

SUICIDE PREVENTION - VETERANS MODULE

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Certain healthcare professionals are required to complete suicide prevention training (RCW 43.70.442). The Department of Health recently adopted minimum standards for the suicide prevention training programs (WAC 246-12-601). Six hour suicide prevention training programs must include at least 30 minutes on content specific to veteran populations. Training program developers must use content developed by the Department of Veterans Affairs or a resource with comparable content.

The following is offered to guide instruction specific to Veterans and suicide. The workshop facilitator has latitude on educating participants about military and Veteran culture, suicide prevention, and other resources unique to this population. This module is a living document subject to future revision.

Credit goes to VA Puget Sound Suicide Prevention Team: Dr. Greg Reger, Ph.D. and Michelle Borsz, MSSA, LISW-S for the sections on Suicide Data and VA Operation S.A.V.E. & Means Reduction.

Neetha Mony, MSW is responsible for the creation of the handout at the end of the curriculum.

OBJECTIVES

Depending upon the workshop curriculum already developed, any one of the following objectives can be sought after as an outcome.

- 1) Cultural Considerations - Brief Overview of Military Culture
- 2) Suicide Data - Highlight Veteran Suicide Data
- 3) VA Operation S.A.V.E. & Means Reduction - Introduce VA S.A.V.E. Model & Means Reduction
- 4) Resources - Mental Health Services - Identify Resources

INSTRUCTIONAL SUGGESTIONS

1) QUOTES - One might begin this part of the curriculum with a military-related quote to begin the discussion.

"I fear they do not know us," Adm. Mullen said of the nation's civilians. "I fear they do not comprehend the full weight of the burden we carry or the price we pay when we return from battle."

Admiral Mike Mullen, 17th Chair, Joint Chiefs of Staff

2) CASE STUDY - A case study, such as the following, may be used to elicit discussion and highlight points in any of the content areas 1) Cultural Considerations, 2) Suicide Data, 3) VA Operation S.A.V.E. & Means Reduction, and 4) Resources - Mental Health Services:

Private First Class Shania Wilson serves in Alpha Company, 181st Brigade Support Battalion, 81st Brigade Combat Team, Washington Army National Guard. A mother of three, she was stationed at Joint Base Balad for eight months providing security for Iraqi business on base and the hospital, escorting local nationals working on base, and providing Personal Security Detail services. Another deployment sent Private Wilson to Afghanistan with the 96th Troop Command based out of Yakima. "I wasn't supposed to be on that deployment, but I was called to duty and had to go," reported Shania. She pulled security duty in a variety of places and on several occasions experienced firefights, witnessed the deaths of three members of her unit, applied first aid to the severely wounded, and on two occasions experienced two separate blasts from an IED. She recalls being lightheaded with ringing in her ears, and since that time Shania has had problems thinking and remembering, becomes more irritable, and experiences sleep disturbances. On her initial arrival to school last spring, she felt isolated and uncomfortable. Shania is feeling hopeless, like there is no reason to live other than her children and unit, and she has increased her use of alcohol. Several students in one of her classes surmised she was in the military and Shania overheard them refer to her one day as a "baby killer." Most recently a video was shown in her science course that made her feel uncomfortable and since that time she's had more difficulty concentrating on her studies. She has not sought any medical or behavioral health assistance at this time for fear that it could interfere with her career in the guard and also remove her from the chance to support her unit on another upcoming deployment. In fact, the 81st Brigade Combat Team and 506th Military Police Company received notices of sourcing from the Pentagon, meaning they could be tapped for an upcoming deployment.

3) VIDEOS - The following links to videos may be used to highlight particular aspects of any one of the content areas.

