistent sadness, anxiety, or depressed mood
- Feelings of hopelessness or pessimism
- Irritability, frustration, restlessness
- Feelings of guilt, worthlessness, or hopelessness
- Loss of interest or pleasure in activities
- Decreased energy, fatigue, or feeling "slowed down"
- 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, 2022)

Traumatic Brain Injury (TBI)

The Department of Defense indicates that between 2000 and 2022 there were 468,424 U.S. service members diagnosed with a traumatic brain injury, the majority of which were classified as mild (MHS, 2023).

A TBI is defined as a blow or jolt to the head or a penetrating head injury that disrupts brain function. These are most commonly caused by explosion. A primary blast injury takes place at the time of impact. Among military personnel, the most common causes of TBI include:

- Secondary blast injury caused by shrapnel propelled by a blast that can strike the head, causing either a closed-head injury through blunt force or a penetrating head injury that damages brain tissue
- Tertiary blast injury resulting from being thrown by the wind from the blast. Kinetic energy from a blast can cause the head to hit a solid object, and once the head stops moving, the brain continues to move in the direction of the force, hitting the interior of the skull and bouncing back into the opposite side (coup-contrecoup injury).

A TBI can also be the result of penetrating and blunt trauma from causes other than explosions (Brainline, 2023).

Service members and veterans who have sustained such an injury may having ongoing symptoms and may experience co-occurring mental health conditions, such as posttraumatic stress disorder and depression (CDC, 2022b).

TBI symptoms can include:

- Headaches
- Emotional instability
- Unpredictability
- Irritability
- Sleep disorders
- Memory lapses
- Slowed thinking
- Depression
- Convulsions or seizures
- Restlessness or agitation
- Slurred speech
  (Cleveland Clinic, 2023)

TBI is associated with varied neuropsychiatric sequelae, including increased suicidal ideation and behaviors. Head injuries, especially mild ones, cause an indirect increase in suicide risk by worsening depressive symptoms and aggressiveness. Veterans with a history of TBI and PTSD are at greater risk for suicide than those without such history (Allen, 2021).

IDENTIFYING THOSE AT RISK

It is important for clinicians to be able to recognize behaviors that indicate an individual is at risk for suicide.

Recognizing Suicide Warning Signs

Besides screening for risk factors for suicide, it is important to be able to recognize statements, behaviors, and moods that indicate an individual may be at immediate risk for suicide.

Statements by a patient that constitute a suicide warning sign include language about:

- Killing oneself

- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Having unbearable pain

Behaviors that may signal risk—especially when related to a painful event, loss, or change—include:

- Increased use of alcohol or drugs
- Searching for a method to end their life, e.g., online search
- Withdrawing from activities
- Risky behaviors
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue
- Writing a will and making final arrangements

People considering suicide often display one or more of the following **moods**:

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation/shame
- Agitation/anger
- Relief/sudden improvement
(AFSP, 2023)

SUICIDE WARNING SIGNS SPECIFIC TO THE MILITARY

Warning signs that a military service member or veteran 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 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
- Defensive speech, such as, "You wouldn't understand"

(Vets Helping Heroes, 2023)

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.

The Veterans Health Administration's suicide risk identification strategy, **Risk ID,** is designed to improve detection and management of suicide risk across all healthcare settings. Risk ID is a two-stage process:

1. Screen to detect who may be at risk for suicide and in need of further evaluation using the **Columbia-Suicide Severity Rating Scale (C-SSRS) Screening Version** or the **Patient Health Questionaire-9 (PHQ-9)** screening tools.
2. Evaluate to inform clinical impression about acute and chronic risk and associated disposition using the **VA Comprehensive Suicide Risk Evaluation (CSRE).**

The VA Comprehensive Suicide Risk Evaluation (CSRE) screens for:

- Suicide ideation

- Suicide behaviors
    - Suicide attempt
    - Preparatory behavior
    - Warning signs
- Risk factors
- Protective factors and reasons for living
- Clinical impression for risk stratification
- Risk mitigation plan
(Brenner, 2021)

"HAVE YOU SERVED IN THE MILITARY?"

Members of the miliary have served in several wars and peacetime intervals around the world. As a result, their healthcare needs may be fundamentally different from those of civilians, related to unique environmental hazards, endemic country diseases, harmful biologics, toxic fumes, traumatic events, and the accompanying psychological facts of war.

