Suicide Risk Assessment & Safety Planning as a Stand Alone Intervention

VISN 19 Mental Illness, Research, Education and Clinical Center (MIRECC)

Revised November 2012

Disclosure

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"I think it took awhile before I realized and then when I started thinking about things and realizing that I was going to be like this for the rest of my life, it gives me a really down feeling and it makes me think like—why should I be around like this for the rest of my life?"

- VA Patient/TBI Survivor

Agenda

- Introduction
- Facts about Veteran Suicide
- Developing a Common Language – Self Directed Violence Classification System (SDVCS)
- Suicide Risk Assessment
- Safety Planning
- Role-play

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Facts about Veteran Suicide

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Facts about Veteran Suicide

- ~34,000 US deaths from suicide/ year

  (Centers for Disease Control and Prevention)

- ~20% are Veterans

  (National Violent Death Reporting System)

- ~18 deaths from suicide/day are Veterans

  (National Violent Death Reporting System)

- ~ 5 deaths from suicide/day among Veterans receiving care in VHA.

  (VA Serious Mental Illness Treatment, Research and Evaluation Center)

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Facts about Veteran Suicide

- More than 60% of suicides among those who utilize VHA services are among patients with a known diagnosis of a mental health condition
  (VA Serious Mental Illness Treatment Research and Education Center)

- Veterans are more likely to use firearms as a means
  (National Violent Death Reporting System)

- ~1000 attempts/month among Veterans receiving care in VHA as reported by suicide prevention coordinators.
  (VA National Suicide Prevention Coordinator)

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OEF/OIF/OND Veterans

- In FY2008, the suicide rate for Veterans *enrolled in VHA* was:
  - **38.6** per 100,000 OEF/OIF
  - 36.5 per 100,000 non OEF/OIF
- In FY2009, the suicide rate was:
  - **31.4** per 100,000 OEF/OIF
  - 36.4 per 100,000 non OEF/OIF

(Blow & Jemp, 2011)

- In 2009, the suicide rate for the general US population was **13.68** per 100,000

(Center for Disease Control and Prevention)

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VA Suicide Prevention Efforts

- Annual depression and PTSD screens
- For each Veteran determined to be at high risk:
  - A VA Safety Plan is created
  - A suicide risk flag is placed in their medical record
- Every VAMC is staffed with a suicide prevention coordinator
- VA Crisis Line (1-800-273-TALK)
- Online chat (www.veteranscrisisline.net/chat)
- Text option (838255)

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Is a common language necessary to facilitate suicide risk assessment?

Do we have a common language?

Case Example 1

A healthy 21-year-old female is brought by her boyfriend to the Emergency Department after telling him she ingested 4-6 regular strength acetaminophen [Tylenol] capsules (1300-1950 mg total dose). She reports no ill effects. Lab tests done at the time of admission to the ED reported her acetaminophen level within the therapeutic range. Four hours later, lab tests reported levels within the low therapeutic range. During triage, she states that before she took the capsules, she was upset and wished she was dead. She feels better now and requests to go home.

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The Language of Self-Directed Violence

Identification of the Problem

- Suicidal ideation
- Death wish
- Suicidal threat
- Cry for help
- Self-mutilation
- Parasuicidal gesture
- Suicidal gesture
- Risk-taking behavior
- Self-harm
- Self-injury
- Suicide attempt
- Aborted suicide attempt
- Accidental death
- Unintentional suicide
- Successful attempt
- Completed suicide
- Life-threatening behavior
- Suicide-related behavior
- Suicide

The Language of Suicidology

Implications of the Problem

- Clinical
- Research
- Public Health

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The Language of Self-Directed Violence

A Solution to the Problem

Nomenclature (def.):

- a set of commonly understood
- widely acceptable
- comprehensive
- terms that define the basic clinical phenomena (of suicide and suicide-related behaviors)
- based on a logical set of necessary component elements that can be easily applied

Silverman et al 2006

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Nomenclature: **Essential Features**

- enhance clarity of communication
- have applicability across clinical settings
- be theory neutral
- be culturally neutral
- use mutually exclusive terms that encompass the spectrum of thoughts and actions

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Classification System

Essential Features

- “Exhaustive”
- Builds upon a nomenclature
- Further differentiates between like phenomena

Silverman et al 2006

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Self-Directed Violence Classification System

Lisa A. Brenner, Ph.D.
Morton M. Silverman, M.D.
Lisa M. Betthauser, M.B.A.
Ryan E. Breshears, Ph.D.
Katherine K. Bellon, Ph.D.
Herbert. T. Nagamoto, M.D.

Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	N/A	•Non-Suicidal Self-Directed Violence Ideation
	Suicidal Ideation	Self-reported thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.	•Suicidal Intent -Without -Undetermined -With	•Suicidal Ideation, Without Suicidal Intent •Suicidal Ideation, With Undetermined Suicidal Intent •Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.	• Suicidal Intent -Without -Undetermined -With	•Non-Suicidal Self-Directed Violence, Preparatory •Undetermined Self-Directed Violence, Preparatory •Suicidal Self-Directed Violence, Preparatory
	Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	• Injury -Without -With -Fatal • Interrupted by Self or Other	•Non-Suicidal Self-Directed Violence, Without Injury •Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, With Injury •Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, Fatal
	Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); **OR** the person is reluctant to admit positively to the intent to die for other or unknown reasons.	• Injury -Without -With -Fatal • Interrupted by Self or Other	•Undetermined Self-Directed Violence, Without Injury •Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, With Injury •Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, Fatal
	Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with a wish to die cutting her wrist with a knife would be classified as Suicide Attempt, With Injury.	• Injury -Without -With -Fatal • Interrupted by Self or Other	•Suicide Attempt, Without Injury •Suicide Attempt, Without Injury, Interrupted by Self or Other •Suicide Attempt, With Injury •Suicide Attempt, With Injury, Interrupted by Self or Other •Suicide

