Approaches to Reducing Suicide in Service Members and Veterans

Murray Raskind, MD
Director, VA VISN 20 Mental Illness Research, Education and Clinical Center (MIRECC) and Staff Psychiatrist,
Madigan Army Medical Center

JUNE 19, 2012

Veterans Health Administration
Employee Education System

Approaches to Reducing Suicide (A Daunting Task)

1. Establish a trusting relationship.
2. Recognize and treat predisposing problems:
   - PTSD attempt risk ↑ X 2.8, especially trauma nightmares and sleep disruption (use prazosin).
   - Depression (CBT with activation; antidepressant medications)
   - Persisting mTBI symptoms, especially pain
   - Moral injury – victimizing noncombats (Lidz et al) and/or jeopardizing comrades
   - Alcohol abuse
   - Financial, family and legal pressures
3. Get firearms under control (good luck!)

The Problem

Despite VAPSHCS Mental Health Leadership's receiving detailed information about veteran suicide attempts, there was little to no information about completed suicides.

This lack of detailed information about completed suicides was also noted at the VISN and VACO leadership levels.

Significance of the Problem

Quality improvement re: suicide prevention in a specific population requires detailed knowledge of the characteristics of completed suicides.

Can we identify potentially preventable suicides and design strategies to enhance prevention?

- VISN-20 Mental Illness Research, Education, and Clinical Center (MIRECC) senior psychiatrist leadership suggested a careful CPRS-based review of VISN-wide FY-09 completed suicides.
- This project received enthusiastic VISN-20 and VACO support.

Methods - Database

For FY-10, all 8 completed suicides in OIF/OEF era Veterans were selected for review.

- Of these, 7 records were evaluable.
- The remaining case had no CPRS record.

Methods – Review

Information from CPRS record.

Each record reviewed jointly by 2 of the following 3 senior psychiatrists: Elaine Peskind, Murray Raskind, Allen Radant

- each with >25 years of VA experience
- for each case, at least one reviewer with forensic experience
- consensus process useful for resolving judgment issues

Results – Demographics

Mean age 32.5 (range 27-48)

Gender: all male

Demographics (cont.)

Marital status

- Married/cohabiting 50%
- Divorced/separated 25%
- Widowed 0%
- Single/never married 25%

Living situation

- With spouse/SO 75%
- Alone 25%

Demographics (cont.)

War zone experience

- 50% OIF/OEF combat Veterans

Service connection

- 50% service-connected
- 25% service-connected for psychiatric disorder

Mental Health Services Utilization Characteristics

Followed in mental health	86%
High mental health care utilizer	0%
Multiple failure to show	0%
Seen MH provider in past 3 months	63%
Mental status exam at last visit	85%

Characteristics of Final Visit Before Death

Days elapsed between final visit and death	
0-7 days	43%
7-30 days	14%
30-90 days	14%
>90 days	14%
Final visit was outpatient visit	100%
Type of final visit:	
Mental health	57%
Gen med/surg	43%
Other	0%

Characteristics of Final Visit Before Death (confirmed)

	Pos	Neg	No info
Suicidal ideation documented	50%	0%	50%
Suicide plans documented	50%	0%	50%
Firearms available	86%	0%	14%

Mental Health Conditions: Depression

	Yes	No	Unkn
Major Depression diagnosis	86%	0%	14%
Depressive symptoms	86%	0%	14%
Treated with anti-depressant	25%	25%	14%
Adequate dose?	48%	5%	48%

Mental Health Conditions: PTSD

	Yes	No	Unkn
PTSD diagnosis	38%	50%	12%
PTSD symptoms	50%	38%	12%
Trauma nightmares	50%	38%	12%
Sleep disruption	75%	12%	12%

Mental Health Conditions: Psychotic Disorders/Symptoms

Schizophrenia/schizoaffective diagnosis	0%
Psychotic symptoms	12%
Suicide command hallucinations	0%

Mental Health Conditions: Other

Other anxiety disorder	12%
Bipolar disorder diagnosis	0%
Mania	0%
Dementia diagnosis	0%

Mental Health Conditions: Substance Abuse/Dependence

Alcohol	12%
Cocaine	0%
Methamphetamine	0%
Opiates	0%
Rx	0%
Hx substance abuse treatment	0%

Relevant History

History of violence	0%
History of arrests	25%
Pending legal action	12% (criminal)
Use of varenecline	0%
Report of pain	62% (moderate/severe 50%)
Taking pain meds	50%
Report of insomnia	50%

Suicide-Related History

Previous suicide attempt	38% (69% of these high lethality)

Means of Completed Suicide

Gunshot	88%
Overdose	12%

Acute Suicide Risk Factors Documented

Acute intoxication	0%
Acute loss	50%
Grossly psychotic	0%
Agitation	25%
Unpredictability	0%
Suicide note found	12%

Life Events within Year Prior to Death (>10%)

Lack of social support	0%
Serious illness/disability	0%
New dx serious illness	0%
Lost job	12%
Major financial stressors	38%
Homelessness	0%

Personal Characteristics

Personality disorder	14%
Sense of alienation/not belonging	0%
Potential for quality of life:	
High	43%
Moderate	57%
Low	0%

Preliminary Categories

3	Inadequate mental health treatment
3	Unpredictable suicide in the context of adequate mental health treatment
1	Refused care
1	No VA care for greater than 2 years

Conclusions

Compared to the last year's review of all completed suicides in VISN 20, the review of only OIF/OEF era Veteran suicides reveals both similarities and contrasts:

- Similar % Caucasian (75% vs 80%)
- By definition younger age range (25-48 years)
- More likely to be married (50% vs 38%)
- Lower incidence of alcohol abuse/dependence (12% vs 30%)
- Similar % moderate-severe chronic pain despite younger age (50% vs 45%)
- Much higher percent gunshot deaths (88% vs 50%)

? Increased impulsivity secondary to mTBI (50% are OIF/OEF combat Veterans)

Conclusions (continued)

In approximately 40% of these Veterans, the suicide may have been preventable (see case examples #1, #2, and #3).

