

SUICIDE AND RURAL VETERANS

The AgriWellness board of directors and the Sowing the Seeds of Hope state partners decided, in 2008, to focus some board resources toward the encouragement and development of services to returning veterans from rural areas. Several states were already partnering with local veterans organizations in order to bring behavioral health services to veterans and their families.

Part of the reason for the board's decision has to do with an alarmingly high rate of soldier suicide. According to a January 2009 article in the New York Times,¹ Army officials said that suicides rose in 2008 for the fourth year in a row and the suicide rate is now higher than it has been in almost three decades. At the time, 128 soldiers had committed suicide and the Army was still investigating a number of other deaths.

The rural areas of the United States are home to almost 40% of veterans. (RacOnline). It can be particularly difficult for rural veterans and their families to access behavioral health and other services from Veteran's Administration facilities because of the often long distances to travel.

The VA is has been working steadily to both increase the number of trained behavioral health staff in its facilities and also to provide more outreach to veterans who may not access care in a facility.

In 2007, Congress passed the Joshua Omvig Suicide Prevention Bill. This bill is named after a young veteran from rural Iowa who committed suicide. The bill mandated that each of the nation's 153 medical centers hire a Suicide Prevention Coordinator (SPC). The SPC provides comprehensive suicide prevention programming in the center, including training of all staff.

One SPC, Janell Christenson, provided a workshop on suicide identification, assessment and intervention in the VA Medical System at the recent *Clock is Ticking for Rural America* conference. Janell is the SPC for the Veterans Administration Medical Center in Sioux Falls, South Dakota. In Janell's presentation she outlined other aspects to the VA response to the rise in veteran suicides. Some aspects to the response include: outreach to the community, identifying and flagging high risk patients, case management for high risk patients, analysis of environments for safety and consultation to providers and other staff.

One of the underlying concepts for the VA risk assessment training is that identifying patients at risk should be everyone's responsibility and not just those persons involved in mental health support. Programming was placed in primary care where providers regularly screen patients for substance dependency, depression, post-traumatic stress disorder (PTSD) and suicide.

All VA providers receive 6-8 hours of training about risk assessment and the dynamics of suicide. All VA

"We are living in difficult times. We all need to be aware of people in our lives who may be showing signs of distress or despair. We can all make a difference by asking some simple questions about suicide. We need to remember, people do not want to die, they just don't know how to live with what is going on. Be a hero, ask a question, you could save a life!"

--Janell Christenson

Suicide Prevention Coordinator
Veterans Administration Medical Center
Sioux Falls, South Dakota

staff receive two hours of training. The risk assessment training includes: risk factors, protective factors, means reduction, involvement of the family and safety planning.

The risk assessment also discusses identifying and assessing risk factors such as specifics on ideation, plan; alcohol/drug use; heightened stressors; family history of suicide and others. The assessment also considers protective factors such as positive social support; spiritual beliefs; life purpose; reality testing abilities and coping skills. Ironically, Janell notes in her presentation that the reality is that 69-78% of persons who commit suicide told their provider that they were not suicidal prior to their deaths.

The risk assessment includes a “means reduction” aspect that is targeted toward keeping the home environment as safe as possible and partnering with the family.

Part of the assessment focuses on the development of a safety plan such as triggers and warning signs, awareness of thoughts and feelings that heighten vulnerability and coping strategies to use when in crisis.

Providers have also increased their reporting which now includes monthly local, regional and national reports about suicide attempts and completions, access to care, pain, military period and diagnoses.

The Veterans Administration has partnered with the national suicide hotline to provide a specific option for veterans who call. Beginning last July, the VA also offers an online chat service called “Veterans Chat” which allows veterans to anonymously “chat” with a trained VA counselor. These types of services are especially important for rural veterans who may worry about the stigma of receiving mental health services in their area or who may face significant geographic challenges to accessing care.

For more information:

Janell Christenson’s presentation from the Clock is Ticking conference:

<http://www.agriwellness.org/ConfInfo.htm>

Suicide Hotline: 1-800-273-TALK, press #1 for veterans or if calling on behalf of a veteran.

Veterans Chat:

www.SuicidePreventionLifeline.org

¹ Lizette Alvarez. Suicides of Soldiers Reach High of Nearly 3 Decades. New York Times, January 30, 2009.