



A Suicide Assessment of Elderly Military Veterans: Best Practice Guidelines in Long-Term Care

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Abstract

Suicide in the United States continues to be a pervasive problem with military veterans. Sadly, effects of previous military service continue to plague many elderly military veterans decades after the war. Many years after the war, some aging elderly veterans, age 65 years of age or older, find themselves fighting a new battle. Suicide is a major cause of mortality worldwide, and research indicates that the rate of suicide is increasing among the military population. Suicidal ideation is more dangerous in war veterans in comparison to the general population because they know how to use firearms and they often own them. Little research has examined the sensitive phenomena of elderly military veterans and the risk of suicide many years after the war. This document serves as a guideline for assessing suicide in elderly military veterans in long-term care, taking in account the available evidence.

Keywords: Suicide assessment; Elderly; Long-term care

Definitions of Terms

In this guideline, the following terms will be used:

- Suicide- self-inflicted death with evidence that the person intended to die.
- Suicidal ideation- thoughts of serving as the agent of one's own death [1].

Suicide prevention starts with recognizing the warning signs and taking them seriously. Suicide in the United States continues to be a pervasive problem with military veterans with adverse outcomes associated with depression, PTSD, and traumatic brain injuries. More than six decades later, many elderly military veteran defined as being age 65 years or older) remain troubled by horrid and devastating memories of war. When old age begins to lead to physical maladies and diminished mental capacity, that defense that they have held on to for so many years begins to fade away. That's when suicidal plans can kick into gear" [2].

Suicide is a major cause of mortality worldwide, and research indicates that the rate of suicide is increasing among the military population. However, being in the military does not necessarily denote being higher risk for suicide. Suicide implicates "a process that begins with suicidal ideation followed by planning and then by a suicidal act" [3]. Suicides in the military has existed for centuries due to combat stress, being directly in a war zone, losses associated with aging, loss of loved ones, and declining physical health. In addition, the death of a comrade, or even enemy, may scar the soul for life. As a result, suicide in the military veteran population has become a topic of public policy.

The Department of Veterans Affairs (VA) is committed to providing care for military veterans diagnosed with PTSD, in addition to preventing suicide. Within the last five years, the VA has undertaken a tremendous task to implement enhancements focused on PTSD care and suicide prevention. In addition, the VA is committed to improving and enhancing access to care and the quality of care delivered, and to expanding knowledge through research [4].

Statement of Problem

More can definitely be done to assess suicidality in elderly veterans in long-term care. The problem is defined as the lack of primary care

recognition in long-term care to assess suicidality in elderly military veterans with and without histories of PTSD. The lack of properly assessing the issue of suicide can lead to further issues such as suicide, homelessness, substance abuse, and criminal behavior. For many combat military veterans the experiences of war were desolate and agonizing and each of their coping abilities differed. Many of these veterans denied that anything was occurring; consequently, their symptoms were unrecognized. In addition, many avoided anything connected to the war; as a result, their problems went undetected.

Most elderly adults experience challenges that occur as part of the normal aging process, such as retirement, loss of spouse or close friends, depreciated physical capabilities, survivor guilt, unresolved grief, and limited social support. For example, death of loved ones is traumatic for most persons and for the combat veteran; these deaths are reminders of friends that were missing or killed during the war. Feelings of hopelessness or powerless felt during combat may also elicit symptoms of PTSD; thus possibly, precipitating suicidal behavior. In addition, a profound statement by Sher [5] provides further evidence that "it is possible that many war veterans suffer from PTSD and their suicidal behavior is related to PTSD" (p: 216). If the VA were successful in winning the battle on suicide in the ageing veteran, then veterans would be able to lead better lives. For what they have done for our country, these services would be a minuscule repayment [6].

The risk for suicide attempts among the PTSD population is six times greater than the general population and is two times more likely to die of suicide than are nonveterans [5]. Specific PTSD symptoms and specific psychological conditions associated with chronic stress

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reactions may contribute or mediate the association between PTSD and suicidal behavior.

Homelessness may also be a contributing factor of suicide in older military veterans. Current research estimates that more than 20% of homeless veterans are aged 55 years or older [7]. This qualitative study based on statistical data from the VA Northeast Program Evaluation Center examined self-reported suicidal behavior of older homeless veterans to establish frequencies and predictors of recent suicidal behaviors and the impact on transitional housing interventions. The sample size included 10,111 veterans who participated in a transition-housing program over a 6 year period, from 2002 to 2008. Schinka et al. [7] also note that approximately 12% of homeless veterans reported suicidal ideation before program admission; 3% reported a suicide attempt in the 30 days before program admission. Suicidal behavior was prevalent in older homeless veterans and was associated with a history of psychiatric disorder and substance abuse.