- a) Finding Hope Again and Reconnection -
<http://maketheconnection.net/conditions/suicide>
- b) Treatment Got Him From Rock Bottom To Living Well -
<http://maketheconnection.net/stories/7>
- c) Healing After the Loss of A Loved One -
<http://maketheconnection.net/events/death-family-friends>
- d) The Reason for Veteran Suicides - Powerful video. One perspective on suicide <https://www.youtube.com/watch?v=AVUHalR8P0I>
- e) Iraq War Vet's Suicide Note Goes Viral - Video could be used as an intro for discussion <https://www.youtube.com/watch?v=ZV22tO93dY8>
- f) Veterans and Suicide - An Epidemic - Part 1 - Family members share the impact. Dated video - 2007 - <https://www.youtube.com/watch?v=XB2-xER8NS8>
- g) Why 22 Veterans A Day Commit Suicide - Compelling message. Can also be used as an intro for discussion
https://www.youtube.com/watch?v=Xp1hWord_hg

Proposed Module Outline

1. Select a video, quote, or any items under 1) Cultural Considerations for a 5-10 minute discussion.
2. Provide an overview of 2) Suicide Data or 3) VA Operation S.A.V.E. & Means Reduction for a 15 minute presentation.
3. Identify specific resources under 4) Resources - Mental Health Services, i.e., Veterans Crisis Line/Chat/Text a clinician can immediately access for a 5 minute overview.
4. Can distribute a summary handout (example on p. 20)

1) CULTURAL CONSIDERATIONS

Objective - Brief Overview Military Culture

The following three questions are to prompt awareness and explore one's thinking about military service and the experiences of a service member. Cultural competence with this population is a must and participants need to be encouraged to further explore their level of comfort and competence with Veterans and military service members.

- a) What images and thoughts come to mind when you think of military or Veterans?
- b) Why does one choose to join the military? What's the transition like entering the military?
- c) What skills and experiences are learned as a result of basic military training and other schooling?

The emphasis of the following is to make one aware, no matter what branch of service, one's loyalty to the mission and others before self is paramount. Values are deeply embedded in the psyche of the service member as is the warrior ideal. To not be able to live up to these ideals can have significant consequences on the Veteran. Missing one's battle buddies/team, not having a mission, and failure to live up to the values and ideals can cause one to feel isolated and inadequate.

- a) Less than .5 % of the general population has served in the last decade.
- b) No matter what branch of service, Veterans were taught service comes before self and the mission comes first.
- c) Strength, valor, courage, fortitude, honor, esprit de corps, respect, and integrity are all noble traits of a warrior.
- d) For a warrior to develop stress symptoms of any kind is a failure to live up to the warrior ideal.

The following questions are offered to create a Vet-supportive environment. Notice Vet-friendly is not asked since being supportive requires systemic change and more effort. Some organizations have a Veterans Coordinating Committee or

a body of dedicated professionals who meet on a regular basis to consider these questions. Some agency workers may have photos of a family member who served, a US flag, challenge coins, posters, etc. on a desk or wall in one's work area.

- a) How would a Veteran or family member of a Veteran know you or your place of work is Vet-aware and supportive?
- b) What signs and symbols in the environment communicate being Vet-aware and supportive?
- c) What would prevent a Veteran or family member of a Veteran from self-identifying affiliation with the military to you or in your place of work?

2) SUICIDE DATA

I. WA Suicide and Armed Forces Participation

Groups at increased risk of suicidal behavior in Washington State

- a) Males over 45 years old
- b) People in rural areas - isolation, fewer resources
- c) American Indian/Alaska Natives and Whites
- d) People from areas with higher poverty & lower educational attainment
- e) Veterans and their families
- f) People with access to firearms

Statistics

- a) About 13% of Washington's population has participated in the armed forces.
- b) From 2000 to 2010, the military suicide rate was higher than the non-military rate every year; 16% of males and 26% of females in the military who died by suicide over those years were under 35; and over 60% of the suicides were by firearm.
- c) From 2012 to 2014, of the 3,150 deaths by suicide in Washington, 700 had participated in the armed forces. More than half of those over 65 who died by suicide were veterans.
- d) 49% of WA suicides are by firearm, and 78% of firearms deaths in WA are suicides

Source Washington State Suicide Prevention Plan 2015

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/631-058-SuicidePrevPlan.pdf>

