Emergency Departments Treating Veterans for Suicide: Ensuring Quality Care for Veterans Outside of Department of Veterans Affairs Health Care Facilities

Authors: Angie Waliski, PhD, Monica M. Matthieu, PhD, LCSW, M. Kathryn Allison, PhD, MPH, Michael P. Wilson, MD, PhD, Elisabeth M. Skaggs, AAS, David A. Adkins, MHA, and Richard R. Owen, MD, Little Rock, AR, and St. Louis, MO

Contribution to Emergency Nursing Practice

- Veterans are at high risk of suicide, and rural veterans are at higher risk of suicide than nonrural veterans.
- Although emergency departments typically inquire about veteran status for billing purposes, this status is not used in assessing, treating, or referring patients for additional care. Implementing veteran-specific suicide assessment and intervention best practices could improve quality care for all ED patients.
- Emergency departments can improve suicide care for at-risk veterans. Identification of veteran status can allow for veterans affairs treatment after discharge. Additional education about mental health and suicide prevention should be provided to emergency clinicians, including using available VHA online education about veteran-specific suicide risk factors and community service providers.

Abstract

Introduction: Veterans die by suicide at higher rates than nonveterans. Given that the emergency department is often the first point of entry to healthcare following a suicide attempt, it would be beneficial for community providers to have knowledge of the characteristics, medical issues, and effective treatments most often associated with those having served in the military to ensure guideline concordant and quality suicide care. This study aimed to identify assessment and referral practices of emergency departments at rural community hospitals related to care for suicidal veterans and explore the feasibility and acceptability of identifying veterans in need of postdischarge aftercare.

Methods: This qualitative exploratory study involved content analysis of semistructured interviews. Ten emergency clinicians from 5 rural Arkansas counties with high suicide rates were interviewed about their experiences working with suicidal

Angie Waliski is a Health Research Scientist, Health Services Research and Development, Central Arkansas Veterans Healthcare System; and an Assistant Professor, Division of Health Services Research, PRI, University of Arkansas for Medical Sciences, Little Rock, AR. **ORCID identifier:** https://orcid.org/0000-0002-6596-2038.

Monica M. Matthieu is a Research Social Worker, Mental Health Service, Central Arkansas Veterans Healthcare System, North Little Rock, AR; and an Associate Professor, School of Social Work, Saint Louis University, St. Louis, MO. **ORCID identifier:** https://orcid.org/0000-0003-2218-9484.

M. Kathryn Allison is a Research Assistant Professor, Department of Health Behavior and Health Education, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences, Little Rock, AR. Twitter: katyallisonphd. **ORCID identifier:** https://orcid.org/0000-0001-6178-0352.

Michael P. Wilson is Associate Professor, Department of Psychiatry, University of Arkansas for Medical Sciences; and Associate Professor, Department of Emergency Medicine, University of Arkansas for Medical Sciences, Little Rock, AR. **ORCID identifier:** https://orcid.org/0000-0003-3069-2274.

Elisabeth M. Skaggs is Technical Writer, Central Arkansas Veterans Healthcare System, North Little Rock, AR. **ORCID identifier:** https://orcid.org/0000-0002-6631-9466.

David A. Adkins is Research Health Science Specialist, Central Arkansas Veterans Healthcare System, North Little Rock, AR. **ORCID identifier:** https://orcid.org/0000-0002-6237-6826.

Richard R. Owen is a psychiatrist, the Director of the Center for Mental Healthcare and Outcomes Research, and Associate Chief of Staff for Research and Development, Central Arkansas Veterans Healthcare System; and Professor, Department of Psychiatry, University of Arkansas for Medical Sciences, Little Rock, AR. **ORCID identifier:** https://orcid.org/0000-0003-2548-2264.

For correspondence, write: Angie Waliski, PhD, Health Services Research and Development, Central Arkansas Veterans Healthcare System, 2200 Fort Roots Drive (152/NLR), North Little Rock, AR 72114; E-mail: angie.waliski@va.gov

J Emerg Nurs 2023;49:255-65.
Available online 17 January 2023
0099-1767

Published by Elsevier Inc. on behalf of Emergency Nurses Association.
https://doi.org/10.1016/j.jen.2022.12.004

patients within the emergency department and perceptions of assessment, management, and referral practices.

Results: Although most of the emergency departments had a process for assessing for suicide risk, emergency clinicians did not always feel confident in their knowledge of assessing and caring for suicidal patients. Military history was not included in assessment, treatment, or aftercare planning, nor were brief interventions such as safety planning or lethal means safety education provided.

Discussion: Best practices for suicide assessment and management of veterans exist; however, challenges specific to the emergency department regarding staff training and engaging the community to effectively link at-risk veterans to needed care hinder implementation. Veteran-inclusive assessment and intervention practices could enhance the quality of care provided in community emergency departments.

