Getting Upstream in Addressing Suicide Prevention: Considerations for Clergy and Collaboration with Mental Health

Jason Nieuwsma, PhD
Associate Director, VA Mental Health & Chaplaincy
Associate Professor, Duke University Medical Center
Durham, NC
Objectives

1. Describe "upstream" targets for suicide prevention, especially those relevant for attention from clergy.

2. Articulate how clergy can make use of certain evidence-based principles to address primary prevention of suicide.

3. Pursue engagement with mental health professionals in providing care for Veterans and Service members at varying degrees of risk for suicidality.

4. Critically evaluate and describe the complexities in understanding how sociocultural factors may intersect with suicide rates among Veteran and Service member populations as well as the general population.
Key Colleagues:
Suicide Prevention & Clergy

- Dr. Keith Meador
- Chaplain Bill Cantrell
- Dr. Jen Wortmann
- Chaplain Keith Ethridge
- Dr. Marek Kopacz
- Chaplain Steve Sullivan
- Numerous chaplains across VA & DoD
Global Suicide Rates*

* Age-standardized, both sexes, 2015.
U.S. Suicide Rates Over Time*

Suicide Rates by Sex: 1999 & 2014

Suicide Rates by Method & Sex, 1999 & 2014

Suicidal Ideation, Attempts, & Death

9.8 million adults had serious thoughts of committing suicide

2.8 million adults made suicide plans

1.3 million adults attempted suicide

1.0 million adults made plans and attempted suicide

0.3 million adults made no plans and attempted suicide

44,193 people died by suicide in 2015 (3-4% of attempts)

Suicide among Veterans

- Approximately 20 Veterans per day die by suicide.¹
- 2/3 of veteran suicides are: individuals 50 y/o or older; from firearms.¹

Military vs. *Demographically-Adjusted* Civilian Suicide Rate

Suicides per 100,000 people

- U.S. population adjusted to military demographics
- Army National Guard
- All military*
- Total U.S. population

*Includes Army, Navy, Air Force and the Marines

SOURCE: CRAIG BRYAN, CENTERS FOR DISEASE CONTROL AND PREVENTION
What is going on?

Suicide rates have been rising in the U.S. throughout the 21st century... especially among females and among veterans.

Why?

“Suicide is an important public health issue involving psychological, biological, and societal factors.”

What else has been happening in 21st century U.S.?

- Technological revolutions.
What else has been happening in 21st century U.S.?

- Technological revolutions.
- Diminished social capital.
What else has been happening in 21st century U.S.?

- Technological revolutions.
- Diminished social capital.
- Growing class divides.
What else has been happening in 21st century U.S.?

- Technological revolutions.
- Diminished social capital.
- Growing class divides.
- Divisive partisanship.

What else has been happening in 21st century U.S.?

- Technological revolutions.
- Diminished social capital.
- Growing class divides.
- Divisive partisanship.
- Decrease in religious affiliation.

What else has been happening in 21st century U.S.?

- Technological revolutions.
- Diminished social capital.
- Growing class divides.
- Divisive partisanship.
- Decrease in religious affiliation.


*Beware spurious correlations! Ice cream sales and murder rates are also correlated.*
So why the increase in suicide rates?

Not entirely clear

...but...

sociocultural context clearly matters

...especially for...

persons faced with transition challenges.

Common transitions for Veterans/Service Members:

- Readjustment to civilian life
- Relationship/family changes
- Employment changes
- Identity transitions
## DoD: Suicide Prevention Guidelines

### Recommendations Pertaining to Chaplains from the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces

<table>
<thead>
<tr>
<th>Recommendation #17</th>
<th>Promote values that encourage seeking the assistance of <em>chaplains</em>, health care, and behavioral health care professionals to enhance spiritual, physical, and psychological fitness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation #43</td>
<td>Encourage Service members to have annual face-to-face &quot;conferences&quot; with <em>chaplains</em> for the purpose of resolving questions of guilt and to obtain referrals to appropriate caregivers for other concerns beyond the <em>chaplain’s</em> scope of expertise and experience.</td>
</tr>
<tr>
<td>Recommendation #61</td>
<td>Train all military health care providers (including behavioral health providers) and <em>chaplains</em> on evidence-informed suicide risk assessment, management, and treatment planning. Create and provide continuing education tailored to their specialty and area of expertise.</td>
</tr>
<tr>
<td>Recommendation #63</td>
<td>Train first responders, <em>chaplains</em>, casualty notification officers, and family interviewers on how to best respond to suicide and suicide-related events when working with families or next of kin.</td>
</tr>
</tbody>
</table>