Depression is the most common diagnosis in the elder person who has attempted suicide. Suicidal ideation in long-term care residents is primarily depicted by the presence of depression as opposed to medical illness(s) or functional disability. "Depression is especially prevalent in physically ill, institutionalized, elderly patients. The likelihood of depression increases with increased severity of illness in the medically ill elderly, and geriatric suicidal ideation, attempts and completions are uncommon outside the context of depressive illness or symptoms" [8]. Untreated depression has significant consequences with regard to suicidality.

The guideline is relevant to all advanced practice nurses and nurses who practice in long-term care settings with the elderly veteran population. Clinical specialties include:

- Behavioral Health
- Geriatrics/Gerontology

In addition, these guidelines may serve useful in accreditation standards, training and education, research, and funding decisions. The potential health benefit of this guideline is the reduction and prevention of risk for suicidal ideation and behavior in the elderly military population who receive care from advanced practice nurses and nurses in a long-term care facility, thus contributing to reduced suicide rates.

Guideline objective(s)

- To assist nurses working in long-term care practice settings to provide evidence-based care to elderly persons at risk for suicidality (i.e., ideation, behaviors).
- To provide nurses with guidelines based on the best evidence related to the assessment of elderly military veterans at risk for suicidal ideation and behavior.
- To increase comfort, confidence, and competence of the nurse providing care for persons in this vulnerable population in order to promote safety in their clients and others.

Vulnerable population

All demographic groups have some level of suicide risk. It is extremely crucial not to dismiss any person at being free of risk because they may be part of a low-risk population. This guideline applies to geriatric military patients at risk for suicidal ideation and behavior treated in any long-term clinical setting.

Rationale for the specific content of the guidelines

Veterans may be at a higher risk for suicide because of depressive disorders and other psychiatric conditions. For example, WW II was a unique and horrid human experience. Of this elite group, most individuals affected by the war are now part of the geriatric/elderly population. The high risk of suicide is great in this population, because of the effects of war, psychological implications, and aging. United States (US) veterans often have multiple risk factors for suicide, including: male gender, elderly, diminished social support, medical and psychiatric conditions associated with suicide, and knowledge of and access to lethal means [9]. In addition, identifying patients at risk for suicide has been a requirement of the National Patient Safety Goals since 2007. The components of a suicide risk assessment, recommended by the American Psychiatric Association, include looking at psychiatric illness, family history of suicide or personal history of attempted suicide, individual strengths and vulnerabilities, and the patient's psychosocial situation.

National International Benchmarks and Related Population Trends

Suicide statistics from VA database

In recent years, suicide rates of military veterans appear to be increasing. The VA estimates that an average of 18 veterans per day commits suicide or 1 out of 5 suicides in the U.S. That is just a guess based on incomplete data [10]. Unless a veteran's suicide occurs in a VA facility, opportunities for the VA to become aware of the incident may be limited. Alarming, exposure to combat may be a contributing factor to later death by suicide. Furthermore, studies have implied that military service may be a risk factor associated with suicidal behavior. Suicide rates vary with rates of firearm ownership, employment status, geographical location and presence of social support, poverty, as well as other clinical and demographic factors. The US Surgeon General, the Institute of Medicine, and the Department of Veterans Affairs (VA) recognize suicide as a key public health problem in need of a national strategy for suicide prevention [11].

Reason suicide assessment not being carried out

Long-term admission patient-assessment forms seldom include questions about suicide, and as a result nurses would not routinely screen patients for suicide risk and many persons are not likely to volunteer information about suicidal ideations or behavior(s). One study indicated that two of every three people who commit suicide might have seen a primary care provider in the month before their death, suggesting that health care professionals are missing opportunities to intervene [12]. Some nurses may feel uncomfortable with the topic of suicide for fear of triggering suicidal ideations or behavior. Furthermore, one may not know what to say or do if a person verbalizes suicidal ideations. In order to prevent suicide, eliminating these barriers is essential by implementing suicide assessment as part of routine nursing assessment.

Role of the DNP

The advanced practice nurse plays a pivotal role in the identification of persons at risk for suicide. It is estimated that 30% of the U.S. population meets Diagnostic and Statistical Manual of Mental Disorders criteria for one or more behavioral disorders in any given year, and less than half receive any mental health care [13]. Therefore, it is vital that they are cognizant of the complex risk factors involved in late life suicide. Moreover, nurses in advanced practice (i.e., DNP) are in an exceptional position to implement current evidence based practice into the lives of military veterans through research and clinical practice.