Key words: Suicide; Emergency departments; Critical care; Veteran; Treatment; Continuity of care

Introduction

The 2022 Veterans Health Administration (VHA) Suicide Report continues to document an alarming rate of veteran suicide, with 16.8 veterans dying by suicide daily.[1] Given that the emergency department is often the first point of entry to health care after a suicide attempt, it would be beneficial for community providers to have knowledge of the characteristics, medical issues, and effective treatments most often associated with those having served in the military to ensure guideline concordant and quality suicide care.[2]

Studies investigating health care utilization among those who die by suicide within the general population reveal that many contacted a health care provider in the year before death,[3-9] indicating a missed opportunity for screening and identification of risk. In addition, rural compared with urban veterans have increased suicide risk stemming from constraints on mental and physical health care access; lower quality of life; socioeconomic inequalities in income, education, and community resources; and increased firearm ownership.[10-15] Individuals at risk of suicide may present for care in a variety of settings to include primary care clinics, social service agencies, urgent care, or the closest medical facility with an emergency department.[16,17]

Current Joint Commission standards mandate that emergency departments screen patients at risk of suicide,[18–20] and thus, all health care providers in the emergency department, especially frontline workers such as nurses, should have knowledge of suicide screening.[21–23] Risk assessment and mitigation,[23] including lethal means counseling and the ability to develop a suicide safety plan, may also be helpful.[2,18,24] Training all clinical staff in the emergency department provides an opportunity to discuss what broader systems are in place when a patient presents to the emergency department in crisis.[20] By all staff in training, it emphasizes how other services and professionals might be available to high-risk patients that nurses could consider triaging to. This qualitative pilot study aimed to assess real-world practices in rural community emergency departments in a southern state with a high rate of suicide. Our goal was to determine whether assessment of suicide risk and military service history among patients reporting suicidal ideations or attempts were common practices in this setting. We also aimed to explore the acceptability and feasibility of community emergency departments referring at-risk veterans to mental health care at a VHA facility or other community organizations after discharge. Finally, this study explored policies and practices of emergency departments regarding suicide risk assessment, identification of military history, aftercare planning for patients with identified suicide risk, and tracking of aftercare.

Methods

STUDY DESIGN AND THEORETICAL FRAMEWORK

This study was a qualitative exploratory study design involving semistructured interviews with key informants (see below) and content analysis.[24–40] Key informant interviews aimed to identify current clinical practices related to the care of suicidal patients and explore the acceptability, feasibility, and determinants of the use of a standardized suicide screening and risk assessment, identification of military history, and discharge and referral practices for continuity of care between community emergency departments and VHA facilities or other mental health organizations. The Consolidated Framework for Implementation Research, which outlines 5 theory-driven domains associated with implementation, informed qualitative key informant interview questions exploring determinants of suicide prevention practices.[29,30] Ethical approval to conduct the study was attained from the Central Arkansas Veterans Health Care System Institutional Review Board. The Consolidated Criteria for Reporting

Qualitative Research was used in the development of this manuscript.[31]

SELECTION OF KEY INFORMANTS

This study used purposive sampling of clinicians working in community hospital emergency departments in rural counties with high rates of suicide deaths. Emergency clinicians, including physicians, nurses, social workers, and other health care providers, and administrators at 2 of 10 identified hospitals were sent a recruitment email by the research team and invited to participate. We conducted interviews with emergency clinicians recruited from these 2 hospitals before the COVID-19 pandemic. After a year-long delay owing to health care deployment and focus on the pandemic, we collaborated with our Arkansas Department of Health partners to send a recruitment email to the point of contacts for rural hospitals in Arkansas. Our inclusion criteria were community hospitals located in the top quartile of rural identified counties that had a high number of veterans and/or a high suicide rate in their service area. This secondary recruitment effort resulted in the addition of 3 hospitals, for a total of 5 hospitals in the study. The study spanned July 2019 to March 2021 with funding provided by the VHA.

SETTING

The novelty of this work is two-fold: first, few contemporary studies have assessed suicide prevention practices in nonveteran emergency departments, and second, the geographic setting is understudied in regard to suicide. Arkansas (the study location where the study team is employed) is a rural state that is home to approximately 227,840 veterans, of which an estimated 114,261 (50.15%) are enrolled in Veterans Affairs (VA) health care.[32,33] The justification for the study is also based on the state having a high rate of gun ownership and in 2019 ranked 14th nationally in suicide deaths, with 62.7% of suicide deaths in Arkansas involving a firearm and 70.6% of those were veterans.[32–37]

PERSONAL CHARACTERISTICS

The first author, a female who has a doctorate in counseling, conducted the interviews. She was employed by the VHA and completed postdoctoral training in mental health services research, completed a mentored suicide prevention research fellowship, and has conducted numerous qualitative studies using interviews. The senior member of the research team is a National Institute of Mental Health postdoctoral fellowship trainee in suicide research and has been a VHA social work researcher for nearly 20 years who provided guidance and feedback on this and other completed collaborative projects and manuscripts.

RELATIONSHIP WITH PARTICIPANTS

A relationship was established between the first 2 study sites and the first author before study commencement owing to her work on a statewide initiative to integrate veterans into the state suicide prevention plan. The participants knew this background and the reasons for doing the research owing to the research team sharing the informed consent and study documents with the participants before participation as part of recruitment efforts. The interviewer's reasons for conducting this study were based on demographic knowledge of county-level suicide rates in the state of Arkansas, her home state, and the high rate of suicide in rural areas in this and other areas of the United States.