VA: Suicide Prevention MOU

VA NCC & Office of Suicide Prevention MOU (2016):¹,²

1. Standardize communication between chaplains and suicide prevention coordinators (SPCs)
2. Encourage chaplains to notify SPCs about at risk Veterans
3. Evidence-based curricula for chaplains
4. Educational materials for SPCs & chaplains describing collaboration
5. Encourage MH to include chaplains on interdisciplinary teams and committees, facilitating protective potential of spiritual care provision

¹ Memorandum of Understanding between the VA National Office of Suicide Prevention and the VA National Chaplain Center (August, 2016).
Prevention Continuum

Mitigating occurrence of risk factors via promotion of life enhancing practices

Intervening early in response to risk factors

Care/treatment of persons (and relations) in whom suicide-related behavior has occurred

Military chaplains perceive knowledge, awareness, training

Military chaplains perceive training need

Getting Upstream in Suicide Prevention: Primary / Secondary / Tertiary Prevention

- Identity
- Meaning and purpose
- Religion / Spirituality
- Values
- Relationships and social connectivity
- Distress tolerance
- Facilitating access to care
- Effective problem-solving
- Anxiety
- Depression
- Substance use/abuse
- Psychiatric hospitalization
- Intersecting with existing programs & policy
- Assessing and responding to imminent risk
- Postvention care
Downstream:
Tertiary Prevention

- Examples:
  - Operation S.A.V.E.
    - Signs of suicidal thinking
    - Ask questions
    - Validate the person’s experience
    - Encourage treatment and Expedite getting help
  - Reducing access to lethal means
  - Psychotherapy, pharmacotherapy, & other interventions

- Resources:
  - Operation S.A.V.E.:
  - Suicide Awareness Voices of Education (SAVE):
    - [https://save.org/](https://save.org/)
  - VA Mental Health Suicide Prevention:
    - [https://www.mentalhealth.va.gov/suicide_prevention/](https://www.mentalhealth.va.gov/suicide_prevention/)
  - National Suicide Prevention Lifeline:
    - [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)
  - Crisis Line: 1-800-273-8255 (1-800-273-TALK)
    - Press “1” for veterans.
Further Upstream: Secondary Prevention

Numerous potential pathways:

- Substance Abuse
- Affective Disorders
- Anxiety Disorders
- Thought Disorders
- Social Problems

Clergy/chaplain engagement:

- Direct care provision
- Care within the context of faith communities
- Collaboration with mental health care

www.mirecc.va.gov/MIRECC/mentalhealthandchaplaincy/
A possible transdiagnostic process:

Experiential Avoidance:  
- Defined: *The tendency to escape or avoid unwanted thoughts, emotions, memories, and sensations, even when doing so is futile or causes harm.*
- A key construct and target within Acceptance and Commitment Therapy (ACT; an evidence-based practice)
- Close overlap / association with concepts tied to suicidal behavior
- Suicide as most extreme expression
- Majority of suicide notes cite reason as escape from emotional pain
- Mindfulness / ACT can reduce experiential avoidance

---

Clergy & Chaplain Engagement

- Experiential avoidance & pastoral presence\(^1\)
  - Individual-level willingness to be present
  - Social/pastoral-level willingness to share presence
  - Willing to be present (to distress)... *for a reason* (values)

- Values clarification\(^1\)

- Promotion of healthy behaviors

- Facilitating social & relational support

- Religious / spiritual practices & resources

---

• It’s a two-way street, but you can only drive your car.

• Developing an elevator pitch for mental health:
  o Have a brief version.
  o Translate it for the local dialect.
  o Anticipate potential barriers.
  o Tailor it for your particulars.
  o Mention concrete offerings.
  o Be ready with a relevant anecdote.
Resources: Online Video Products

- **Bridging Mental Health and Chaplaincy** (≈ 1 hour each)
  1. “Why do it?”
  2. “Knowing Our Stories”
  3. “Opening a Dialogue”

- **Learning Collaborative** (≈ 1 hour each)
  1. “Establishing Awareness”
  2. “Communicating and Coordinating Care”
  3. “Formalizing Systematic Processes”

- **Clergy & Faith Communities**
  - **Clergy** (≈ 1 hour each)
    1. “Signposts Toward Collaboration”
    2. “Abiding with Those Who Suffer”
  - **Faith Communities** (≈ 20 minutes each)
    1. “Partners in Care”
    2. “Trauma”
    3. “Moral Injury”
    4. “Belonging”

Videos available on program website: [www.mirecc.va.gov/MIRECC/mentalhealthandchaplaincy/](http://www.mirecc.va.gov/MIRECC/mentalhealthandchaplaincy/)
Contact Information

Jason Nieuwsma, PhD

jason.nieuwsma@va.gov
jason.nieuwsma@duke.edu

www.mirecc.va.gov/MIRECC/mentalhealthandchaplaincy/

mh-c@va.gov