Assessment Specifics

The suicide evaluation is the essential element of the suicide assessment process. Assessments are conducted at first contact and whenever the clinician anticipates that risk may be elevated. "Suicide cannot be predicted and in some cases cannot be prevented, but an individual's suicide risk can be assessed and a treatment plan can be designed with the goal of reducing that risk" [14]. Therefore, it is vital to have an assessment tool as part of the admission criteria. There are two main types of measures used in PTSD evaluations, structured interviews and self-report questionnaires. Structured interviews consist of standard sets of questions that an interviewer asks and a self-report questionnaire is a set of printed questions requiring an answer. If the person has a history of depression, PTSD or a screening test result that indicates a risk of suicide, members of the direct care staff should observe him or her for suicidal ideation and behavior. Recommendations include:

1. An initial screening should be conducted on all new patients for symptoms of PTSD and then annually or more frequently if clinically indicated due to clinical suspicion, or history of PTSD. The following screening tools have been validated and should be considered for use (Appendices A and B).
 - GDS-5/15 Geriatric Depression Scale
 - PTSD Checklist (PCL)
2. Patients should be screened for symptoms of risk for suicide using paper-and-pencil or on electronic screening tools.
3. There is insufficient evidence to recommend one suicide risk-screening tool versus another. The following screening tools have been validated and should be considered for use (Appendices C and D)
 - Scale for Suicide Ideation (SSI)
 - Nurses' Global Assessment of Suicide Risk (NGASR)

It is imperative that healthcare workers are cognizant of warning signs of suicide. Warning signs include:

Threatening to hurt or kill him/her or talking of wanting to hurt or kill him/her

- Looking for ways to kill him/herself by seeking access to firearms, available medications, or other means
- Talking or writing about death, dying or suicide
- Anxiety, agitation
- Insomnia or sleep disturbance
- Increased alcohol or drug use
- Purposelessness – no reason for living
- Hopelessness
- Withdrawing from family, friends, and society
- Rage, uncontrolled anger, seeking revenge
- Engaging in risky activities
- Dramatic mood changes
- Feeling trapped – like there is no way out [15].

Clinical Situation

H.S. is an 86 year old Caucasian widowed resident who resides in a veteran's home. He frequently voices his feelings of unhappiness to the staff. "I wish I was dead!" "Can you give me a pill to not make me wake up?" "If I don't get out of here soon I'll kill myself" are some of the statements he has made. He suffers from chronic pain secondary to osteoarthritis, and diabetes. He is confined to a wheelchair with an Under the Seat Wheelchair Alarm System in place due to his high risk for falls. He is on an antidepressant and has no prior suicidal attempts. He is a veteran of WWII.

Looking at H. S., notes that he is Caucasian, widowed, has chronic illnesses and pain, is depressed, is over age 85, and has voiced a wish to die. Caucasian males over age 85 complete suicide at almost 6 times the national average.² Caucasian males over 65 have the highest suicide rate twice the rate of the general population and 6 times the rate in women over 65.2 [16]. In addition, suicide is more common in divorced and widowed persons. Elderly men who lose their wives lose social contacts leading to isolation [17]. Studies have shown that 45-80 percent of those in nursing homes suffer chronic pain [16].

Screening/Treatment Interventions

Once an assessment of the person's suicide has been determined, an individual treatment plan must be developed. Numerous screening and treatment interventions for suicidality in older military veterans exist, encompassing a broad array of assessment approaches. Elderly patients who were in combat or were prisoners of war may have special healthcare needs that may not be obvious [18]. Effective screening and intervention is necessary to reduce suicidal ideations and behavior experienced by this aged and vulnerable population; as well as, utilizing the appropriate assessment tool to identify indicators of suicide. Suggestions for long-term care suicide precautions include:

- Conduct a suicide assessment
- Create a suicide risk assessment/reassessment procedure
- Create a close observation sheet for 5-15 min face to face checks
- Renew suicide precaution orders daily
- Maintain a high level of suspicion even if the symptoms lighten

In addition, according to (JCAHO), the greatest clinical root cause of inpatient suicide is a failure of clinical assessment. Risk was not adequately assessed in about 60% of suicides or else the risk level was not accorded appropriate precautions [19].

Symptom Management

Working with elderly suicidal veterans can be anxiety provoking. Over the past few years, the VA has significantly increased its efforts to respond to the behavioral health needs of veterans, especially attentive to veterans from the Iraq and Afghanistan conflicts. Older veterans have benefited from these efforts to prevent suicide, to increase accessibility to treatment, to use evidence-based treatments, and to build delivery systems that integrate physical and mental health services [20].