Self-Directed Violence (SDV) Classification System
Clinical Tool

BEGIN WITH THESE 3 QUESTIONS:

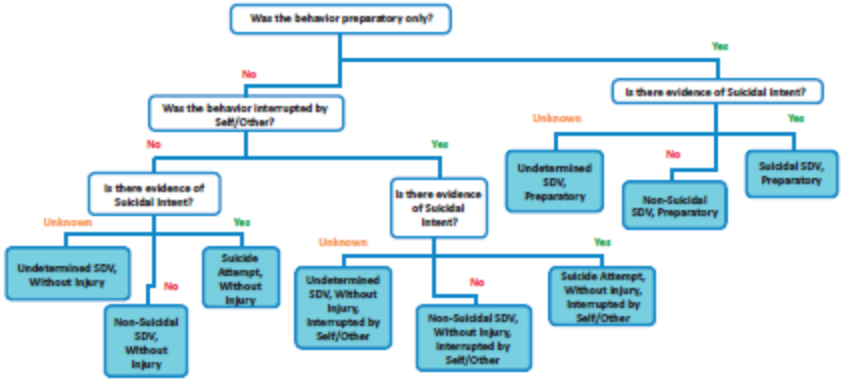
1. Is there any indication that the person engaged in self-directed violent behavior that was lethal, preparatory, or potentially harmful? (Refer to Key Terms on reverse side)
   If NO, proceed to Question 2
   If YES, proceed to Question 3

2. Is there any indication that the person had self-directed violence related thoughts?
   If NO to Questions 1 and 2, there is insufficient evidence to suggest self-directed violence → NO SDV TERM
   If YES, proceed to Decision Tree A

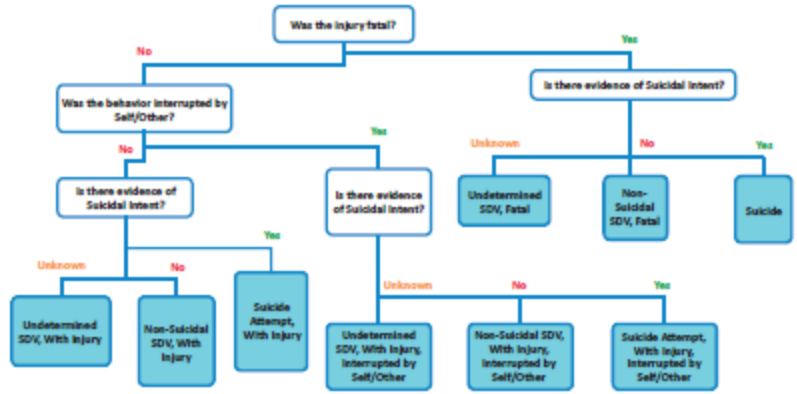
3. Did the behavior involve any injury or did it result in death?
   If NO, proceed to Decision Tree B
   If YES, proceed to Decision Tree C

DECISION TREE A: THOUGHTS

DECISION TREE B: BEHAVIORS, WITHOUT INJURY



DECISION TREE C: BEHAVIORS, WITH INJURY



Self-Directed Violence (SDV) Classification System
Clinical Tool

Key Terms (Centers for Disease Control and Prevention)

Self-Directed Violence:	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.
Suicidal Intent:	There is past or present evidence (explicit and/or implicit) that the individual intended to kill him/herself and wished to die, and that he/she understood the probable consequences of his/her actions or potential actions.
Preparatory Behavior:	Acts or preparation towards imminently making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
Physical Injury (paraphrased):	A bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance (e.g., bodily harm due to suffocation, poisoning or overdoses, lacerations, gunshot wounds, etc.). Refer to the Classification System for the full CDC definition.
Interrupted By Self or Other	A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point.
Suicide Attempt:	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior
Suicide:	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior

Reminder: Behaviors Trump Thoughts

Now that we are using a common language

How should we be assessing risk?

Suicide Risk Assessment

- Refers to the establishment of a
  - clinical judgment of risk in the near future,
  - based on the weighing of a very large amount of available clinical detail.

Jacobs 2003

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We assess risk to…

Identify modifiable and treatable risk factors that inform treatment

Simon 2001

Take care of our patients

We should also assess to…Take care of ourselves

- Risk management is a reality of psychiatric practice
- 15-68% of psychiatrists have experienced a patient suicide (Alexander 2000, Chemtob 1988)
- About 33% of trainees have a patient die by suicide
- Paradox of training - toughest patients often come earliest in our careers

Good Clinical Practice is the Best Medicine

- Evaluation
  - Accurate diagnosis
  - Systematic suicide risk assessment
  - Get/review prior treatment records
- Treatment
  - Formulate, document, and implement a cogent treatment plan
  - Continually assess risk
- Management
  - Safety management (hospitalize, safety plans, precautions, etc)
  - Communicate and enlist support of others for patient's suicide crisis

"Never worry alone." (Gutheil 2002)

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Suicide Risk Assessment

- No standard of care for the prediction of suicide
- Suicide is a rare event
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment
- Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients

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Suicide Risk Assessment

- Standard of care does require suicide risk assessment whenever indicated
- Best assessments will attend to both risk and protective factors
- Risk assessment is not an event, it is a process
- Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
- Research identifying risk and protective factors enables evidence-based treatment and safety management decision making

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Suicide Assessment Indications

- Emergency department or crisis evaluation
- Intake evaluation
- ***Prior to change in observation status or treatment setting***
- Abrupt change in clinical presentation
- Lack of improvement or gradual worsening with treatment
- Anticipation/experience of loss or stressor
- Onset of physical illness

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Important Domains of a Suicide-Focused Psychiatric Interview

- Psychiatric Illness
- History
- Psychosocial situation
- Individual strengths and vulnerabilities
- Current presentation of suicidality
  - Specifically inquire about suicidal thoughts, plans and behaviors

APA Practice Guidelines (2003)

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Elicit any suicidal ideation
  - Focus on nature, frequency, extent, timing
  - Assess feelings about living
- Presence or Absence of Plan
  - What are plans, what steps have been taken
  - Investigate patient's belief regarding lethality
  - Ask what circumstances might lead them to enact plan
  - Ask about GUNS and address the issue

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Assess patient's degree of suicidality, including intent and lethality of the plan
  - Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  - Realize that suicide assessment scales have low predictive values
- ***Strive to know your patient and their specific or idiosyncratic warning signs***

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Identify Suicide Risk Factors

- Specific factors that may generally increase risk for suicide or other self-directed violent behaviors
- A major focus of research for past 30 years
- Categories of risk factors
  - Demographic
  - Psychiatric
  - Psychosocial stressors
  - Past history

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Warning Signs

- Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior
- Proximal to the suicidal behavior and imply imminent risk
- The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment

Rudd et al. 2006

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Risk Factors vs. Warning Signs

Characteristic Feature	Risk Factor	Warning Sign
Relationship to Suicide	Distal	Proximal
Empirical Support	Evidence-base	Clinically derived
Timeframe	Enduring	Imminent
Nature of Occurrence	Relatively stable	Transient
Implications for Clinical Practice	At times limited	Demands intervention

Rudd et al. 2006

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Risk Factors vs. Warning Signs

Risk Factors	Warning Signs
•Suicidal ideas/behaviors •Psychiatric diagnoses •Physical illness •Childhood trauma •Genetic/family effects •Psychological features (i.e. hopelessness) •Cognitive features •Demographic features •Access to means •Substance intoxication •Poor therapeutic relationship	•Threatening to hurt or kill self or talking of wanting to hurt or kill him/herself • Seeking access to lethal means •Talking or writing about death, dying or suicide •Increased substance (alcohol or drug) use •No reason for living; no sense of purpose in life •Feeling trapped - like there's no way out •Anxiety, agitation, unable to sleep • Hopelessness •Withdrawal, isolation

Determine if factors are modifiable

Non-modifiable Risk Factors

- Family History
- Past history
- Demographics

Modifiable Risk Factors

- Treat psychiatric symptoms
- Increase social support
- Remove access to lethal means

Develop a Treatment Plan

- For the suicidal patient, particular attention should be paid to modifiable risk and protective factors
- Static risk factors help stratify level of risk, but are typically of little use in treatment; can't change age, gender, or history
- Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc

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Don’t Neglect Modifiable Protective Factors

- These are often key to addressing long-term or chronic risk
- Sense of responsibility to family
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Enhanced social support
- Positive therapeutic relationships

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Acute v. Chronic Risk

- These are very different, and each carry there own specific treatment/safety

  A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

- Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk

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Acute v. Chronic Risk

- Acute and chronic risk are dissociable
- Document estimation for each

  "Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior."

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Assessment Measures

Elements of Useful Assessment Tools

- Clear operational definitions of construct assessed
- Focused on specific domains
- Developed through systematic, multistage process
  - empirical support for item content, clear administration and scoring instructions, reliability, and validity
- Range of normative data available

Gutierrez and Osman, 2008

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Self-Report Measures

- Advantages
  - Fast and easy to administer
  - Patients often more comfortable disclosing sensitive information
  - Quantitative measures of risk/protective factors

- Disadvantages
  - Report bias
  - Face validity

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Suicide Specific Self-Report Measures

- Self-Harm Behavior Questionnaire (SHBQ; Gutierrez et al., 2001)
- Reasons for Living Inventory (RFL; Linehan et al., 1983)
- Suicide Cognitions Scale-Revised (SCS-R; Rudd, 2004)
- Beck Scale for Suicidal Ideation (BSS; Beck, 1991)

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Sample SHBQ Question

Times you hurt yourself badly on purpose or tried to kill yourself.

2. Have you ever attempted suicide? **YES** **NO**

If no, go on to question # 4.

If yes, how? _____

(**Note:** if you took pills, what kind? _____; how many? _____ ; over how long a period of time did you take them? _____)

a. How many times have you attempted suicide? _____

b. When was the most recent attempt? *(write your age)* _____

c. Did you tell anyone about the attempt? **YES** **NO**

Who? _____

d. Did you require medical attention after the attempt? **YES** **NO**

If yes, were you hospitalized over night or longer? **YES** **NO** How long were you hospitalized? _____

e. Did you talk to a counselor or some other person like that after your attempt? **YES** **NO** Who? _____

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Sample RFL Items

____ 1. I have a responsibility and commitment to my family.

____ 2. I believe I can learn to adjust or cope with my problems.

____ 3. I believe I have control over my life and destiny.

____ 4. I have a desire to live.

____ 5. I believe only God has the right to end a life.

____ 6. I am afraid of death.

____ 7. My family might believe I did not love them.

____ 8. I do not believe that things get miserable or hopeless enough that I would rather be dead.

____ 9. My family depends upon me and needs me.

____ 10. I do not want to die.

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Sample SCS-R Items

1) The world would be better off without me.
2) Suicide is the only way to solve my problems.
3) I can't stand this pain anymore.
4) I am an unnecessary burden to my family.
5) I've never been successful at anything.
6) I can't tolerate being this upset any longer.
7) I can never be forgiven for the mistakes I have made.
8) No one can help solve my problems.
9) It is unbearable when I get this upset.
10) I am completely unworthy of love.