DATA COLLECTION METHODS, INSTRUMENTS, AND TECHNOLOGIES

Eligible participants—those employed in an emergency department located in the state of Arkansas—were emailed a description of the study purpose and a copy of the previously pilot-tested interview questions, and an interview was scheduled. The semistructured interview guide focused on 6 categories: the practices and procedures emergency departments use in the (1) identification of military history, (2) assessment for suicidal ideation and suicide risk, (3) treatment/stabilization for reported suicidal crisis, and (4) aftercare instructions and referral practices; (5) perceptions of common suicide attempt methods among ED patients; and (6) recommendations about how to improve care for veterans reporting suicidal crisis (see Table). During the interview, the interviewer explained the study and conducted the interview. Interviews lasted approximately 30 minutes. There were no repeat interviews owing to technology challenges or returned transcripts of interviews or field notes for member checking.

DATA ANALYSIS

Each interview was audio recorded using Audacity for Windows version 3.0.0[38] and stored on a VHA secure server. Audio recordings were transcribed verbatim by administrative staff trained in transcription services. Transcripts were reviewed by the principal investigator, who is a doctorally trained clinical researcher with experience in qualitative

TABLE
Example key informant interview questions

CFIR domain	Example interview questions
Intervention characteristics	What kinds of changes or alterations do you think you will need to make to identify military history, assess for suicide risk, refer Veterans for mental health treatment, and track aftercare? Are these practices acceptable and feasible within your emergency department?
Inner setting	Would your emergency department assess for suicide risk of ED patients? Would your ED ask about military service history or Veteran status? How well does this inquiry fit into your existing practices? How do you think your organization's culture (general beliefs, values, assumptions that people embrace) will affect whether and how these questions are asked? What are the discharge practices for patients reporting suicide risk? What tracking or follow-up practices does your emergency department use for patients reporting suicide risk?
Outer setting	How well do you think these procedures will meet the needs of the individuals served by your hospital? How do you think the individuals served will respond to these procedures?
Characteristics of individuals	On a scale from 1 to 10, how confident are you that you will be able to successfully implement the inquiry of military history, provide veteran-specific referrals at discharge, and provide follow-up to discharge suggestions? What gives you that level of confidence (or lack of confidence)? Would each of these practices be acceptable to and feasible for you in your practice?
Implementation process	Who would need to be engaged to implement identification and tracking of veterans at risk of suicide? What costs would be incurred to implement the practices described? Would each of these practices be acceptable and feasible within your ED system?

CFIR, consolidated framework for implementation research; ED, emergency department.

methods, for completeness and accuracy. She corrected any errors or omissions before entry into Atlas.ti, version 7[39] a software program that facilitates management, coding, and analysis of narrative data. Two members of the study team who were trained in qualitative analysis read each interview and coded them independently to identify primary themes that emerged. Coding and saturation were discussed, and any discrepancies were identified and discussed until 100% agreement was met. Resulting themes were guided by the previously developed interview guide and discussed and approved by 2 additional doctoral-level investigators from the team who possess qualitative expertise to ensure there were no additional identified concerns.

REPORTING

Criteria for assuring scientific rigor in qualitative research include consistency, reliability of coding, auditability, and validity.[40–43] An audit trail was kept of the procedures, with all quotes identifiable. To assure consistency and mitigate bias, all interviews used the same broad opening and probing questions, and transcripts were monitored for problems such as drift or failing to probe for answers in enough detail to maximize the interview content. Participant quotations are presented to illustrate the major themes and findings, which were consistent.

Results

Participants included 10 clinicians, including 6 nurses (4 emergency nurses, 1 nurse case manager, and 1 nurse patient experience specialist), 2 social workers, 1 case worker, and 1 emergency physician employed in rural community hospitals in Arkansas.

PERCEPTIONS OF SUICIDE ATTEMPT METHOD

All participants perceived that overdose was the most prominent method of suicide attempt among their ED patients. Most participants perceived the drugs used by most patients for the suicide attempt were drugs the patient obtained

illegally. Other suicide attempt methods reported included cutting, hanging, and asphyxiation. No participant mentioned firearms as a method used by patients for suicide attempts or mentioned lethal means counseling as an intervention. One participant said, "Usually if somebody attempts with a firearm, they are successful, honestly."

SETTING, INTERVENTION, AND INDIVIDUAL CHARACTERISTICS: CURRENT PRACTICES AND PROCEDURES

Identification of a Patient's Military Service

Each of the 5 emergency departments identified veteran status only during administrative registration at triage and only for billing purposes. Emergency clinicians did not inquire about military service as part of clinical assessment or treatment practices. Veteran status was also not considered for treatment or for referral purposes. One participant indicated it is only discussed if the patient disclosed their veteran status voluntarily: "The only true time that would be assessed is when our … insurance people go and talk to the patient and … they tell them at that time they are a veteran or say if they have TRICARE or something like that." Another participant stated, "Point blank, we don't ask that question in the emergency department." Participants reported no identified barriers to asking about military history as it related to assessment and triage, and they consistently indicated the military service questions could be added to the triage questioning with relative ease if approved by the leadership of the facility. They also indicated that collecting these data could be facilitated through the electronic health record system.