The "Have You Ever Served in the Military?" campaign is an awareness initiative created by the American Academy of Nursing. Healthcare providers learn how to identify military members and veterans by asking questions specific to their military histories The campaign also helps providers gain insights into the possible etiologies of health issues that can inform assessments, therapeutic intervention, and consultations (Sheehy & Schwartz, 2021).

ASSESSING PATIENTS WHO ARE AT RISK FOR SUICIDE

The most effective assessment of the patient who has screened positive for suicidal ideation begins with the establishment of a therapeutic relationship. In order to effectively intervene with someone who may be at risk for suicide, it is essential that healthcare professionals are skilled at establishing rapport quickly. It is imperative that the person be given privacy, be shown courtesy and respect, and be made aware that the concerned individual wants to understand what has happened or is happening to them.

Basic Attending and Listening Skills

Basic attending and listening skills are valuable in establishing rapport in order to obtain information and assist in determining how one should intervene. These skills range from nondirective listening behaviors to more active and complex ones.

Positive attending behaviors are nonverbal and include:

- Eye contact. Maintaining eye contact communicates care and understanding and can show empathy and an interest in the person's situation. Cultures vary in what is considered appropriate. Asian and Native Americans, for example, may view eye contact as aggressive.

- 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. Vocal qualities can be used to lead the patient.

- Verbal tracking. This involves using words to demonstrate that the interviewer has accurately followed 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, 2023)

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

Nondirective listening responses are described below:

- 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.
- Nondirective questioning includes asking for clarification, more facts, and details, best done by using open-ended questions.
- 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.
- Empathizing is used to show that the listener identifies with the patient's information and allows the patient the right to their feelings.
- Supporting includes agreement, offers to help, reassurance, and focusing on the here and now.
- Analyzing is helpful in gaining different alternatives and perspectives by offering an interpretation of the patient's message, making sure the person will be receptive.
- 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.
  (Wrench et al., 2022)

Directive listening skills:

- 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*, goes beyond surface feelings or emotions to uncover deeper, underlying feelings, which can bring about strong emotional insights or defensiveness.
- Interpretation*,* also known as *reframing,* is a classic psychoanalytic technique that can produce patient insight or a solution-focused way to help patients view their problems from a new and different perspective.
- Confrontation involves pointing out perceptual inaccuracies or inconsistencies 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.
  (Panna, 2020)

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 with suicidal thoughts should be encouraged and given the opportunity to express thoughts and feelings and be allowed to discharge pent-up and repressed emotions. Asking **open-ended questions** encourages the person to elaborate on their answers, which can provide important context on their level of risk, access to means, and presence of intent (Aamar, 2021).

OPEN-ENDED QUESTIONING IN RESPONSE TO PERSONS WITH SUICIDAL IDEATION	
Person's Statement	**Appropriate Responses**
Everyone will be better off without me.	• Who would be better off? • What would be better for those people? • Where are you planning to go?
I just can't bear it anymore.	• What is so hard to bear? • What would make your life better? • When did you begin to feel this way?
I just want to go to sleep and not deal with it again.	• What do you mean by "sleep"? • What is it you don't want to deal with anymore?
I want it to be over.	• What is it you want to be over? • How can you make it be over?
I won't be a problem much longer.	• How are you a problem? • What is going to change in your life so you won't be a problem any longer? • When will you no longer be a problem?
Things will never work out.	• What can you do to change that? • What, then, do you propose to do?
It is all so meaningless.	• What would make life more meaningful? • What are some aspects of your life that make it worth living? • What is happening in your life that makes it so meaningless?

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. The patient should be asked if the thoughts are new and if there are changes in the frequency or intensity of chronic thoughts. It is also important to inquire about the patient's ability to control these thoughts.

The next step is to determine if the patient has developed a suicide plan and their degree of intent. This includes asking whether or not they have made any preparations and what they are. It is also important to determine whether the patient has a history of impulsive behaviors or substance use that may increase impulsivity, and whether they have a past history of suicidal ideation and behavior.

In addition, the clinical interview includes observing whether the patient is disconnected, disengaged, or shows a lack of rapport, as these signs are associated with an increased risk of suicide (Schreiber & Culpepper, 2022).

SUICIDE RISK 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 when positive results have been obtained with one of the screening tools mentioned above. The following are validated/evidence-based suicide risk assessment tools:

- **Columbia-Suicide Severity Rating Scale (C-SSRS),** Risk Assessment version. The risk assessment version of this tool provides a checklist of protective and risk factors for suicide and is used along with the C-SSRS screening tool. It is appropriate in all settings for all ages and for special populations in different settings. The tool features a clinician-administered initial evaluation form, a "since last visit" version, and a self-report form. The Columbia protocol questions have also been incorporated into the SAMHSA SAFE-T model with recommended triage categories.