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“Although self-report measures are often used as screening tools, an adequate evaluation of suicidality should include
both interviewer-administered and self-report measures.”

http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-113.pdf

Population of Interest: Operation Enduring Freedom/Operation Iraqi Freedom

At risk for traumatic brain injury (TBI), post traumatic stress disorder, and suicide

Can we draw from what we know about these conditions, suicidology, and rehabilitation medicine to identify novel means of assessing risk?

OIF and Suicide/Homicide

- **425** patients (Feb – Dec, 2004) – Evaluated by the MH Team at Forward Operational Base Speicher
  - 23% Reserves, 76% Active Duty Army, 1% Active Duty AF
    - 19% Combat Units, 81% Support Units
      - 127 had thought of ending life in the past week
        - 81 had a specific suicide plan
      - 26 had acted in a suicidal manner (e.g. placed weapon to their head)
      - 67 had the desire to kill somebody else (not the enemy)
        - 36 had formed a plan to harm someone else
          - 11 had acted on the plan
- **75** of the cases were deemed severe enough to require immediate mental health intervention
  - Of the 75 soldiers, 70 were treated in theater and returned to duty
    - **5 were evacuated**

Hill et al 2006

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Risk Factors for those with a History of TBI

Individuals with a history of TBI are at increased risk of dying by suicide

Members of the military are sustaining TBIs

Role of Pre-injury vs. Post-Injury Risk Factors

Post-injury psychosocial factors, in particular the presence of **post injury emotional/psychiatric disturbance** (E/PD) had far greater significance than pre-injury vulnerabilities or injury variables, in predicting elevated levels of suicidality post injury.

Higher levels of hopelessness were the strongest predictor of suicidal ideation, and high levels of SI, in association E/PD was the strongest predictor of post-injury attempts

Simpson and Tate 2002

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Respondents with a co-morbid history of psychiatric/emotional disturbance **and** substance abuse were 21 times more likely to have made a post-TBI suicide attempt.

Simpson and Tate 2005

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TBI – Symptoms, Functioning and Outcomes

Qualitative Analysis of Suicide Precipitating Events, Protective Factors and Prevention Strategies among Veterans with Traumatic Brain Injury

Brenner, L., Homaifar, B., Wolfman, J., Kemp, J., & Adler, L., Qualitative Analysis of Suicide Precipitating Events, Protective Factors and Prevention Strategies among Veterans with Traumatic Brain Injury, Rehabilitation Psychology.

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Cognitive Impairment and Suicidality

- “I knew what I wanted to say although I'd get into a thought about half-way though and it would just dissolve into my brain. I wouldn't know where it was, what it was and five minutes later I couldn't even remember that I had a thought. And that added to a lot of frustration going on….and you know because of the condition a couple of days later you can't even remember that you were frustrated.”

- “I get to the point where I fight with my memory and other things…and it’s not worth it.”

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Emotional and Psychiatric Disturbances and Suicidality

- I got depressed about a lot of things and figured my wife could use a $400,000 tax-free life insurance plan a lot better than….I went jogging one morning, and was feeling this bad, and I said "well, it's going to be easy for me to slip and fall in front of this next truck that goes by…"

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Loss of Sense of Self and Suicidality

- Veterans spoke about a shift in their self-concepts post-injury, which was frequently associated with a sense of loss
  - "…when you have a brain trauma…it's kind of like two different people that split…it's kind of like a split personality. You have the person that's still walking around but then you have the other person who's the brain trauma."

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Evidence-Based Measures: Suicidality in Those With TBI:

1

RESEARCH NEEDED!!!

PTSD and Suicide

Members of the military developing PTSD

Those with PTSD at Increased Risk for Suicidal Behavior

14.9 times more likely to attempt suicide than those without PTSD

(community sample)

Davidson et al 1991

Why?

- Veteran Population
  - Survivor guilt (Hendin and Haas, 1991)
  - Being an agent of killing (Fontana et al., 1992)
  - Intensity of sustaining a combat injury (Bullman and Kang, 1996)

Self-harm as a means of regulating overwhelming internal experiences

unwanted emotions

flashbacks

unpleasant thoughts

Post-Traumatic Symptoms and Suicidality

- Avoidance/Numbing
- Hyperarousal
- Re-experiencing

Re-experiencing Symptom Cluster Associated with Suicidal Ideation

Nye et al., 2007

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A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

Brenner LA, Gutierrez PM, Cornette MM, Betthauser LM, Bahraini N, Staves P. A qualitative study of potential suicide risk factors in returning combat veterans. Journal of Mental Health Counseling. 2008;30(3): 211-225.. 2009; 24(1):14-23.