In approximately 40% of these Veterans, there was no obvious intervention that would have prevented the event.

Acute Loss or “Humiliation” as Risk Factor

Three cases with very similar theme:

- 48 y.o. Veteran with PTSD and depression. Lost case in divorce proceeding; suicide by gunshot that day.
- 27 y.o. Veteran with PTSD and depression. Found out wife having affair with co-worker. Suicide by gunshot 8 days later.
- 35 y.o. Veteran with no contact order with family. Sent Xmas gift to son---court revoked bail, awaiting trial. Suicide by OD approximately 2 weeks later.

Inadequate Mental Health Treatment: Case Example #1

27 y.o. Veteran with psychotic depression moderately symptomatic with SI and AH when last seen by MH. Scheduled for f/u visit 6 weeks later, but never seen again by MH.

Six weeks too long for f/u appointment given SI/AH and failure to follow through on missed appointment.

Inadequate Mental Health Treatment: Case Example #2

33 y.o. OIF/OEF Veteran with PTSD, depression, and panic disorder.

Suicide note “killed self because tired of waking up with constant nightmares”.

Rx’d with sertraline 200 mg + diazepam and hydroxyzine for sleep.

Endorsed trauma nightmares 6 months prior to suicide, but had no specific treatment for trauma nightmares.

Inadequate Mental Health Treatment: Case Example #3

30 y.o. Veteran with depression, alcohol abuse and personality disorder. Chronic pain, major financial stressors, felt he was burden to family.

Recently he was transitioned from MH care to Primary Care. Complex patient - probably inappropriate for management of MH problems in Primary Care.

Recommendations

MIRECC team will continue to review selected completed VISN-20 suicides in FY-2011.

Suicide review instrument has been refined and simplified.

We believe this review process is exportable to other VISNs.

Recommendations (continued)

There should be regular VISN-wide V-tel mortality conferences to review completed suicides to increase awareness and provide a teaching forum for both mental health and general med/surg providers to refine clinical expertise in suicide prevention.

Facilitate access to timely psychiatric consultation (both formal and informal) in the primary care medicine setting.

Moral Injury as a Contributor to Behavioral Dysfunction Including Suicide

There are at least two types of moral injury precipitants that can produce pervasive remorse, shame and guilt:

- perpetuation of harm to innocent noncombatants
- action, error or failure to act causing harm to warrior comrades

This remorse and guilt can contribute to suicidal ideation and suicide. How often this occurs is unknown.

Moral Injury and Moral Repair
Brett Litz et al, Clin Psychol Rev 2009

Proposes two routes to moral repair and renewal:

- **Psychological and emotional processing of the "moral transgression" memory regarding its meaning, significance and implications.**
- **Exposure to corrective life experience.**

Litz (continued)

- Litz advocates exposure “to foster sustained engagement in the raw aspects of the experience and its aftermath”
- However, such exposure can enhance suicidal ideations.
- Recommend not using exposure-based therapy for moral injury events in suicidal persons until empiric outcome data are available!

Other Approaches to Moral Repair

- Group therapy with other combat SMs and Veterans who have “been there.”
- Volunteer and charitable work for the community.

Can we develop empiric data about the relationship between perpetration of atrocities, moral injury and suicidality?

For example, what has been the incidence of moral injury, suicidality and suicide in the "Charlie" Company soldiers of the American Division who massacred hundreds of unarmed Vietnamese civilians in March 1968?

There is one documented suicide per "Wikipedia."

Prazosin as a Potential Tool for Suicide Prevention – Vietnam Veterans

The first two Vietnam Veterans ever treated with prazosin (in 1995) had severe PTS with trauma nightmares, alcohol abuse and active suicidal plans.

As prazosin eliminated (5 mg and 10 mg bedtime) trauma nightmares and normalized sleep, alcohol use and suicidal ideation ceased.

These two African American Veterans have continued on maintenance prazosin for 17 years to the present (2012) with no alcohol use or suicidal ideation.

Prazosin as a Potential Tool for Suicide Prevention in OIF/OEF Veterans with PTSD Trauma Nightmares and Sleep Disruption

Although moderate or high risk for suicide was an exclusion criteria for a recent prazosin trial for PTSD in active duty soldiers at Joint Base Lewis McChord, a subgroup of soldiers endorsed suicidal ideation on the PHQ-9 depression scale at baseline.

Suicidal Ideation* Response to Treatment

	Soldiers with SI	SI Improved	SI Worsened
Placebo	5	1 (20%)	4 (*80%)
Prazosin	2	2 (100%)	0 (0%)

*PHQ-9 item *i*: “Thoughts that you would be better off dead or Thoughts of hurting yourself in some way.”