

# **SUICIDE and PREVENTION**

**VA San Diego Healthcare System**

**Every 16.2 minutes someone in the U.S. commits Suicide**

**Every 17 minutes someone is left to make sense of it**

## **SUICIDE ATTEMPT**

**A *non-fatal* self-inflicted *potentially* injurious behavior with any *intent* to die as a result of the behavior.**

## **SUICIDE**

***Death* caused by self-inflicted injurious behavior with any *intent* to die as a result of the behavior.**

# GENERAL SUICIDE STATISTICS

- 800,000+ U.S. citizens *attempt* annually
- 32,000+ *complete & die by* suicide each yr
- **11<sup>th</sup>** leading cause of death in the U.S.
- **10<sup>th</sup>** ranking cause of death in California
- Suicides outnumber homicides **3:2**

Info Sources: VA BIRLS; SSA; National Center for Health Statistics/National Death Index; CDC and Prevention; Dr. A. Smith

## ACTIVE DUTY SUICIDE STATISTICS

Suicides are surging among America's troops, averaging nearly one a day (2012) - the fastest pace in the nation's decade of war.

The **154** suicides for *active-duty* troops in the first **155** days of this year, far outdistanced the U.S. forces killed in action in Afghanistan- about **50%** more according to Pentagon statistics.

# VETERAN SUICIDE STATISTICS

- **18** veteran suicide deaths in U.S. *per day*
- **5** deaths per day among vets receiving VHA care
- Among vets who use VHS care – **60%** MH Dx
- Vets more likely to use firearms as means.

## ***FY 12 San Diego Statistics***

- Attempts: 171/Overdose most common method
- Completions: 28/Firearm most common method

# AI/AN Mortality Data 2004-2008

- The suicide rate for American Indians/Alaska Natives was 14.68 per 100,000, much higher than the overall U.S. rate of 11.15.
- Males aged 20–24 had the highest rate of suicide in the American Indian/Alaska Native population, 47.47 per 100,000. This is the highest rate of all racial/ethnic/age groups in the United States
- Suicide ranked as the eighth-leading cause of death for American Indians/Alaska Natives of all ages.
- Suicide was the second-leading cause of death for both males and females between the ages of 10 and 34 with rates of 33.50 and 9.70 per 100,000 respectively.

# SUICIDE METHODS

<b>Males</b> 2000-2009		<b>Females</b> 2000-2009	
<b>Firearm</b>	<b>40%</b>	<b>OD/Poison</b>	<b>42%</b>
Hang/Asphyxia	23%	<b>Firearm</b>	<b>20%</b>
<b>OD/Poison</b>	<b>14%</b>	Hang/Asphyxia	20%
Other	10%	Other	11%
Jump	7%	Jump	7%

# WW II KOREA VIETNAM VIETNAM ERA VETERANS

*Suicide rates are highest in older age group:*

Age 60+ - **20%** population

Age 75+ - **3x** higher than average

Age 80+ - **6x** higher than average

# WHAT ROLE DOES AGE HAVE IN SUICIDE?

- In a recent study published in the [American Journal of Public Health](#), a statistician from the [University of Chicago Center for Health Statistics](#) found that the ***youngest group of veterans, 17-24, were almost 4x likely to commit suicide than non-vets.***
- The number drops off after age 24, but still remains around 1.5x higher.
- Bottom Line – an increased risk for suicide at time of separation from military.
- Among American Indians/Alaska Natives aged 15- to 34-years, suicide is the second leading cause of death.
- The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 (31 per 100,000) is 2.5 times higher than the national average for that age group (12.2 per 100,000) (CDC, 2012)

# COMMON FOR PERSON TO MAKE MORE THAN 1 ATTEMPT?

**YES!**

- Ratio of attempts to completed suicides is **10:1**
- **30-40%** who suicide had made a *previous* attempt

## ON-GOING RISK

- For those admitted to hospital for a SA, the risk of a repeat attempt is *greatest within 8 days s/p discharge*.
- Within **1st** year s/p attempt, risk is **100x** > than average.