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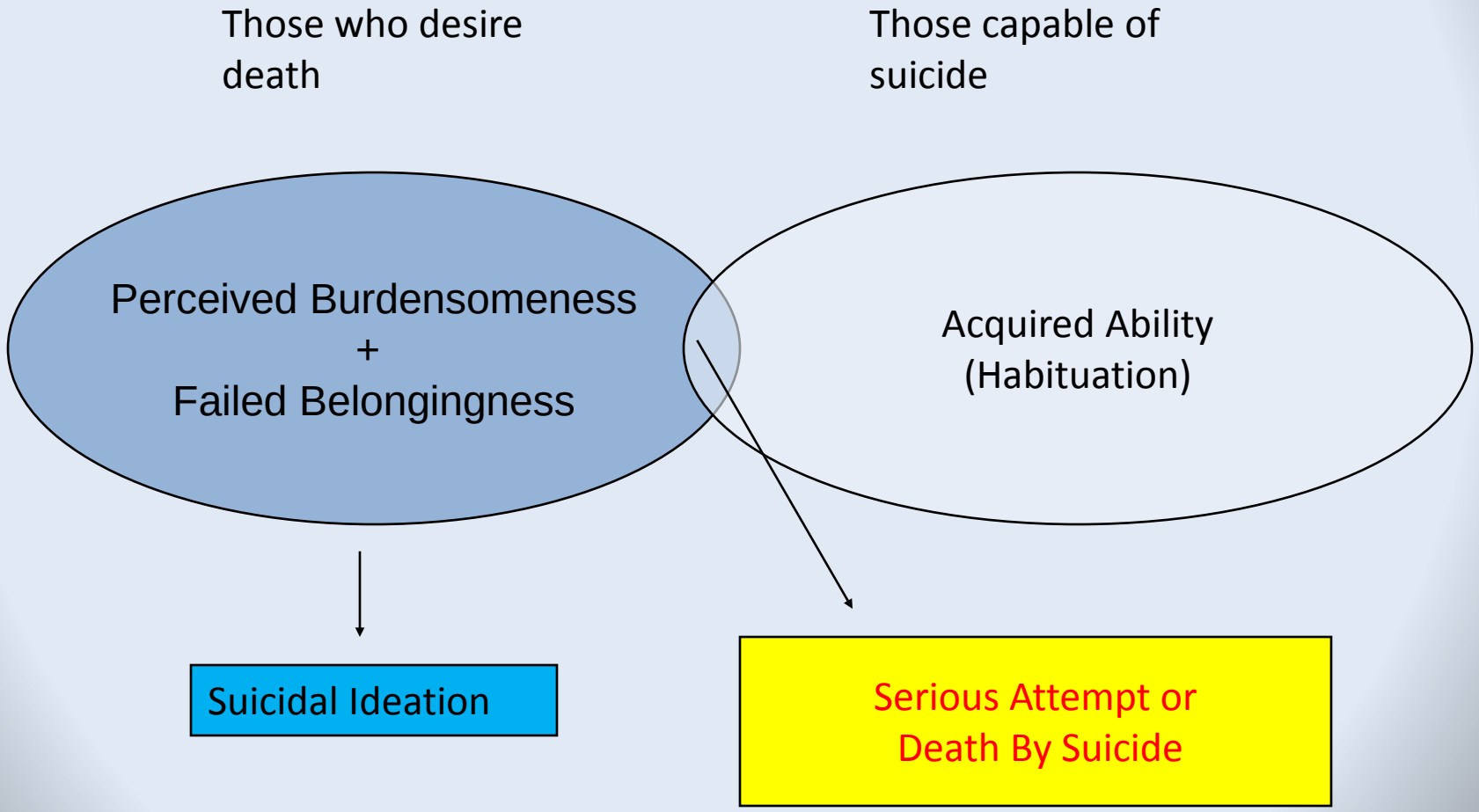
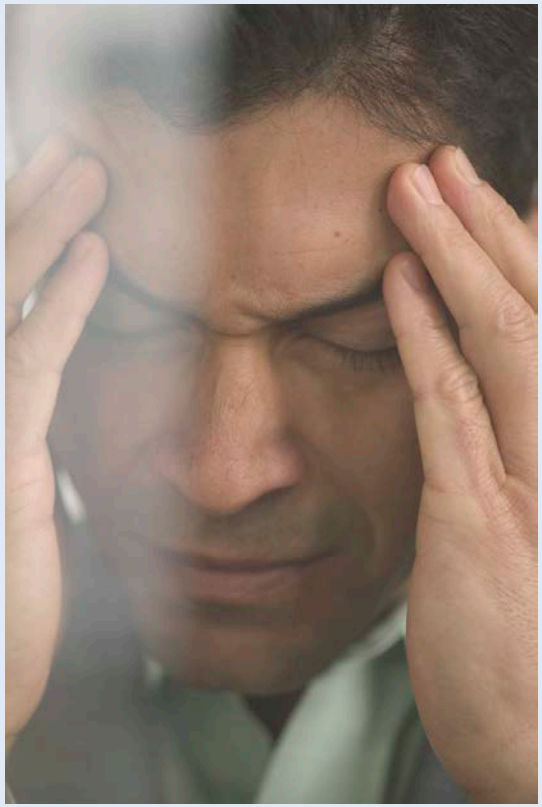
Interpersonal-Psychological Theory of Suicide Risk

Joiner 2005



Themes

- Combat experiences were a setting for exposure to pain
- It takes more to be hurt now than in the past
- Increased tolerance for pain in conjunction with a variety of maladaptive coping strategies



Pain

- “I think that during the time that I was overseas I ah, kind of lost connection with reality and lost connection with my feelings…if you don’t have any emotions, then you are not scared or afraid either, which really helps you to get through the days in such a dangerous environment.”