II. Veterans Data

- a) 22% of U.S. deaths from suicide are Veterans (VA Suicide Data Report, 2012) <http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf>
- b) No clear changes in suicide rates in the total population of Veterans Health Administration (VHA) users or in male clients overall.
- c) Almost 70% of male VHA suicide deaths are by firearm; 35% for females (VA Suicide Data Report Update, January 2014)
http://www.mentalhealth.va.gov/docs/Suicide_Data_Report_Update_January_2014.pdf
- d) 950 suicide attempts per month among Veterans receiving VA healthcare services (VA National Suicide Prevention Coordinator reports, 10/1/2008-12/31/2010)
http://www.sprc.org/system/files/private/event-training/StateTribal%204B_Stephenson_At%20Risk%20Youth%20Veterans.pdf
- e) 33% of recent suicides have a history of previous attempts (VA National Suicide Prevention Coordinator reports, 10/1/2008-12/31/2010)
http://www.sprc.org/system/files/private/event-training/StateTribal%204B_Stephenson_At%20Risk%20Youth%20Veterans.pdf

III. VA Suicide Prevention Efforts

- a) Suicide rates among the overall population of VHA users have remained more or less constant over the past several years...
- b) However, there are indicators that VHA's program for suicide prevention has led to positive outcomes:
 - Decreased rates of suicide among VHA users with mental health conditions
 - Decreased mortality in the 12 months following a survived suicide attempt

- Decreased rates of suicide among VHA male users aged 35-64 years
 - Decreased rate of non-fatal suicide events
 - Decreased percentage of calls to the Veterans Crisis Line resulting in a rescue (perhaps because more people are calling before acute crisis)
- c) Recent findings regarding suicide rates in young male Veterans and female Veterans call for increased efforts
(Source: Jan Kemp, VHA, January 2014)
<http://www.cbsnews.com/news/suicide-rate-among-young-male-vets-spikes-va/>

IV. Veterans Crisis Line

- a) 1-800-273-8255 and Press 1
- b) Confidential Online Chat - www.VeteransCrisisLine.net/chat
- c) Text Message - 838255 to a VA Responder
- d) Statistics since the Crisis Line launched in 2007
 1. 2 million calls
 2. 267,000 Chats
 3. 48,000 texts
 4. 320,000 referrals
 5. 56,000 rescues

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

3) VA OPERATION S.A.V.E. & MEANS REDUCTION

Objective - Introduce VA S.A.V.E. Model & Means Reduction

a) Operation S.A.V.E. will help you act with care and compassion if you encounter a Veteran who is in suicidal crisis. The acronym “S.A.V.E.” helps one remember the important steps involved in suicide prevention:

- Signs of suicidal thinking should be recognized
- Ask the most important question of all
- Validate the Veteran’s experience
- Encourage treatment and Expedite getting help

I. Signs of Suicidal Thinking

Learn to recognize these warning signs:

- Hopelessness, feeling like there’s no way out
- Anxiety, agitation, sleeplessness, or mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

The presence of any of the following signs requires immediate attention:

- Thinking about hurting or killing themselves

- Looking for ways to die
- Talking about death, dying, or suicide
- Self-destructive or risk-taking behavior, especially when it involves alcohol, drugs, or weapons

I. a. Veteran-Specific Risks

- a) Exposure to extreme stress
- b) Physical/sexual assault while in the service (not limited to women)
- c) Service-related injury
- d) Traumatic Brain Injury (TBI)
- e) PTSD
- f) Lower rank or recent demotion
- g) Access to/familiarity with firearms
- h) Times of transition are particularly at risk
- i) LGBT status

I. b. Protective Factors

- Connection to social support, sense of belonging
- Sense of responsibility to loved ones, especially children in home
- Reasons for living, a sense of purpose/mission
- Cultural/spiritual beliefs that are deterrents to suicide
- Engaged in care, positive rapport and belief it will help
- Future orientation: making goals and plans

- Willing to safety plan and seek help
- Restricted access to lethal means
- Problem-solving skills

II. Asking the Question

- a) Ask the following in a way that is natural and flows with the conversation.
- b) Be careful of asking the question as if to receive a “no” response.
- c) Are you thinking about killing yourself?
- d) Are you thinking of suicide?
- e) Have you had thoughts about taking your life?

