Facilitating Treatment Engagement During High-Risk Transition Periods: A Potential Suicide Prevention Strategy

The Departments of Defense (DoD) and Veterans Affairs (VA) have made it a priority to combat suicide. Each of the military services and the VA have developed educational campaigns to reduce the stigma associated with reporting emotional distress, raise awareness of the risk of suicide, and teach military personnel, veterans, and their families suicide prevention strategies. Within the DoD and VA, significant resources have been leveraged toward studying and implementing both public health and clinical intervention strategies. These resources have also fostered significant collaborative efforts between individuals in the DoD and VA.

Within the Veterans Health Administration (VHA) vital components of the suicide prevention program are the Veterans Crisis Line and online chat service. Strategies for assessing, identifying, and tracking those at increased risk for suicide have been implemented. Moreover, at VA Medical Centers and large Community Based Outpatient Clinics, Suicide Prevention Coordinators are in place to ensure that veterans at high risk receive needed counseling and services.

Despite these advances, rates of suicide within the military and among veterans support enhancing current efforts. In 2001, for every 100 000 individuals serving in the military, 9.9 died by suicide.[1] By 2009, military suicide rates rose to 18.3 per 100 000 with 1.3 per 100 000 deaths still under investigation.[1] Suicide continues to be a concern for military personnel, even after returning to civilian life. In fiscal year 2010, veterans made nearly 15 000 suicide attempts, with 18 veterans dying by suicide every day.[2]

Facilitating treatment engagement, particularly during high-risk periods of transition, might be an important means of reducing suicide. Valenstein et al.[3] conducted a retrospective cohort study of 887 859 VA patients receiving care for depression, and calculated suicide rates for five sequential 12-week periods after treatment events (e.g., psychiatric hospitalization, new antidepressant starts). Findings suggested that the highest risk period for suicide among VA patients was in the 12-week period after psychiatric hospitalization. Although the suicide rate for all time periods was 114 per 100 000 person-years, the rate after psychiatric hospitalization was 568 deaths per 100 000 person-years. In support of these results, Hunt et al.[4] found that among members of the general population, 43% of suicides after inpatient psychiatric treatment occurred within the first month after discharge. The first week after discharge was noted as being a particularly high-risk period. Knox et al.[5] highlighted the risk for suicide after acute psychiatric services (e.g., care in Emergency Department [ED]), the reality that a visit to the ED might be the "sole point of contact" for an individual, and the importance of using the contact to engage individuals in care; thereby facilitating a transition from crisis to outpatient services.

Research also suggested that transitions associated with life events increased risk for suicidal behavior. For example, Binswanger et al.[6] conducted a retrospective cohort study of all inmates from the Washington State Department of Corrections. Results supported an increased rate of suicide in the two weeks after being released from prison (136 deaths by suicide per 100 000 person-years). After the first 2 weeks, the rate dropped to 69 deaths by suicide per 100 000 person-years. Other life transitions associated with increased risk for death by suicide included job loss,[7] divorce or romantic breakup,[8,9] and physical injuries or illnesses.[7,10]

Of particular import to DoD and VHA providers are data that suggested periods of increased risk during deployment and post-discharge. Warner et al.[11] explored suicidal thoughts and behaviors among US soldiers over a 15-month deployment cycle and found three distinct time periods of increased suicidality. The first occurred around month two and was hypothesized as being in response to separation from families and friends. A second peak was noted after six months in theater. The authors indicated this was a common time for using leave (e.g., two weeks back in the United States with family and friends), and suggested that upon return to the combat zone, soldiers might experience increased stress and feelings of isolation. The final peak was noted around month 12, in close proximity to the end of deployment when individuals might be increasingly focused on stressors at home. In the United Kingdom, Kapur et al.[12] examined the rate for suicide among individuals who left the Armed Forces (1996–2005) and found that among men under the age of 25 years, the risk of suicide was two to three times higher than the risk for the general and serving populations (same age groups).

Moreover, Brenner et al.[13] conducted a qualitative study of potential suicide risk factors (burdensomeness, belongingness, and acquired ability) among returned combat veterans, which explicated some potential causes of

postdischarge suicide risk. Many of these were related to the need to re-establish or redefine occupational, social, and recreational roles. The veterans interviewed described a loss of sense of self and purpose postdischarge. Many veterans found it difficult to leave their well-defined and meaningful military roles to re-establish their place in the civilian world. Veterans also reported a heightened sense of burdensomeness and described struggling to provide their families with financial and emotional support. Many also reported feeling disconnected from civilians. This was in contrast to the sense of belongingness they felt when among those in the military or other veterans. During the course of the interviews veterans linked perceived burdensomeness and a failed sense of belongingness with a desire for death.[14]

With the growing recognition of the risk associated with stressful life transitions, researchers have begun developing engagement strategies to decrease negative outcomes. Early work in this area expanded the notion of treatment by focusing on supporting patients in their transition from an inpatient psychiatric setting to their home environment.[15] Motto and Bostrom[15] explored the impact of sending caring letters on suicide prevention among 843 patients who refused ongoing outpatient care. The focus of the letters, each of which was worded differently, was an "expression of concern that the person was getting along all right and invited a response if the patient wished to send one."[15(p829)] The authors hypothesized that the letters would decrease patients' sense of isolation and enhance their sense of connectedness. Findings suggested that those who received letters had lower suicide rates than a control group in all five years of the study. The authors did not report rates of treatment re-engagement. However, they noted that an incidental benefit of the contact program, which might have contributed to the outcome, was that patients who received the caring letters occasionally turned to project personnel for help re-entering the health care system.