Suicide Screening and Risk Assessment

Most participating emergency departments reported some procedure for identifying suicidal ideation among all patients presenting to the emergency department; however, one suggested that they asked questions about mental health more broadly but did not ask all patients about suicidal ideation. Although no participant was able to specify the exact suicide assessment instrument used, participants indicated that the questions generally asked whether the person had thought of harming themselves, and if so, they would be asked additional questions that would guide the plan for treatment. One participant described the assessment as, "Every time for every patient during triage, we ask if they feel like they want to hurt themselves. We ask if they have felt down, depressed, or hopeless. Do you have any thoughts of harming yourself? Do you have a plan? Have you recently thought about killing or harming yourself?" No participant was able to provide copies of assessment tools or exact wording of triage questions.

Treatment/Stabilization Process

All participating emergency departments described procedures to stabilize the patient in a separate, safe location, removing all potentially harmful objects, and monitoring to determine whether inpatient or outpatient services were warranted. Participants reported observation time varied based on the patient's intoxication level. If the individual was deemed to be at imminent suicide risk, they would be immediately referred to inpatient services. However, if intoxicated, the patient would be held in the emergency department until sober enough for the clinician to reassess. One participant said, "Half of them we see are intoxicated with other drugs onboard. The other half is just truly intoxicated with a blood alcohol level of 0.2 or 0.3 and say that they don't want to live anymore, whether that's associated with depression or alcohol.… We have to sober them back up and then reassess."

Aftercare Instructions and Referral Practices

Participants were asked to describe their aftercare instructions. If outpatient services were warranted, most participants said this was done by referral, with one institution providing a warm hand-off either by phone or online telehealth visit. One facility had an inpatient mental health unit, whereas others had to collaborate with other facilities that provided inpatient mental health care. Participants at one hospital mentioned a community mental health provider serving the catchment area that would either meet the patient at the hospital for further assessment or conduct the assessment using an online, face-to-face platform. One participant said, "The main thing we do is always contact [name of local counseling clinic]. We can also do video conferencing with them. They can talk to … and interview the patient." Some participants said that a patient can be held at a critical care unit until an inpatient facility was identified and a bed made available.

Three of the 5 participating emergency departments provide a resource document to the patient at discharge. Three emergency departments are using nonharm contracts with patients. Two of the participating emergency departments provide a follow-up call to the patient after discharge. Some participants discussed concerns for their facility's

aftercare instructions, such as concerns about access to timely follow-up care. One participant said,

> I believe it says on the ER discharge paperwork, follow up within 3 to 5 days. A lot of times that's not physically possible. They can't actually get into a community behavioral health provider within that time frame. Either they can't get their insurance pre-approved, or they don't physically have an opening for those patients, especially here in rural Arkansas. So, our ideal is 3 to 5 business days, but I think probably the reality is more like 10 to 14 days.

This participant went on say,

> Fourteen days is not a feasible amount. It's not going to meet their needs. So, a reasonable amount of time where they could look forward to that tomorrow or the next day. And then in the very near future set up a longer appointment where we can visit. I feel like technology and that local connection, meeting them at their local VA clinic or whatever. It's kind of like a carrot of a thing, a face-to-face connection.

Another participant reported that when a patient indicates they are a veteran, are enrolled in care through the VHA, and are suicidal, a referral is made to the VHA, but placement in VA-supported community services is not always possible. The participant said,

> With some VA doctors, it's hard to get patients' home health. Those are some barriers with that. It takes a lot. Usually there's a call list. We'll call, get the person on the list. Most of the times we've done it, the patient ended up just staying here, and then was ready for discharge and we just discharged them. I don't think it's been really successful chance for us, but it is an option in case they needed it. It takes so many days that, at that point, they were already ready for discharge.

IMPLEMENTATION PROCESS: RECOMMENDATIONS TO IMPROVE ED CARE FOR ALL SUICIDAL PATIENTS

In general, participants indicated a need to improve management and treatment of all patients with suicidal thoughts or attempts in the emergency department. Overall, reports from ED staff indicate they thought treatment options for suicidal behavior were limited compared with traditional procedures in the emergency department. Participants identified their roles being to provide emergency care for physical ailments and having limited, if any, training in mental health care. Participant comments were primarily within 2 target areas: staff training and education and engaging the community to support linkage and referral efforts.

Training and Education of Emergency Clinicians on Mental Health and Suicide Interventions

Participants recommended additional education about mental health, suicide risk factors, and suicide treatment options owing to the limited resources available in rural settings. One participant said,

> I want to get an in-service for my nurses over mental health.… Just some tactics about building rapport.… We're not mental health, but just to get some education because sometimes there is a day or 2 gaps where we have to take care of patients while waiting placement. Our techs and nurses would obviously benefit from anything to take better care of somebody who is going through a crisis.