Considerations: Conversation with a Veteran at Risk for Suicide

- a) Remain calm
- b) Listen more than you speak
- c) Maintain eye contact
- d) Act with confidence
- e) Don't argue
- f) Use open body language
- g) Limit questions - let the Veteran do the talking
- h) Use supportive, encouraging comments
- i) Be honest - there are no quick solutions, but help is available

III. Validate the Veteran's Experience

- a) Talk openly about suicide. Be willing to listen and allow the Veteran to express his or her feelings
- b) Recognize that the situation is serious
- c) Do not pass judgment

IV. Encourage Treatment and Expediting Getting Help

- a) What should I do if I think someone is suicidal?
- b) Don't keep the Veteran's suicidal behavior a secret
- c) Do not leave him or her alone
- d) Reassure the Veteran that help is available
- e) Try to get the person to seek immediate assistance from primary care or ER

- f) Direct the Veteran to the **Veterans Crisis Line** or call the number with them. **1-800-273-8255**, Press 1
- g) If the Veteran is in immediate danger, call 911.

IV. a. Safety Planning and Means Reduction

Key Elements:

- a) Recognizing Warning Signs
- b) Using Internal Coping Strategies
- c) Social Contacts Who May Distract from Crisis
- d) Contacting Family Members/Friends Who Can Help Resolve the Crisis

- e) Contacting the Professionals and Agencies
- f) Reducing the Potential for Use of Lethal Means
- g) Many suicide attempts are impulsive
- h) Intent alone doesn't determine life or death; the MEANS also matter
- i) Guns are drastically more lethal than other methods
- j) 50% of U.S. suicides are by firearm
- k) 78% of all firearm deaths in WA state are suicides
- l) Firearm attempts are fatal over 85% of the time
- m) Veterans are even more likely to use firearms
- n) 90% of attempters who survive do NOT go on to die by suicide later

IV. b. Reducing the Potential for Use of Lethal Means

- a) "Do you own a firearm?"
Always ask this even if a firearm is not in their identified plan.
- b) "What other means do you have access to and may use to attempt to kill yourself?"
- c) "How can we go about developing a plan to limit your access to these means?"
- d) For low lethality methods, you may ask the Veteran to remove themselves.
- e) For high lethality methods, consider involving a family member, close friend, or even police.

IV. c. Means Reduction Recommendations

- a) Access to firearms; 49% of WA suicides are by firearm, and 78% of firearms deaths in WA are suicides
- b) Remove guns from home in times of crisis
- c) Identify a friend or family member to take weapon
- d) Or have weapon properly stored and locked with the key out of possession of person in crisis (gunlocks are free at the VA)
- e) If unwilling take these steps and at a minimum have ammo separated from the weapon
- f) Lok-It-Up: Promoting the Safe Storage of Firearms:
 - a. <http://www.kingcounty.gov/depts/health/violence-injury-prevention/violence-prevention/gun-violence/LOK-IT-UP.aspx>
- g) www.meansmatter.org: key source of current data and educational material on suicide, guns, and public health

4) RESOURCES - MENTAL HEALTH SERVICES

Objective - Identify Resources

I. Resources - Federal, State, Not for Profit

- 1) Veterans Health Administration - provides inpatient and outpatient mental health services at its medical centers and community-based outpatient clinics. www.mentalhealth.va.gov
- 2) Vet Centers - VA community-based centers that provide counseling, outreach, and referral services. www.vetcenter.va.gov
- 3) WDVA PTSD & War Trauma Counseling - Behavioral health clinicians provide no cost outpatient services to Veterans and family members across the state. <http://www.dva.va.gov/benefits/ptsd>
- 4) The Soldiers Project - no cost counseling services to post-911 Veterans. <https://www.thesoldiersproject.org>
- 5) Give an Hour - no cost counseling services for Veterans, U.S. military and families. <https://www.giveanhour.org>
- 6) **Veterans Crisis Line/Chat/Text**
1-800-273-8255, Press 1
<http://www.veteranscrisisline.net/>
Text to 838255
- 7) **VA Suicide Prevention Coordinators** - Each VA Medical Center has a suicide prevention coordinator to make sure Veterans receive needed counseling and services.
Resource locator - <http://www.veteranscrisisline.net/>