- **Beck Scale for Suicide Ideation (BSI).** This 21-item self-report instrument can be used in inpatient and outpatient settings for detecting and measuring the current intensity of the patient's specific attitude, behaviors, and plans to die by suicide during the preceding week. It assesses the wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and the amount of actual preparation for the contemplated attempt. (TJC, 2023)

CLINICAL INTERVIEW

The clinical interview is the **"gold standard"** for suicide assessment and intervention. Topics covered during this interview include suicidal ideation, plans, self-control, intent, and safety planning.

There are three effective **approaches** to asking about suicide:

- Use a normalizing tone. About 60% of people who died by suicide denied suicidal ideation when asked by a healthcare provider, indicating the presence of psychological and interpersonal barriers to disclosure. It is helpful to use a statement that normalizes suicide ideation, such as: "I asked you this question because almost all people at one time or another have thoughts about suicide."
- Use gentle assumption. To make it easier for patients to disclose suicidal ideation, the interviewer assumes that certain thoughts and behaviors are already occurring in the person and gently structures questions accordingly. So, instead of asking if the person has been thinking about suicide, ask "When was the last time you had thoughts about suicide?"

- Assess the person's mood. An exploration of mood states might include asking permission to discuss mood, and then asking patients to rate their mood using a zero–10 scale. This is followed by questions that refer to the worst or lowest mood rating the person has ever had as well as what was happening at those times that made them feel so down. In order to end with a positive note, the patient is asked about the best mood rating they've ever had.

Explore suicidal ideation. When the patient discloses the presence of suicidal ideation, collaboratively explore the frequency, triggers, duration, and intensity of the suicidal thoughts. During this process, it is important to show curiosity, empathy, and interest instead of judgment. If the patient denies suicidal thoughts and the denial appears to be genuine, acknowledge and accept the denial, but if the denial seems forced or is combined with symptoms of depression or other risk factors, acknowledge and accept the denial but return to the topic later.

Explore suicide plans. Once rapport is established and the patient has talked about suicidal ideation, it is important to explore suicide plans. If patients admit to a plan, further exploration is crucial. Evaluation includes assessing the specificity of the plan, its lethality, availability of the means, and proximity of social support (i.e., availability of individuals who might intervene and rescue the patient) (see "Assessing the Plan, Lethality, and Risk" below).

Assess self-control. This requires asking directly about self-control and observing for agitation, arousal, or impulsivity. Arousal and agitation adversely affect self-control and are the inner push that drives persons toward suicidal acts (Sommers-Flanagan, 2022).

[end box]

[H3] Assessing the Plan, Lethality, and Risk

The evaluation of a suicide plan is extremely important in order to determine the degree of suicidal risk. When assessing the 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.

Suicidal deaths are more likely to occur when persons use highly damaging, fast-acting, and irreversible methods—such as jumping from heights or shooting—and do so when rescue is fruitless.

STEPS TO TAKE WHEN A PATIENT REFUSES ASSESSMENT

- Obtain information from other sources, such as:
    - Collateral reports from staff

    - Patient's past medical records
        - Past suicide attempts
        - Past nonsuicidal self-injury
        - Past episodes of suicidal thinking
    - Mental status assessment
- For patients who are competent and refuse services, document efforts made to gain cooperation.
- Document an explanation of the limitations of assessment and how level of risk was determined.

(Obegi, 2021)

IMPULSIVITY AND SUICIDE

Some suicides are carefully planned and deliberate, while others appear to have been impulsively decided upon, involving little or no planning. Impulsiveness is thought to play an instrumental role in suicide because of the presumption that suicidal behaviors are carried out via rash decisions with little consideration for the consequences. A study of survivors of nearly lethal suicide attempts found that 1 in 4 individuals deliberated for less than 5 minutes. Another study found that 48% reported deliberating less than 10 minutes (HSPH, 2023a).

A recent study has found an altered pattern of ventromedial prefrontal cortex and frontoparietal connectivity in impulsive people who exhibit suicidal behavior, as well as reduced ventromedial prefrontal cortex value signals. This altered connectivity has been found to be disrupted in people who attempted suicide and is believed to underlie disrupted choice processes in a suicidal crisis (Wislowska-Stanek et al., 2021; Brown et al., 2020).
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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%
- Jumping: 34.5%

- Drug/poisoning: 1.5%
- Cutting/piercing: 1.2%
- Other: 8.0%
  (HSPH, 2023b)

It is of utmost importance for clinicians to recognize that these methods, as well as other highly lethal suicide methods, are widely accessible and must be considered when determining the disposition of someone who has suicidal ideations.