Another participant commented how they were trained not to cross the line of providing mental health care but instead leaving that for the mental health professional. They said,

> Mental health is one of the biggest stigmas in the United States as we speak right now. No one knows what to do with it. Nobody knows when you can talk about it. I have nurses that struggle if somebody is suicidal, and I'm like, they already know they are suicidal. Let's build a rapport with them and treat them. There's just this stigma and this cloud that goes along with it. So, I do think that we would definitely benefit from getting involved, diving deep into our community.

Community Support Efforts for Linkage and Referral

Comments were made indicating disbelief that the health care system was going to solve the suicide crisis. One participant suggested that veteran-serving organizations will need to collaborate to effectively link at-risk veterans to needed care, saying,

> It's not going to be one organization that comes in and says, "OK, we are pushing out mental health for veterans." It's not going to be just the VA.... It's going to be a collaboration to kick it off, and it will be

> tough.… We are not mental health. We don't have a mental health facility at [town name], so the biggest thing would have to be in a collaboration effort with organizations to push out and work together to figure out what this community would need, what our weaknesses are, and how to best serve them.

In addition to recommending improved access to mental health services in the emergency department and collaboration among veteran-serving organizations in the community, participants recommended the development and promotion of web resources, including telehealth, websites, chatrooms, and online support, that link veterans in suicidal crisis to health care services, resources, and peer support. In addition, several comments were made about the need to develop and promote community services for treatment and postdischarge support. This included linking those experiencing suicidal thoughts to community resources, support groups, and other people with similar experiences. One participant said,

> If they feel alone in the things that they go through, as a health professional, I cannot understand. I was not in a war zone. I can't imagine what they have seen. I can't imagine what they have gone through and all of the trauma that has taken place. My perspective in the things we are lacking, it doesn't necessarily start in our ED, but in this community. They don't need to feel alone. They don't need to feel like they can't talk about it. Or, they need to be surrounded by people that understand what they've gone through and can help them and that is the safe place.

This participant went on to say,

> These people feel like they have got no help. We could identify them all day long, but pushing them off to the next thing, if you don't have a community-based resource where you have people who have walked through that. I have a friend who, her husband dealt with (posttraumatic stress disorder), and he helped veterans with the same thing around the world and travels. I think that's what we need, because I don't think our health care system is ever going to be able to address that. But I think if we individualize the problem and make it community based, I think that would help.… Build that community around the veterans and what they are going through.

Participants also recommended improving veteran-centric care and support by welcoming veterans from the community to volunteer by assisting other veterans who were seeking care in that facility. One hospital reported current discussions on improving veteran awareness and support among providers to include magnets on the doors of identified veterans so that staff would know about their military service, as well as instituting a veteran ambassador program where identified veterans would receive a visit each day from a veteran ambassador. This would be an opportunity to learn more about any concerns or needs of the veteran and the potential for linkage to resources. Although the participant indicated there were veterans interested in establishing the program, identified barriers included facility buy-in and commitment to build the infrastructure needed to promote and sustain efforts.

Discussion

This study is novel in that it documents the variability in management practices of patients with suicide ideation in rural Arkansas emergency departments, as well as the lack of assessment and referral practices related to identifying military history, suicide risk, and postdischarge aftercare of patients admitted to community emergency departments serving rural Arkansas. Although all hospitals assessed veteran status for billing purposes, this was not a characteristic used in assessing, treating, or planning aftercare of patients. Participants recommended identifying military history as part of assessment practices for diagnosis and treatment, recognizing the importance of using this information in aftercare planning to promote continuity of care and connection with veteran-specific mental health services, and believed this would be possible at their hospital if presented to and approved by hospital administration. Finally, participants in this study identified many implications for improvements that could be made in the areas of suicide care education and involving the community for support.

Our findings highlight the need to educate all emergency clinicians, including nurses, social workers, and physicians, about suicide risk, suicide prevention interventions, lethal means counseling, and mental health broadly, as well as about risk factors and services specific to veterans. The VHA currently provides training for clinical and nonclinical staff about suicide and how to assist people experiencing warning signs for suicide, and the online ICAR^{2}E[44] tool was created by the American College of Emergency Physicians and the American Foundation for Suicide Prevention for civilian patients at risk of suicide. However, clinicians in this study were unaware of these resources. Findings from this study suggest that all emergency clinicians might benefit from these resources to better manage suicidal patients in general and to

coordinate available services and care within the broader health care environment. Another finding is that collaboration with veteran-serving organizations might better link at-risk veterans to needed care from existing community services and resources, as well as providing more services that promote these connections to veteran-specific services.

Limitations

One limitation of this study was the extended time frame and changes to recruitment for the project owing to the coronavirus disease 2019 pandemic. Some ED staff responded to recruitment emails reporting inability to participate owing to the competing demands on their time owing to the pandemic. Potential sample bias may be caused by the recruitment modification using a snowball approach seeking participants from any rural hospital in the state and limiting the sample owing to budget and timeline restrictions, yet there was great consistency in the responses received from the 10 participants, and unless specified, we only reported findings consistently reported by at least 8 participants. A second limitation is that responses about policies and procedures are only the opinions of the participants. Each interview ended with a request to receive a copy of the facilities policies and procedures for treating suicidal patients in the emergency department. Although many indicated they would send the documents, none were received. Additional methods and resources for collecting this information may be needed in future studies.