Several other more recent engagement strategies also added to the evidence base for assisting patients during times of transition. Work by Davis et al.[16] suggested that outreach (i.e., letters, face-to-face contact, telephone calls) might result in individuals with severe mental illness returning to care. Preliminary findings from a VA hospital ED project, SAFE VET, suggested that targeted follow-up might increase treatment engagement in terms of outpatient services.[5] An integral component of SAFE VET is the Acute Services Coordinator, who is a resource to the veteran during the transition period and facilitates engagement in outpatient care. Moreover, work by Verwey et al.[17] highlighted the potential positive impact of home-based assessment postdischarge from hospital psychiatric emergency services. Lastly, in addition to tracking suicidal thoughts and behaviors, Warner et al.[11] implemented a deployment cycle-specific suicide prevention plan that included targeted interventions during periods of increased risk. As noted previously, these high-risk periods seemed to coincide with deployment-related transitions.

Because heightened stress could be anticipated during times of transition, such events might mark opportune times for prevention and intervention. Findings presented in this editorial support identifying individuals during periods of transition and implementing treatment engagement protocols as a means of enhancing current suicide prevention efforts. Actual interventions indicated might vary in terms modality and intensity (e.g., psychoeducation, caring letter, outpatient mental health treatment). Based on the needs of the population, a focus on increasing psychosocial functioning might also be warranted (e.g., employment services). An example of such a program is the VHA's Health Care for Re-entry, which was "designed to address the community re-entry needs of incarcerated veterans."[18] Although initial evidence exists regarding treatment engagement during periods of transition as a suicide prevention strategy, further work in this area is required to establish efficacy and effectiveness. It is hoped that continued efforts to maximize treatment engagement during high-risk transitional periods will enhance clinicians' ability to care for those who have served our country. ■

Lisa A. Brenner, PhD
Sean M. Barnes, PhD

About the Authors

Lisa A. Brenner and Sean M. Barnes are with the Veterans Integrated Service Network 19, Mental Illness Research, Education and Clinical Center, Denver Veteran Affairs Medical Center, Denver, CO, and the University of Colorado Denver, School of Medicine, Denver.

Correspondence should be sent to Lisa A. Brenner, PhD, 1055 Clermont St., MIRECC, Denver, CO 80220 (e-mail: Lisa.Brenner@va.gov). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints/Eprints" link.

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Contributors

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Lessons Learned from Mental Health Enhancement and Suicide Prevention Activities in the Veterans Health Administration

This publication of a special issue of the *American Journal of Public Health,* which focuses on suicide in veterans and service members, is occurring when America has been at war for over a decade. Over this time, suicide in veterans and service members has become a national concern. This can be documented in a number of ways. For one, a search of the Medline database for articles indexed under the expanded subject heading "suicide" and the text words "veteran" or "veterans" identified one article in the year 2000 and three in 2001, but 23 in 2009 and 33 in 2010. For another, a search of the *New York Times* archives for "veteran" and "suicide" followed by review of the citations identified three articles referring to suicide among American veterans in 2000 and one in 2001, but 11 in 2009 and 15 in 2010. Perhaps most significantly, the 2001 US National Strategy for Suicide Prevention[1] did not address suicide in military and veteran populations. However, the National Action Alliance for Suicide Prevention, the public–private partnership charged with revising the strategy, was structured to ensure relevant input. The partnership's public sector cochair is the Secretary of the Army; it includes representatives of the Department of Defense (DoD), the Department of Veterans Affairs (VA), and relevant support groups on its Executive Committee; and it has formed a work group on military and veterans issues.

There are a series of possible reasons for the recognition of suicide in military and veteran populations as a national priority. As Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), the wars in Afghanistan and Iraq, have gone on, suicide rates have increased in active duty service members, including those who have recently returned from deployment. The American public has responded, in part, to support the troops, and, in part, to ensure that America recognizes the full measure of the costs of war. A number of stories of individual suicides have been widely reported; each one speaks for itself, demonstrating the tragedy and suffering associated with each death. Specifically for VA, there have been a substantial number of reports of problems with mental health services and calls for improvement. There have also been reports recognizing the innovative nature of the VA's programs for suicide prevention. One summary of recent activities[2] stated, "In the past few years the Department of Veterans Affairs has become one of the most vibrant forces in the US suicide prevention movement, implementing multiple levels of innovative and state of the art interventions, backed up by a robust evaluation and research capacity." Anticipating the formation of the National Action Alliance for Suicide Prevention and the revision of the National Strategy for Suicide Prevention, the same document included the recommendation to: "Evaluate and assess practices being implemented in the VA for dissemination to the broader healthcare delivery system.[1,2]

The VA's current suicide prevention program began with the approval of its Mental Health Strategic Plan by the Under Secretary for Health in 2004. The plan was motivated by the recommendations of the 2003 release of the report of the President's New Freedom Commission on Mental Health,[3] and by early recognition of the mental health problems facing veterans returning from Afghanistan and Iraq. It included 242 actions that could be factored into 6 domains, including increasing access and capacity, integrating mental health with primary care, transforming mental health specialty care into recovery-oriented services, and implementing evidence-based practices, as well as prioritizing services for returning veterans and suicide prevention. To promote the implementation of the strategy, VA established the Mental Health Initiative as a way to complement its usual mechanisms for funding clinical services with targeted funding for mental health enhancements. This led to an increase in core mental health staff on a national level by 50%, from about 14 000 in 2005 to 21 000 by the end of 2010; approximately half of the increase