II. Other Resources

- 1) **Make the Connection** - one-stop resource where Vets, families, and friends can privately explore information on physical and mental health symptoms. www.MakeTheConnection.net

- 2) **Post-Traumatic Stress Disorder (PTSD)** – National Center for PTSD.
<http://www.ptsd.va.gov/public/problems/ptsd-suicide.asp>
- 3) **Traumatic Brain Injury (TBI)**
<http://dvbic.dcoe.mil> – Defense and Veterans Brain Injury Center
- 4) **Suicide Prevention Resource Center**
<http://www.sprc.org/about-suicide>
- 5) **Center for Deployment Psychology**
<http://deploymentpsych.org/military-culture>
- 6) **VA Coaching Into Care**
<https://www.youtube.com/watch?v=7irBvan2XB4>
- 7) **Now Matters Now**
<http://www.nowmattersnow.org/>

Article of Interest

SUICIDE IN THE MILITARY, OTHER ANSWERS

The suicide rate among military service members has seen a dramatic increase since 2001. Mastroianni and Scott (2011) in *Reframing Suicide in the Military* question the causes and explore Durkheim and Joiner's theories on suicide and how they apply to the current context of military-civilian life.

The authors acknowledge how there is common understanding that repetitive and stressful deployments, military hardships, PTSD, TBI, substance abuse, etc. can all be risk factors for suicide and despite raised awareness, training modules, and screenings, suicide numbers continue to rise, particularly in the Army and Marine Corps (slight increases have occurred in the Navy and Air Force).

Contrary to popular belief, while ground services have experienced the stress of repetitive and extended deployments, the "2009 Department of Defense Suicide Evaluation Report (DODSER) identifies only 7 percent of military suicides occurred among service members with multiple deployments". The report also stated "while 51 percent of military suicides had been deployed at some time to Iraq or Afghanistan, only 17 percent experienced combat." Another curious finding is senior noncommissioned officers typically experience repetitive deployments, and that suicides occur among junior enlisted.

The Army released the Health Promotion, Risk Reduction, Suicide Prevention Report (2010), which found potential causes for the Army's higher suicide rate. Reasons included "lapses in garrison leadership supervision and control", lowering recruitment standards through increased use of waivers, and admittance of recruits who engage in high-risk behavior. The 2009 DODSER identified few service members who committed suicide that went AWOL (10%), received Article 15's (15%), experienced civilian legal problems (12%), and where less than a one-third (27%) experienced job-related difficulties.

Durkheim believed the health of a society is reflected in its incidence of suicide and that a society sustains itself through "regulation" (well-defined norms and customs that govern interactions) and "integration" (immersed in the life of the community where there are shared ideas of what is inappropriate and appropriate). If regulation or integration is too high or low, then suicides and other social ills will occur.

Durkheim described varying types of suicides. "Fatalistic" will occur when there is too much societal regulation and stifling existence, as for example, one's living under slavery. Little societal regulation and breakdown in established rules will predict "anomic" suicides. An individual who operates outside of the collective bonds of the group, or poorly integrates, can result in "egotistic" suicide. "Altruistic" can occur when there is strict adherence, for example, to a custom; it is one's duty to kill one's self when no longer constructively able to contribute to society.

Joiner offered the potential for suicide exists when there is failed belongingness, when one perceives self as a burden and when there is habituation to self-injury. Failed belongingness and burden are akin to Durkheim's concept of integration, and habituation occurs when one has gradually overcome the desire for self-preservation and lowered resistance to self-injury through rehearsal or observed self-harmful actions.

The military changes and builds one's identity and espouses values, beliefs, and norms that are quite contrary to civilian life, so upon separation, rules begin to disintegrate, leaving the option of anomie. If one does want to remain in the military and not engage in combat, the only other perceived option would be fatalistic.

In the absence of a deployed service member, a family will become more independent and self-reliant, leaving the soldier to feel less needed and with a perception the family can survive just fine without her or him. Reintegration with family becomes an issue and can result in altruistic suicide.