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 to stop a method such as jumping off a bridge or using a gun.
- Acceptability to the individual. The method must be one that does not cause too much pain or suffering. For example, fire is readily accessible, but it is a method seldom used in the United States.
  (HSPH, 2023b)

LEVEL OF RISK

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

Patients who are **low risk** of suicide:

- Are experiencing recent suicidal ideation or thoughts
- Have no specific current suicide plan
- Have no clear intent to act
- Have not planned or rehearsed a suicide act
- Have identifiable and multiple protective factors
- Have limited risk factors
- Have no history of suicidal behaviors
- Have evidence of self-control

- Have supportive family members or significant others
- Have a high degree of ambivalence

Most people with suicidal ideation 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 such persons. Almost everyone with suicidal thoughts 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 current suicide ideation
- Have no clear plan for suicide
- Have had no preparatory behavioral or rehearsal of act
- Have limited or no intention to act
- Have limited identifiable protective factors
- Are able to control the impulse
- Have the ability to maintain safety, independent of external support
- Have no recent suicidal behavior
- Have supportive family or significant others
- Have a high degree of ambivalence

Patients who are at **high/severe/imminent risk**:

- Have strong, persistent suicidal ideation
- Have strong intention to plan or act
- 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 inability to maintain safety, independent of external support
- Have a poor social support network
- Have severe psychiatric symptoms and/or an acute precipitating event
- Have a history of prior suicide attempt

(VA, 2022b)

PREDICTING SUICIDE BY RISK LEVEL

There has been no improvement in the accuracy of predicting suicides in the past 40 years.

- 95% of "high-risk" patients will not die by suicide.
- 50% of suicides are from "low-risk" patients.
- 50% of individuals who complete suicide have no prior history of suicide attempts.

(PsychDB, 2021)

Documentation of Suicide 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. The best records reflect awareness of risk and the process of professional judgement that recognized it, took steps to reduce it, and balanced it with patient needs. The following documentation should be present in the record:

- Reason for suicide assessment
- Review of past available records
- Evaluation of warning signs and risk and protective factors
- Initial and ongoing suicide risk assessment
- Access to lethal means and mitigation
- Consultations with colleagues
- Referrals to behavioral health
- Rationale and follow-up for treatment options
- Safety planning and discharge coordination
- Plans for follow-up
  (Stefan, 2020)

MODELS OF CARE FOR PATIENTS AT RISK FOR SUICIDE

A model of care is a set of interventions that can be consistently carried out in various settings to ensure that people get the right care, at the right time, by the right provider or team, and in the right place. Newer models of care for management of patients at risk for suicide include:

- Crisis support and follow-up (e.g., center hotline)

- Brief intervention and follow-up
- Suicide-specific outpatient management
- Emergency respite care
- Tele–mental health
- Inpatient psychiatric hospitalization, with suicide-specific treatment
(EDC, 2022)

Crisis Support and Follow-Up

Crisis support and follow-up can include mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, peer-based crisis services, and other programs designed to provide assessment, crisis stabilization, and referral to an appropriate level of ongoing care. Crisis centers can also serve as a connection to the patient between outpatient visits and are helpful for patients with barriers to accessing outpatient mental health services. Crisis services also include care coordination. Mobile crisis teams provide care in the community at the location of the person who is considering suicide (EDC, 2022).

Brief Intervention and Follow-Up

Brief interventions range from a single, in-person session, to a computer-administered intervention in a primary care office, to an online screening and feedback intervention that can be done on a personal electronic device. Brief interventions can be an immediate intervention and also can be used in conjunction with any other level of care. Safety planning is recommended for those who refuse outpatient care. Outreach and follow-up are provided through phone calls, letters, and texts (EDC, 2022).

Suicide-Specific Outpatient Management

Suicide-specific outpatient management involves several sessions that may include dialectical behavior therapy, cognitive therapy for suicide prevention (CT-SP), and collaborative assessment and management of suicide (CAMS). It is critical that outpatient mental health providers monitor patients between appointments and follow up when patients miss appointments (EDC, 2022).