Thoughtful symptom management strategies, attending to the safety needs of the person and to their well-being may help reduce suicide risk. In addition, the VA has undertaken several initiatives that are specific to older veterans, in the VA's long-term care centers and in hospice and palliative care settings, spinal cord injury centers and rehabilitation centers for the blind [21]. The VA cannot do this alone,

direct care workers, especially the advanced practice nurse need to possess essential assessment skills in order to assess the person at risk for suicide. See Appendices C and D for examples of suicide assessment tools. Most importantly, we need to acknowledge, thank and honor our older veterans for their service and sacrifice and assure them that our nation will stand by them throughout their lives [20].

Education

The role of education of current and future direct care workers in the assessment of suicide among older adults is vital and there is definitely an increased need. Identification of risk factors, tools for assessment should be implemented in education and training programs. Recommendations include:

- Implementing culturally sensitive education and training regarding assessment of suicide in long-term care
- Provide education regarding suicide, stigma, and assessment to healthcare workers and caregivers

Critique of the Literature

Elderly persons who were in combat or were prisoners of war might have distinctive health care needs that may not be apparent until decades later. Many WWII veterans and Holocaust survivors continue to define their war experiences as being the most significant stressors that they have ever experienced. The search strategy utilized during the development of this guideline focused on two essential areas. One was the identification of clinical practice guidelines published on the topic of assessment of suicide risks in elderly military veterans in long-term care facilities and the second was to review scholarly article and studies published in this area from 1981 to 2012.

A total of fifty-two searches from Medline, EMBASE, PsycINFO, PILOTS and PubMed were conducted using the search terms, "elderly, military veterans", "suicidality", "assessment", "PTSD", "clinical practice guidelines" and long-term care. Results revealed a highly significant positive association between a PTSD diagnosis and suicidality. This literature review provides a comprehensive overview of the known risk factors for suicide. It examines the effectiveness of different assessment instruments aimed at preventing completed suicide, suicidal behaviors, and suicidal ideation, in key risk groups (i.e., aged military veterans).

Much evidence has revealed that PTSD is significantly associated with suicidal ideation and suicide attempts. Specific PTSD symptoms and specific psychological conditions associated with chronic stress reactions may contribute or mediate the association between PTSD and suicidal behavior. The American Psychiatric Association (APA) Practice Guideline is one of many clinical practice guidelines for the assessing and treating patients with suicidal behavior. Recommendations of the guideline provide extensive information on a variety of topics related to the assessment and treatment of suicidal patients. The suicide risk assessment entails an estimation of suicide risk (i.e., low, moderate or high). Estimating the degree of the person's suicide risk guides decisions about immediate safety measures and the most appropriate treatment setting [14].

The Scale for Suicide Ideation (SSI) and the Nurses' Global Assessment of Suicide Risk (NGASR) are two useful tools for the comprehensive assessment of suicide ideation and suicidal behavior. Strong evidence in the literature suggest that the Nurses' Global Assessment of Suicide Risk (NGASR) tool represents only one aspect of the necessarily broader assessment of risk, the NGASR appears to provide a useful template for the nursing assessment of suicide risk, especially for the novice [22]. The NGASR involves determining risk

factors because statistics have proven a positive correlation with the risk of suicide. In addition, the NGSAR helps to develop judgment in less knowledgeable staff (i.e., novice nurse). The tool involves 15 variables such as hopelessness, recent stressors, and interpersonal interactions are measured to determine suicide risk. Using these tools for assessment, nurses can help reduce the risk of suicide [23].

Application to Practice Setting(s)

Suicide is a significant problem associated with considerable adverse outcomes associated with depression, PTSD and traumatic brain injuries. Many social and ethical concerns have impeded suicide research in elderly military veterans 50 years after the war has ended. Given the magnitude of the problem, addressing the problem of suicidality in the elderly veteran population should be a priority for clinicians and researchers. Moreover, nurses in the advanced practice role are in an exceptional position to implement current evidence based practice to protect vulnerable populations through research and clinical practice. The incidence of suicidality in military veterans is vacillating and there will be a strong need to be extremely cognizant of this issue in the soldiers returning from military service. There is definitely a need for increased awareness to identify subjects at risk of suicide. This guideline demonstrates the importance of acknowledging the need for early recognition of suicide in the elderly military veteran.

LTC and Why

There is little in the literature regarding the prevalence of suicide in long-term care (LTC) settings. Yet since nursing home patients suffer from chronic debilitating conditions, their cause of death is often unquestioned and the majority of states do not demand an autopsy or investigation into nursing home deaths [8]. Therefore, it is definitely possible that the suicide rate in long-term care facilities is higher.