# WHAT ROLE DO SUBSTANCES HAVE IN SUICIDE ?

## Substance abuse/misuse

- A **key** risk factor
- May be involved in **1/2** of all suicide cases
- **20%** of suicides involved alcohol
- Lifetime rate of suicide among those w/alcohol-use problems = **3-4x** the average

**Encourage treatment**

# GENERAL POPULATION RISK FACTORS

- Male/60+/Caucasian/Widowed, Divorced, Single
- Female/45-54/Caucasian/Divorced, Single, Widowed
- Mental health disorder; Substance Use disorder
- A chronic or terminal medical condition + pain
- A previous suicide attempt or family history
- Feeling sad, hopeless, lonely
- Feeling like “a burden” to family or friends
- Feeling like “there’s no way out” of difficult situation
- Loss (personal, physical, emotional, financial)
- Access to means

# MILITARY SPECIFIC RISK FACTORS

- **Deployments** - multiple, extended expos to hostile events
- **Separation** - cohorts, family, significant other
- **Trauma** - MST, combat, other **treatment available**
- **Loss** - physical, emotional, financial, spiritual **help available**
- **MH** - depression, impulsivity, other **treatment available**
- **Injury** - PTSD, TBI, other physical **treatment available**
- **Chronic medical condition + Pain** **treatment available**
- **Familiarity/comfort/access to firearm** **limit access to means**

MST: VHA DIRECTIVE 2010-033; Veterans Health Administration Washington, DC 2042- July 14, 2010.

12/24/09 Memo "Recent Findings Re Chronic Pain Conditions and Suicide Risk"

# AI/AN RISK FACTORS

- Hopelessness
- Poverty
- Impulsivity
- Unemployment
- Antisocial Behavior
- Cultural Distress
- Family Dysfunction
- Child Abuse
- Limited Access to Services
- Access to Lethal Means
- Historical Trauma
- History of Suicidality
- Psychiatric Diagnosis
- Dual Diagnosis
- Substance Abuse
- Geographic Isolation
- Family History of Suicidality
- Domestic Violence
- Discrimination
- Level of Acculturation



## WARNING SIGNS (behavior)

- Noticeable changes in eating/sleeping/hygiene
- Engaging in reckless behavior; looking for a fight
- Using the internet to explore ways to kill self
- Talking, writing, sending emails about death or dying
- Isolation or withdrawal from sig other, family, friends
- Increase in alcohol or drug use
- Preparatory bx - seeking access to means, hoarding meds
- Rehearsing/experimenting
- Challenging authority; “death by cop”
- Putting oneself in dangerous situations
- Agitation – pacing, racing
- Finalizing personal affairs; giving away personal possessions

# Suicidal Thinking and Communication

- *S/He endorsed difficulty finding purpose in life, feeling hopeless*  
*"I was very important...I have medals; I did things others couldn't, and now I'm just regular..."*  
*"There's no reason to live...no sense of purpose in my life"*
- *S/He reported experiencing traumatic events*  
*"I can't shut off my mind... there are too many thoughts in my head"*  
*"I don't deserve to live"*
- *S/he feels trapped...there's no way out*  
*"I'm tired...I just want to rest"*
- *S/He said he's suspicious, trusts no one*
- *S/He's threatened to hurt or kill self/others*
- *Reported s/he's had bouts of irritability, anger, rage*

# PROTECTIVE FACTORS

- Effective care for mental, physical, substance disorders
- Easy access to a variety of clinical interventions
- Therapeutic alliance with Provider
- Connection to family/friends/community
- Good problem-solving skills
- Beliefs that discourage suicide
- Resilience – ability to recover quickly
- On-going sense of hope in face of adversity
- Reduced/limited access to means

# AI/AN PROTECTIVE FACTORS

- Life Skills
- Self-Determination
- Available Resources
- Cultural Pride
- Self-Esteem
- Traditional Healing Practices
- Cultural Identity
- Help-Seeking Behavior
- Spiritual Beliefs
- Strong Traditional Culture
- Elder Involvement
- Family Connectedness
- Social Support
- Healthy Attachments
- Hope
- Belonging