Emergency Respite Care

Emergency respite care is an alternative to inpatient or emergency department services for a person in a suicidal crisis when the person is not in immediate danger. Respite centers are usually located in residential facilities designed to be more like a home than a hospital. These facilities may include staff members who are peers who have lived experience of suicide. Respite care is increasingly being utilized as an intervention and may include help with establishing continuity of care and provision of longer-term support resources, as well as support by text, phone, or online following a stay (EDC, 2022).

Tele–Mental Health

Tele–mental health involves electronic communication to provide clinical mental health services from a distance. Healthcare organizations can use these services to provide emergency assessments and treatment, especially for those patients located in remote geographic regions and for organizations with limited access to mental health resources (EDC, 2022).

Hospitalization

Inpatient hospitalization is the most restrictive option for addressing suicide risk. Research has found that patients may be at higher risk immediately after discharge from inpatient care. The reasons why this may happen are not known; however, experts have questions as to whether there is something about the experience of hospitalization itself that may be harmful. Involuntary hospitalization has been found to be associated with increased risk of suicide both during the hospitalization and afterward. It is therefore recommended that hospitalization be carefully weighed against other options (EDC, 2022).

INVOLUNTARY HOSPITALIZATION.

Involuntary hospitalization (or commitment) means placing a person in a psychiatric hospital or unit without their consent. The laws governing involuntary hospitalization vary from state to state, but in general, they confine involuntary commitment to persons who are mentally ill and/or under the influence of drugs or alcohol and are deemed to be in imminent danger of harming themselves or others

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. Develop and test prevention strategies.
3. Assure widespread adoption of strategies shown to be successful.
(VA, 2018)

Under the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020, veterans in suicidal crisis can receive free emergency healthcare at any VA or non-VA healthcare facility (VA, 2023).

Resources available for veterans and their families include:

- Suicide Prevention Coordinator, available at each VA medical center, who provides veterans with counseling and other services; as appropriate, callers to the Veterans Crisis Line are referred to their local coordinator
- Coaching Into Care, a national telephone service to educate, support, and empower family members and friends seeking care or services for a veteran (call 888-823-7458)
- Veterans Crisis Line (call 988 or text 838255)
- Suicide Safety Plan template
- inTransition, a free, confidential program offering coaching and 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)
https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Columbia-Suicide Severity Rating Scale (C-SSRS)
https://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)
https://www.haveyoueverserved.com/intake-questions.html

Suicide Prevention Resource Center
https://sprc.org/

Veterans Crisis Line
https://www.veteranscrisisline.net/
988, press 1
838255 (text)

Veterans self-check quiz
https://www.vetselfcheck.org/welcome.cfm

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TEST

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1. Which statement is correct regarding 2020 data on suicide among veterans and active-duty military?

a. Young enlisted females were at greatest risk.
b. Suicide deaths increased for all branches of active-duty military.
c. The suicide rate for male veterans was the lowest since 2016.
d. There was a rising trend in veteran suicides in 2020.

2. For which reason are military personnel **most** likely to make a suicide attempt or die by suicide?

a. They have a history of abuse, family violence, neglect, or trauma.
b. They have limited social and familial support.
c. They have access to lethal means of self-harm, such as firearms or medications.
d. They experience emotional distress from depression and posttraumatic stress.

3. Which statement is a **true** regarding suicide risk 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 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. 4. Which phrase describes an **external/environme**ntal protective factor for suicide?

a. Good impulse control
b. Strong sense of cultural identity
c. Strong relationships
d. Strong problem-solving skills

5. Which cause is **most** closely associated with traumatic brain injury in deployed military personnel?

a. Falls
b. Assaults
c. Explosions
d. Motor vehicle rollovers

6. Which suicide warning sign is associated specifically with military personnel?

a. Giving away personal possessions
b. Visiting or called people to say goodbye
c. Searching for a method to end their life
d. Cleaning a souvenir weapon

7. Which action is considered the "gold standard" for suicide assessment and intervention?

a. Reviewing the patient's history of mental disorders
b. Conducting a clinical interview
c. Administering the Patient Health Questionnaire (PHQ)
d. Screening with the Scale for Suicide Ideation-Worst (SSI-W)

8. At which level of risk would a patient having thoughts of death, no plan for suicide, and no history of suicidal behavior be categorized?

a. High
b. Moderate
c. Low
d. None

9. Which model of care is an alternative to inpatient or emergency department services for a person in a suicidal crisis when the person is not in immediate danger?

a. Tele–mental health
b. Emergency respite care
c. Crisis support and follow-up
d. Brief intervention and follow-up