In addition, despite occurrences of suicide rates in long-term care facilities, the rates are generally lower than expected. This is perhaps because of greater supervision and residents' limited access to potentially lethal means and physical inability to carry out the act as well as underreporting or misattribution of self-destructive behaviors to accident or natural death [24].

Individualization of Care

Globally an act of suicidal behavior or suicidal ideation is a serious public health issue. Because nurses play a pivotal role in the identification of persons at risk for suicide, it is important that they be cognizant of the complex risk factors involved in elder suicide. When establishing the presence of suicidal ideation, the overall goal is to determine the risk for death by suicide. Therefore, history taking and a thorough psychological assessment, especially addressing suicide risk factors, are important components.

Most clinicians rely solely on the clinical interview and certain valued questions and observations to assess persons at risk for suicide. Approximately 25% of suicidal patients deny suicidal ideation when asked [25]. When the patient denies suicidal ideation, additional questions should be asked about prior suicide attempt(s) and family history of mental illness and/or suicide. Denial of suicidal ideation should not end the assessment process but should be the beginning of further inquiry. The clinician must do more.

Ethical Issues

Ethical issues are important topics for consideration for those

involved in the care of the person who is suicidal. There is strong ethical and legal agreement that respect and confidentiality are part of the healthcare worker and patient relationship. Health care workers need access to information about a person; ensuring confidentiality is often a challenge in health care settings. Arguably, ethics and the law agree that the right to confidentiality is not absolute. Clinicians have a duty to take steps to prevent suicide if they can reasonably anticipate the danger.

“Suicidal thoughts are symptoms that can be helped and changed with the proper intervention. Your advocacy can help them manage symptoms and connect with self-help groups, social support and therapeutic resources” [26].

Furthermore, with a large number of suicides in the military having been committed with privately owned firearms, the Pentagon and Congress are moving to establish policies to separate at-risk service members from their personal weapons. The ethical issue is a difficult one for the Pentagon. Gun rights advocates and many service members fiercely oppose any policies limiting the private ownership of firearms. In addition, Defense Department officials are developing a suicide prevention campaign that will encourage friends and families of potentially suicidal service members to safely store or voluntarily remove personal firearms from homes.

Policy Issues

This guideline has significant clinical and potential policy implications. The VA has implemented a policy to screen all veterans for depression, PTSD, and alcohol make an accurate diagnosis in this population standardized PTSD assessments should be implemented in long-term care settings. This point is highlighted by the fact that mental disorders in nursing home patients are frequently undiagnosed, misdiagnosed, or diagnosed in a way that obscures treatable conditions [11]. Older adults residing in long term care facilities diagnoses with PTSD may be overlooked because their symptoms (or medication effects) may be confused with dementia or psychosis, thus complicating treatment. In addition, a great need exist for PTSD and suicide risk assessment tools for veterans with severe cognitive impairment or are unable to communicate verbally. There is also a need for new standardized PTSD assessment instruments for combat veterans who are more severely cognitively impaired or unable to communicate verbally. Identifying people at high risk of suicide is an important task for long-term care facilities. Few well-validated screening measures exist and many of the available assessment instruments are cumbersome for health professionals to use given the time restraint sand practical challenges of daily tasks, in addition to one more piece of paper work to fill out.

Quality and Cost

Financial considerations are minimal to implement these guidelines if any monies at all. However unless suicide risk is diagnosed and treated damaging financial consequences can occur. Yearly millions of dollars are spent to care for elderly veterans in addition to the veterans currently returning form deployment. According to Tanielian et al. [27] these consequences can have a high economic toll to the government. Yet, direct costs of treatment are only a fraction of the total costs related Far higher are the long-term individual and societal costs stemming from reduced quality of life, long-term care placement and suicide. Therefore, it is important to consider the direct costs of care in the context of the long-term societal costs of providing inadequate care or no care.

Conclusion

Because of this guideline, nursing can play an integral role in committing to protect vulnerable populations, such as the elderly military veteran decades after the wars have ceased against stressors that impact their health and illness. It is very important that nurses in every health care arena educate staff on the symptoms and course of suicidality. Moreover, nurses in advanced practice are in an exceptional position to implement current evidence based practice into the lives of military veterans through research and clinical practice. As elderly veterans are passing on, a strong need exists to manage suicidal ideations and behavior in the soldiers currently returning from combat. There is definitely a significant need for future investigation. This guideline demonstrates the importance of acknowledging the need for assessing suicidal ideations and behaviors for at risk military veterans [28].

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