Implications for Emergency Nurses

Many clinicians noted practices that are at odds with current best practices for managing ED patients at risk of suicide.[45–48] Three of the participating emergency departments in this study disclosed that they are using nonharm contracts with patients at risk of suicide—a practice that is no longer recommended by suicide prevention organizations, given that it does not protect the clinician against subsequent malpractice claims and may unethically restrict a patient's choices when they may be already struggling for control.[49] Despite evidence about the efficacy of safety planning,[50,51] lethal means counseling,[52,53] and postdischarge caring contacts,[54] no emergency department in our study reported use of these as part of a routine clinical practice. Training on suicide prevention interventions,[55] such as safety planning, coupled with stabilization and medication management, as indicated in the VA/Department of Defense CPG for the Assessment and Management of Patients at Risk for Suicide (https://www.healthquality.va.gov/guidelines/MH/srb/), could potentially improve care for ED patients and promote safety in the time between ED discharge and follow-up.

Other recommendations for emergency departments to include in veteran-specific assessments include screening for posttraumatic stress disorder (PTSD).[56] The VA/Department of Defense CPG for PTSD and Acute Stress Disorder (https://www.healthquality.va.gov/guidelines/MH/ptsd/)[57] recommend screening for comorbid conditions such as PTSD when evaluating a patient's suicide risk. In the nonmilitary population, approximately 6% to 7% of adults experience PTSD; however, in the veteran population in 2016, the VHA reported 10.6% of veterans had a diagnosis of PTSD. In veterans who served in Afghanistan and/or Iraq, 26.7% had a diagnosis of PTSD. Because the veteran's medical history may not be available in the emergency department, additional screening using the Primary Care PTSD Screen for DSM-5[58] and the PTSD Checklist for DSM-5[59] may be warranted.

Conclusion

Findings from this study indicate that participating ED providers assessed for suicidal ideation within ED settings, but the staff did not always feel confident in their knowledge of suicide and how to intervene. In addition, military history, which confers increased suicide risk, was not taken into consideration for treatment and referral, nor were veterans linked back to treatment at the VA, which uses evidence-based interventions such as safety planning, lethal means safety education, and postdischarge caring contacts. These suicide prevention strategies, which are unavailable in many community emergency departments, have been shown to reduce suicide mortality. Identification of veteran status in the emergency department can potentially improve connections to VA care, thereby increasing the potential for suicidal veterans to receive evidence-based interventions in VA settings after ED discharge. Although further investigation using a larger sample is warranted, findings suggest a need for all emergency clinicians, especially emergency nurses who are on the front lines, to have educational opportunities to learn about issues commonly reported by those with military service history, such as suicide risk, and interventions for suicide in the emergency department and veteran-specific health care services and resources.

Acknowledgments

The authors thank the participants for their contributions to this study.

Author Disclosures

Conflicts of interest: none.

This work was supported by the Department of Veterans Affairs Health Services Research and Development Award #PPO-18-278. The Central Arkansas Veterans Health Care System, North Little Rock, AR, provided infrastructure and resources. The results described are based on data analyzed by the authors. The views expressed in this article are those of the authors and do not necessarily represent the views of the United States government, Department of Veterans Affairs, Veterans Health Administration, universities, or other affiliates.

Data are stored, monitored, and available per the Central Arkansas Veterans Health Care System Institutional Review Board guidelines.