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Belongingness

- Feeling disconnection from civilians and/or society in general

- “I separate myself from society, that part of society. I don’t know how to deal with those people….I just keep myself away.”

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Findings – Belongingness

- “That connection [to other veterans] never weakens. That’s the strange thing about it. I mean I may not communicate as much with active duty soldiers, soldiers from my unit…but every where I go, I run into vets. It’s just the way of life, and we talk and we talk about things we’ve done…”

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Belongingness

- Loss of sense of self post-discharge
  - This loss seemed to be exacerbated when separation from the military was not their choice

- “They made me retire when I got back from this one, and it wasn't a choice…I still haven’t redefined who I am.”

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Burdensomeness

- Despite ambivalence - veterans reported feeling a sense of importance regarding their mission overseas relative to their civilian avocational and occupational activities

- “I said I'm going to try and find something where I don't have to worry about hurting people. That would be nice for once in my life, but I don't know what that is. So I'm trying to redefine myself.”

Burdensomeness

- “I feel like I am burden, 100%, I don’t feel like I belong anywhere … like if I'm out with some friends, I don't feel like I belong. Family, I'm the outsider.”

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The International Classification of Functioning (ICF)

- Disability – impairment in bodily function (e.g., cognitive dysfunction)
- Activity limitation – "…difficulties an individual may have in executing" a task or action (e.g., not being able to drive)
- Participation restriction – "…problems an individual may experience in involvement with life situations" (e.g., not being able to work)

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The International Classification of Functioning (ICF)

Model developed by the World Health Organization (WHO)

Means of understanding factors that can impact how people live with TBI

REGARDLESS OF INJURY SEVERITY

Key Terms

- Disability – impairment in bodily function (e.g., cognitive dysfunction)
- Activity limitation – "…difficulties an individual may have in executing" a task or action (e.g., not being able to drive)
- Participation restriction – "…problems an individual may experience in involvement with life situations" (e.g., not being able to work)

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It is necessary to consider individual functioning and disability post-TBI in the context of personal and environmental factors

History of combat experience

Pre-TBI history of depression

Limited public transportation

Limited social supports

TBI and Suicide Risk Assessment Strategy

- Assess for
  - Acquired Ability
  - Burdensomeness
  - Failed Belongingness
- In the context of
  - Disability
  - Activity limitation
  - Participation restriction

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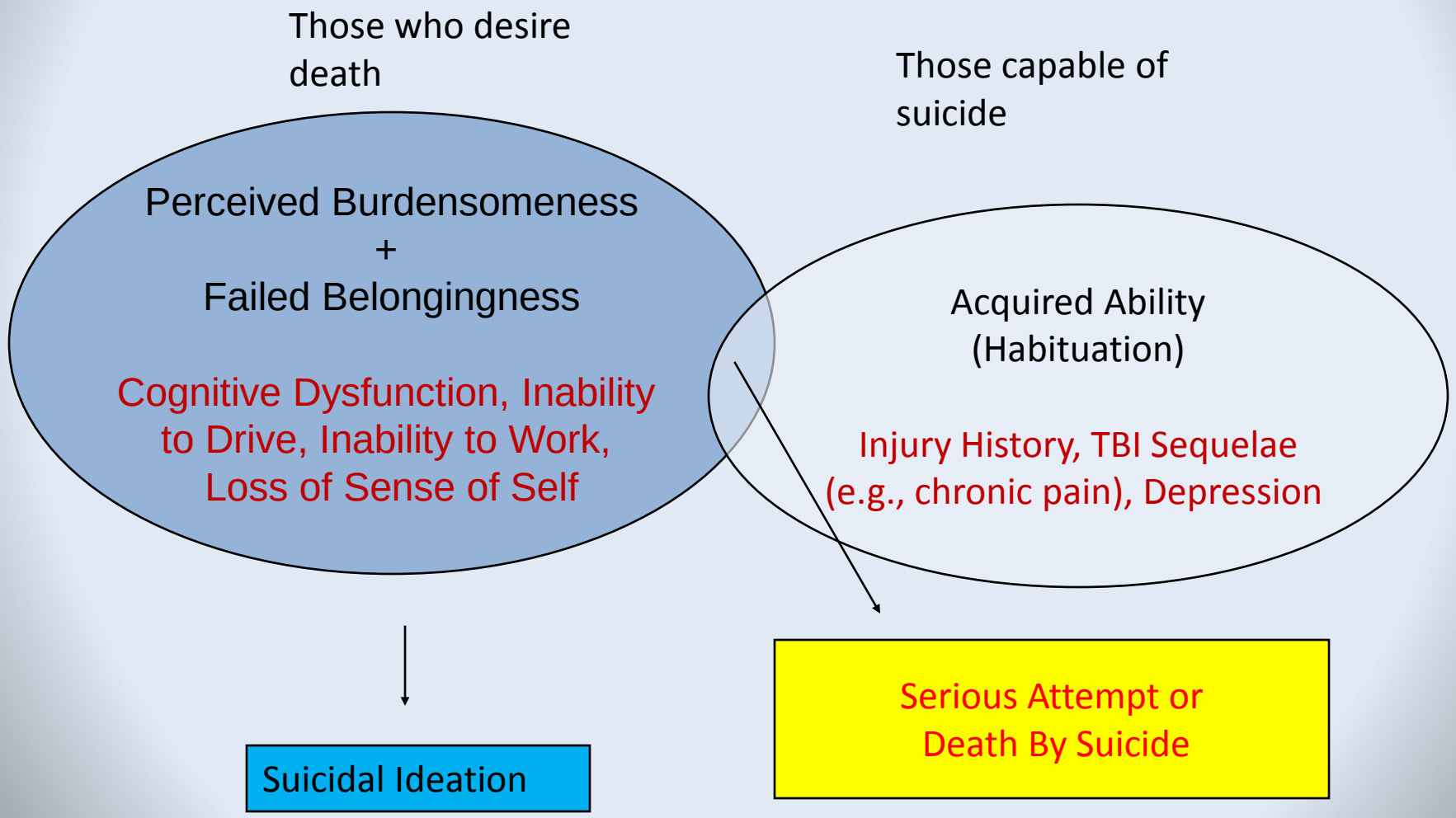
Interpersonal-Psychological Theory of Suicide Risk