Combat leadership is trained for deployment and the war zone and not accustomed to the care of soldiers in a garrison environment, as cited in the HS/RR/SP Report. Inconsistencies in leadership, values, and norms can lead to anomic suicide. The authors cite examples of failed leadership such as Abu Ghraib (2003), the deception found during the investigation of Pat Tillman's death (2004), the murders of 24 Iraqi civilians by several Marines (2005), hindered investigation by leadership, etc. Each of these incidents and others cited by the authors has a common theme of inept or poor leadership and how those in authority deceived, obstructed, and failed in their duties. Interviews conducted by Mental Health Advisory Teams with soldiers and Marines revealed how a majority had received ethics training, and a third of Marines and quarter of soldiers reported not receiving clear guidance from NCO's and officers about noncombatant mistreatment.

Close relationships are formed within units, and these become disrupted when transferred or moved to other units and at the end of a deployment. The intensity of such relationships is seldom found in civilian life. Guard and Reserves return home with decreased opportunity to participate as intensely in military culture. The transition to civilian life, where unlike the rules and regulations of the military, can also leave one feeling less integrated and where, by comparison, there is little regulation.

The authors postulate how multiple and extended deployments and training modules on resilience, stress and preparation have done little to curb rising suicide rates. The emphasis must go deeper to explore issues such as regulation, integration, belongingness, burden and habituation and allow service members to reflect meaningfully upon and interpret military experience. Variance in leadership and little awareness of transition issues and their impact leaves the service member to question identity, role, values, and norms, within the context of the military and in relation to family.

The political, cultural, and social differences between civilian and military can also lend understanding to the complex issue of suicide. Our military is controlled by civilians where leaders involve us in conflicts not wholeheartedly supported by the majority of

citizens, where civilians have little understanding of the sacrifice and impact of military service on the individual and family, where the burden of military service rests on the shoulders of a few, and where little honest, open and thoughtful dialogue transpires between civilians and military. To better understand and prevent suicide means to explore further what is meant by the saying, “An injury to one is an injury to all.”

Published in the Repetition and Avoidance Quarterly, Volume 16, Number 4, Summer 2012, The Washington State Veterans Affairs PTSD Program.

VETERAN SUICIDE PREVENTION HANDOUT

Operation S.A.V.E.

Signs of suicidal thinking should be recognized

Ask the most important question of all

Validate the Veteran's experience

Encourage treatment and Expedite getting help

Warning Signs and Risks

- Loss of sense of belonging or identity
- Loss or change of job
- Unresolved Posttraumatic Stress Disorder (PTSD)
- Traumatic Brain Injury (TBI)
- Recent deployment
- Difficulty reintegrating into family after deployment
- Withdrawing from family and friends
- Lack of access to old support network, such as military team
- Increasing alcohol or drug use
- Rage or anger
- Hopelessness, feeling like there's no way out
- Anxiety, agitation, sleeplessness, or mood swings
- Engaging in risky activities without thinking
- Feeling like there's no reason to live
- Access to guns

Military Cultural Considerations

- The Warrior ideal: No matter what branch of service, Veterans are taught service comes before self and the mission comes first.
- Feeling like they cannot live up to the Warrior ideal can lead to Veterans feeling like failures.
- Being in the military provides a sense of purpose and identity that veterans might not have in their civilian lives.
- Missing one's battle buddies/team, not having a mission, and failure to live up to the values and ideals of the military can cause one to feel isolated and inadequate.
- Being out of the military often takes away the support system that helps to justify actions in combat.

Get Help

Talk

Veterans Crisis Line

1-800-273-8255, Press 1

Text a VA Responder

838255

Online Chat

www.VeteransCrisisLine.net/chat

Statistics

- In WA, 79% of Veterans receive care from community providers; only 21% receive healthcare from a VA Medical Center
- 22% of U.S. deaths from suicide are Veterans
- Almost 70% of male VHA suicide deaths are by firearms; 35% for females
- 950 suicide attempts per month among Veterans receiving VA healthcare services
- 33% of recent suicides have a history of previous attempts

Ask

- Have you ever served in the armed forces, guard, or reserves?
- Are you thinking of suicide?
- Do you own or have access to a firearm?