REFERENCES

1. Office of Mental Health and Suicide Prevention. *2022 National Veteran Suicide Prevention Annual Report*. U.S. Department of Veterans Affairs; 2022. Accessed October 18, 2022. https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf
2. National strategy for preventing veteran suicide 2018-2028. U.S. Department of Veterans Affairs. Published 2018. Accessed March 4, 2022. https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf
3. Owens PL, Fingar KR, Heslin KC, Mutter R, Booth CL. Emergency department visits related to suicidal ideation, 2006-2013. In: *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs*. Agency for Healthcare Research and Quality; 2017.
4. Bridge JA, Olfson M, Fontanella CA, Marcus SC. Emergency department recognition of mental disorders and short-term risk of repeat self-harm among young people enrolled in Medicaid. *Suicide Life Threat Behav*. 2017;48(6):652-660. https://doi.org/10.1111/sltb.12377
5. Dekker WPH, Vergouwen ACM, Buster MCA, Honig A. Acceptance of guidance to care at the emergency department following attempted suicide. *BMC Psychiatry*. 2017;17(1):332. https://doi.org/10.1186/s12888-017-1491-z
6. Ahmedani BK, Simon GE, Stewart C, et al. Health care contacts in the year before suicide death. *J Gen Intern Med*. 2014;29(6):870-877. https://doi.org/10.1007/s11606-014-2767-3
7. Leavey G, Rosato M, Galway K, Hughes L, Mallon S, Rondon J. Patterns and predictors of help-seeking contacts with health services and general practitioner detection of suicidality prior to suicide: a cohort analysis of suicides occurring over a two-year period. *BMC Psychiatry*. 2016;16(1):120. https://doi.org/10.1186/s12888-016-0824-7
8. Targum SD, Friedman F, Pacheco MN. Assessment of suicidal behavior in the emergency department. *Innov Clin Neurosci*. 2014;11(9-10):194-200.
9. Larkin GL, Beautrais AL. Emergency departments are underutilized sites for suicide prevention. *Crisis*. 2010;31(1):1-6. https://doi.org/10.1027/0227-5910/a000001
10. Wallace AE, Weeks WB, Wang S, Lee AF, Kazis LE. Rural and urban disparities in health-related quality of life among veterans with psychiatric disorders. *Psychiatr Serv*. 2006;57(6):851-856. https://doi.org/10.1176/ps.2006.57.6.851
11. Weeks WB, Wallace AE, Wang S, Lee A, Kazis LE. Rural-urban disparities in health-related quality of life within disease categories of Veterans. *J Rural Health*. 2006;22(3):204-211. https://doi.org/10.1111/j.1748-0361.2006.00033.x
12. West A, Weeks WB. Physical and mental health and access to care among nonmetropolitan Veterans Health Administration patients younger than 65 years. *J Rural Health*. 2006;22(1):9-16. https://doi.org/10.1111/j.1748-0361.2006.00014.x
13. Cukrowicz KC, Brown SL, Mitchell SM, Roush JF, Hirsch JK. Feasibility of assessing suicide ideation and history of suicidal behavior in rural communities. *Suicide Life Threat Behav*. 2018;48(5):522-530. https://doi.org/10.1111/sltb.12378
14. McCarthy JF, Blow FC, Ignacio RV, Ilgen MA, Austin KL, Valenstein M. Suicide among patients in the Veterans Affairs health system: rural-urban differences in rates, risks, and methods. *Am J Public Health*. 2012;102(Suppl 1):S111-S117. https://doi.org/10.2105/AJPH.2011.300463
15. Bonnar KK, McCarthy M. Health related quality of life in a rural area with low racial/ethnic density. *J Community Health*. 2012;37(1):96-104. https://doi.org/10.1007/s10900-011-9422-2
16. *Recommended standard care for people with suicide risk: making health care suicide safe*. National Action Alliance for Suicide Prevention. Education Development Center, Inc.; Published 2018. Accessed October 4, 2021. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
17. Stuck AR, Wilson MP, Chalmers CE, et al. Healthcare usage and suicide risk screening within one year of suicide death. *J Emerg Med*. 2017;53(6):871-879. https://doi.org/10.1016/j.jemermed.2017.06.033
18. R3 report: requirement, rationale, reference. The Joint Commission. Published November 20, 2019. Accessed November 8, 2021. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf.
19. Facts about suicide. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Published April 2021. Accessed October 4, 2021. https://www.cdc.gov/suicide/facts/index.html
20. Carroll R, Metcalfe C, Gunnell D. Hospital management of self-harm patients and risk of repetition: systematic review and meta-analysis. *J Affect Disord*. 2014;168:476-483. https://doi.org/10.1016/j.jad.2014.06.027
21. Bolster C, Holliday C, O'Neal G, Shaw M. Suicide assessment and nurses: what does the evidence show? *Online J Issues Nurs*. 2015;20(1):2. https://doi.org/10.3912/OJIN.Vol20No01Man02