Joiner 2005



Clinical Consultation Services for Providers with Patients at Suicide Risk

Professional Psychology: Research and Practice
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Consultation as a Means of Veteran Suicide Prevention

Peter M. Gutierrez and Lisa A. Brenner
Denver VA Medical Center and University of Colorado Denver School of Medicine

Jennifer H. Olson-Madden, Ryan E. Breshears, Beeta Y. Homaifar, Lisa M. Betthauser, and Pamela Staves
Denver VA Medical Center

Lawrence E. Adler
Denver VA Medical Center and University of Colorado Denver School of Medicine

The development and implementation of a suicide consultation service being run by an interdisciplinary team in a metropolitan Veteran's Administration (VA) medical center is described. This service is grounded in a collaborative theoretical framework. An overview of the consultation process and theoretical and empirical literature to support the framework used by the service are provided. Some of the interventions commonly recommended to referring clinicians to reduce client suicide risk are reviewed. Although there are many challenges to running a service such as this, the authors conclude that the model presented is flexible enough to be applied in a variety of settings.

Keywords: suicide, veterans, consultation, assessment, collaboration

What options exist for mental health providers to increase clinical competence in working with high-risk suicidal patients? To whom can clinicians turn for help with case conceptualization and treatment planning? By what means can clients become increasingly engaged in their own treatment? In order to address these clinical issues within a Veteran Affairs (VA) Medical Center setting, a novel suicide prevention consultation service was developed. This service was organized by an interdisciplin-

Peter M. Gutierrez received his PhD in clinical psychology from the University of Michigan. He is a clinical/research psychologist and Assistant Director of Psychology Training at the VA VISN 19 Mental Illness Research, Education and Clinical Center. He is also an associate professor in the Department of Psychiatry at the University of Colorado Denver School of Medicine. His areas of research and practice include veteran suicide, assessment of risk and protective factors for suicide, scale development, and psychometrics.

Lisa A. Brenner received her PhD in clinical psychology from The Wright Institute and is ABPP-certified in Rehabilitation Psychology. She is the Director of Education and the Psychology Training Program for the VISN 19 Mental Illness Research Education and Clinical Center. She is also a research psychologist at Craig Hospital, and an assistant professor in the Departments of Psychiatry and Neurology, and an assistant clinical professor in Physical Medicine & Rehabilitation at the University of Colorado, School of Medicine. Her areas of research include suicide, traumatic brain injury, and posttraumatic stress disorder.

Jennifer H. Olson-Madden received her PhD in Counseling Psychology from the University of Denver. She is a Senior Psychology Post-doctoral Fellow at the VA VISN 19 Mental Illness Research, Education and Clinical Center. Her areas of professional interest include psychotherapy and consultation; rehabilitation psychology with a particular emphasis in the assessment and treatment of traumatic brain injury and co-occurring Psychiatric disorders; suicide prevention; and veterans' issues.

Ryan E. Breshears received his PhD in counseling psychology from the University of Georgia. He is currently a postdoctoral clinical psychology fellow at the VA VISN 19 Mental Illness Research, Education and Clinical Center. His research interests include psychological assessment, consultation, theories and clinical assessment of suicidal behavior, health psychology, and psychological test development.

Beeta Y. Homaifar received her PhD in Counseling Psychology from the University of Iowa. She is a research/clinical psychologist at the VA VISN 19 MIRECC and coordinates clinical activities of the Consultation Service. Her research and professional interests include suicide assessment and consultation; and the interplay of executive functioning and suicidality.

Lisa M. Betthauser received her MBA in Health Administration from the University of Colorado at Denver and the Health Sciences Center. She is a Study Coordinator for the Mental Illness, Research, Education and Clinical Center (MIRECC) at the Denver Veteran's Affairs Medical Center. She supports research at the MIRECC specifically in the areas of suicide, posttraumatic stress disorder and traumatic brain injury. She has professional interest in resilience and mindfulness-based therapies.

Pamela Staves received her MS in psychiatric mental health nursing from the University of Colorado. She is board certified as a Psychiatric Nurse Clinical Specialist and Nurse Practitioner and serves as the clinical coordinator and OEF/OIF (Operation Enduring Freedom/Operation Iraqi Freedom) outreach coordinator for the VISN 19 MIRECC. Her areas of professional interest are posttraumatic stress disorder, suicidology, and the transitioning OEF/OIF veteran.

Lawrence E. Adler received his MD from the University of Medicine and Dentistry of New Jersey/Robert Wood Johnson Medical School. He is director of the VA VISN 19 MIRECC, professor of psychiatry at the University of Colorado Denver School of Medicine and Schizophrenia Center, and vice chair of psychiatry for the Denver Veterans Affairs Medical Center. His research has focused on sensory gating deficits in schizophrenia using evoked potentials; abnormality in catecholamines effecting sensory gating; differences in mania and schizophrenia; detailed electrophysiologic tracing transmission of amphetamine and PCP in the neurological pathways of rats; sensory gating impairments in schizophrenics and their first-degree relatives linked to deficits in nicotinic cholinergic neurotransmission; and clozapine enhancement of auditory sensory gating in schizophrenia.