# Culture as a Protective Factor

- One study of American Indians living on reservations found that individuals with a strong tribal spiritual orientation were half as likely to report a suicide attempt in their lifetimes.
- A report by the Suicide Prevention Action Network-USA and SAMHSA's Suicide Prevention Resource Center, indicate that the most significant protective factors against suicide attempts among AI/AN youth are the opportunity to discuss problems with family or friends, feeling connected to their family, and positive emotional health.
- When a suicide has occurred, the possibility of suicide contagion (i.e., one suicide seeming to cause others) seems to be decreased by a healing process that involves the role of elders and youth in decision-making, the presence of adult role models, and the use of traditional healing practices.

## IF YOU KNOW SOMEONE WHO IS AT RISK FOR SELF HARM

- Listen
- Don't judge
- Encourage the patient to seek help
- Contact a Chaplain, Physician, MH Provider, Elder
- Provide safe environment - remove firearm/other means
- Escort the patient to a behavioral health facility ASAP
- Call the **Veterans Crisis Line 1-800-273-8255**

# PRIMARY CARE

## Consider:

For the suicidal patient, a visit with the **PCP** may be the *only* chance to connect with the healthcare system and access effective treatment.

## Early Detection:

Only **32%** of individuals who died by suicide had contact with MH services in the year prior to their deaths; but, **75%** of them saw their **PCP**.

# PRIMARY CARE CLINIC

## *Effective strategies for suicide prevention:*

- Train staff to identify and respond to warning signs (bx) of suicide
- Provide brief intervention
- Recognize and effectively treat depression
- Counsel patients on limiting access to lethal means

Long-standing patient relationships and frequency of contacts between PCP's and their patients, makes PC an ideal setting for suicide prevention interventions.

# **VA WORKS TO PREVENT SUICIDE**

## ***VA MAKES SUICIDE PREVENTION A TOP PRIORITY***

Increased the number of MH professionals by 48% since 2006

In process of hiring an additional 1600 MH providers

Since 2009, VA has increased the MH care budget by 39%

## ***The DoD works to reduce the number of active duty suicides***

Increased Behavioral healthcare providers by 35% over past three years

Increased the number of these HC providers in front line units

## VASDHS SUICIDE PREVENTION PROGRAM (2007) SUICIDE PREVENTION AND MANAGEMENT WORKGROUP (2009)

- CSRA - includes questions re length of deployment & # of tours
- SBR - standardized the procedure for reporting SA & completions
- Safety Plan – encourages therapeutic relationship with provider
- High risk Patient Record Flag
- Suicide Risk policy
- Suicide risk screening in Primary Care
- Employee education re vet suicide/prevention; created pwrpts and brochure
- OD Precaution Flag 14-day med restriction; **suicide by OD reduced by 26%**
- Firearm Safety education; created brochure; assisted distribution of safety locks
- Collaboration with the County Medical Examiners office
- VCL information included on appointment letters and pharm/med packaging
- Environment of Care – routine safety rounds on inpt units
- S.P. Mail Program
- Collaboration with County MH agencies
- SPC rep for SDC SPAPC – collaborative community-wide effort

2012 Suicide Prevention Program recognized by **OMHO Strong Practice Project**  
2009 SP&M Workgroup awarded **Blue Ribbon** at Performance Improvement Fair

**Contact PCP, Psychiatrist, Pharmacist  
Present to the VA Hospital E.D. located on main floor  
Walk-In Psychiatric Emergency Clinic 2-North 8a-4p  
Vet's Chat Line [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)**

**Suicide Prevention Coordinators**

<b>Lindsay Gold LCSW</b>	<b>619-400-5046</b>
<b>Dawn K. Miller LCSW</b>	<b>858-552-8585 x2660</b>



# IT'S YOUR CALL

Confidential help for Veterans  
and their families



Confidential chat at [VeteransCrisisLine.net](https://www.VeteransCrisisLine.net)