22. Clua-García R, Casanova-Garrigós G, Moreno-Poyato AR. Suicide care from the nursing perspective: a meta-synthesis of qualitative studies. *J Adv Nurs*. 2021;77(7):2995-3007. https://doi.org/10.1111/jan.14789
23. Runeson B, Odeberg J, Pettersson A, Edbom T, Jildevik Adamsson I, Waern M. Instruments for the assessment of suicide risk: a systematic review evaluating the certainty of the evidence. *PLoS One*. 2017;12(7):e0180292. https://doi.org/10.1371/journal.pone.0180292
24. Office of the Surgeon General. National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*. 2012. US Department of Health & Human Services.
25. Columbia-Suicide Severity Rating Scale (C-SSRS) risk assessment (lifeline crisis center version). https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf
26. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x
27. Zero Suicide Institute. Toolkit: engage. Education Development Center. Accessed March 30, 2022. https://zerosuicide.edc.org/toolkit/evidence-base/engage
28. Zero Suicide Institute. Toolkit: treat-intervention/treatment. Education Development Center. Accessed March 30, 2022. https://zerosuicide.edc.org/toolkit/treat/interventiontreatment#footnote1_
29. Damschroder LJ, Lowery JC. Evaluation of a large-scale weight management program using the consolidated framework for implementation research (CFIR). *Implement Sci*. 2013;8(1):51. https://doi.org/10.1186/1748-5908-8-51
30. The Consolidated Framework for Implementation Research–Technical Assistance for Users of the CFIR Framework. Center for Clinical Management Research. Consolidated framework for implementation research team. Accessed March 3, 2018. https://cfirguide.org/
31. Tong A, Sainsury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349-357. https://doi.org/10.1093/intqhc/mzm042
32. *Arkansas vital statistics.* Suicide Rates in Arkansas. Arkansas Department of Health; 2017.
33. Veteran population projection model 2016. Office of Enterprise Integration, Data Governance & Analytics. U.S. Department of Veterans Affairs. Published June 2017. Accessed September 15, 2017. https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/Vetpop16_Executive_Summary.pdf
34. Miller M, Hemenway D. Guns and suicide in the United States. *N Engl J Med*. 2008;359(10):989-991. https://doi.org/10.1056/nejmp0805923
35. America's Health Rankings analysis of CDC WONDER. multiple cause of death files, explore suicide in Arkansas–2019 annual report. United Health Foundation. America's Health Rankings. Accessed March 30, 2022. https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/AR
36. Anestis MD, Anestis JC. Suicide rates and state laws regulating access and exposure to handguns. *Am J Public Health*. 2015;105(10):2049-2058. https://doi.org/10.2105/ajph.2015.302753
37. Anestis M, Capron DW. The associations between state veteran population rates, handgun legislation, and statewide suicide rates. *J Psychiatr Res*. 2016;74:30-34. https://doi.org/10.1016/j.jpsychires.2015.12.014
38. Audacity. Softonic. Accessed October 4, 2021. https://audacity.en.softonic.com/?ex=BB-1857.0
39. Muhr T, Friese S. *User's manual for ATLAS*. Scientific Software Development; 2004.
40. Bernard HR, Ryan GW, Wutich AY. *Analyzing Qualitative Data: Systematic Approaches*. Sage Publications; 2010.
41. Guba EG, Lincoln YS. *Naturalistic Inquiry*. Sage Publications; 1985.
42. Morse M, Field A. *Qualitative Research Methods for Health Professionals*. Sage Publications; 1995.
43. Speziale HJ, Carpenter DR. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 5th ed. Lippincott Williams and Wilkins; 2011.
44. Wilson M, Moutier C, Wolf L, Nordstrom K, Schulz T, Betz ME. ED recommendations for suicide prevention in adults: The ICAR2E mnemonic and a systematic review of the literature. *Ann Emerg Med*. 2020;38(3):571-581. https://doi.org/10.1016/j.ajem.2019.06.031
45. Betz ME, Wintersteen M, Boudreaux ED, et al. Reducing suicide risk: challenges and opportunities in the emergency department. *Ann Emerg Med*. 2016;68(6):758-765. https://doi.org/10.1016/j.annemergmed.2016.05.030
46. Wilson MP, Moutier C, Wolf L, Nordstrom K, Schulz T, Betz ME. Emergency department recommendations for suicide prevention in adults: the. *Am J Emerg Med*. 2020;38(3):571-581. https://doi.org/10.1016/j.ajem.2019.06.031
47. Betz ME, Boudreaux ED. Managing suicidal patients in the emergency department. *Ann Emerg Med*. 2016;67(2):276-282. https://doi.org/10.1016/j.annemergmed.2015.09.001
48. Caring for adult patients with suicide risk a consensus guide for emergency departments. Suicide Prevention Resource Center. Education Development Center, Inc.; Published 2015. http://www.sprc.org/sites/default/files/EDGuide_full.pdf. [Accessed 30 May 2018].
49. McMyler C, Prymachuk S. Do no-suicide contracts work? *J Psychiatr Ment Health Nurs*. 2008;15(6):512-522. https://doi.org/10.1111/j.1365-2850.2008.01286.x
50. Stanley B, Brown GK. Safety planning intervention: a brief intervention to mitigate suicide risk. *Cogn Behav Pract*. 2012;19(2):256-264. https://doi.org/10.1016/j.cbpra.2011.01.001
51. Stanley B, Brown GK, Brenner LA, et al. Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*. 2018;75(9):894-900. https://doi.org/10.1001/jamapsychiatry.2018.1776
52. Diurba S, Johnson RL, Siry BJ, et al. Lethal means assessment and counseling in the emergency department: differences by provider type and personal home firearms. *Suicide Life Threat Behav*. 2020;50(5):1054-1064. https://doi.org/10.1111/sltb.12649
53. Boggs JM, Quintana LAM, Powers JD, Hochberg S, Beck A. Frequency of clinicians' assessments for access to lethal means in persons at risk for suicide. *Arch Suicide Res*. 2020:1-10. https://doi.org/10.1080/13811118.2020.1761917
54. Luxton DD, June JD, Comtois KA. Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the

evidence. *Crisis*. 2013;34(1):32-41. https://doi.org/10.1027/0227-5910/a000158

55. Veterans Health Administration. TRAIN. Learning Network. Train.org. Accessed December 7, 2021. https://www.train.org/vha/welcome
56. Ostacher MJ, Cifu AS. Management of posttraumatic stress disorder. *J Am Med Assoc*. 2019;321(2):200-201. https://doi.org/10.1001/jama.2018.19290
57. *VA/DOD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder*. Department of Veterans Affairs. Department of Defense; Published June 2017. Accessed October 10, 2021 https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf
58. Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). National Center for PTSD. Accessed October 10, 2021. https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf
59. PTSD: national center for PTSD. US Department of Veterans Affairs. Accessed October 10, 2021. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp#obtain