Correspondence regarding this article should be addressed to Peter M. Gutierrez, Denver VA Medical Center, MIRECC, 1055 Clermont Street, Denver, CO 80220. E-mail: peter.gutierrez@va.gov

What is the consult service?

- Interdisciplinary group of clinicians with expertise in suicide, treatment, and assessment
  - (e.g., psychodiagnostic, neuropsychological)
- Provides assistance with diagnostic and treatment conceptualization
- Consultees – VA outpatient Mental Health Clinic and a psychiatric inpatient unit

Fundamental Components

- The larger system as context must be considered
- Consultation is an inherently complex process involving a triadic relationship - client, consultee, and consultant
- Ultimately, the consultant relationship is non-coercive
  - The consultee is free to accept or reject whatever the consultant says
- Didactic element - helps consultees and clients function with an increased sense autonomy when similar situations arise in the future

Components of a Consult

- Medical record review
- Clinical interview
- Standardized psychological and neuropsychological measures
  - Self report measures of suicide-related constructs
- Collateral data

The consultant first reviews the case with the consultee and makes sure that the idea of the consult has been discussed with the veteran

The consultant and client meet for an average of 8-10 hours

With outpatient consults this process may occur over the course of 4-6 weeks

Facilitating Communication

- Preliminary findings discussed throughout the assessment
  - Progress note in the client's medical record at each appointment
- Veteran is aware that this sharing will occur
- Encourage consultees to remain active participants throughout the consultation process

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Risk and Protective Factors

- Risk - historical events, psychopathology, personality structure, cognitive functioning, and current stressors
- Protective factors - responses to treatment, available supports, and religious, spiritual, and cultural beliefs

Early, 1992; Jobes & Mann, 1999; Malone et al., 2000; Quinnett, 2000; Simpson & Tate, 2007

Warning Signs and Safety Planning

- Warning signs - the "earliest detectable sign that indicated heightened risk for suicide in the near term (i.e., within minutes, hours, or days)" (Rudd et al 2006, p. 258)
- Identified veteran specific warning signs discussed with clients and consultants -- potentially imminent risk and facilitate safety planning (Stanley, Brown, Karlin, Kemp, & VonBergen, 2008)

Feedback

- Components
  - Psychodiagnostic information
  - Conceptualization of suicide risk
  - Treatment recommendations (therapy, meds)
  - Recommendations - systemic factors
- Feedback meetings
- Written report

Process Issues for Veterans

- Assessment can be activating to the client
  - Concept of self-discovery - the ability to organize and understand one's life experiences - quite powerful
  - Normalize clients' experience - talking openly, candidly, and non-judgmentally about suicidality

COLLABORATION

Termination

- Addressed early in the consultation process
- Revisited throughout
- Facilitated by the ongoing message that consultant is the primary provider

Brown et al., 2001

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Lessons Learned

- Maintaining good collaborative relationships with the mental health staff
  - Active involvement with mental health team meetings, complex case reviews, and morbidity and mortality conferences
- Vital for the consultant provide recognition of the clinicians' skills and efforts

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Lessons Learned

- The “consultant-consultee” dyad embodies its own dynamics – requires respect for the complexity of this relationship and attention
- Systemic challenges can also arise
- Consultant’s responsibility to convey and manage the boundaries in the triad

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1-800-273-8255

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"…talk to a professional. That's why you guys are here professionally trained to deal with people with my problem or problems like I have, you know…Left to myself, I'd probably kill myself. But that didn't feel right so I turned to professionals, you guys. "

- VA Patient/TBI Survivor

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Safety Planning: A Stand Alone Intervention

Major Challenges

1. How can a patient manage a suicidal crisis in the moment that it happens?
2. How can a clinician help the patient do this?

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What is Safety Planning?

- A brief clinical intervention
- Follows risk assessment
- A hierarchical and prioritized list of coping strategies and sources of support
- To be used during or preceding a suicidal crisis
- Involves collaboration between the patient and clinician

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.* Retrieved from http://www.sprc.org/library/SafetyPlanTreatmentManualReduceSuicideRiskVeteranVersion.pdf

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“No-Suicide Contracts”

- No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive.

- No-suicide contracts may provide a false sense of assurance to the clinician.

- DON’T USE THEM!

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SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

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Tips for Developing a Safety Plan

- Ways to increase collaboration
  - Sit side-by-side
  - Use a paper form
  - Allow the patient to write
- Brief instructions using the patient's own words
- Easy to read
- Address barriers and use a problem-solving approach

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.* Retrieved from http://www.sprc.org/library/SafetyPlanTreatmentManualReduceSuicideRiskVeteranVersion.pdf

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6 Steps of Safety Planning

- Step 1: Recognizing Warning Signs
- Step 2: Using Internal Coping Strategies
- Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support
- Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve the Crisis
- Step 5: Contacting Professionals and Agencies
- Step 6: Reducing the Potential for Use of Lethal Means

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Step 1: Recognize Warning Signs

- Purpose: To help the patient identify and pay attention to his or her warning signs
- Recognize the signs that immediately precede a suicidal crisis
- Personal situations, thoughts, images, thinking styles, mood or behavior
- “How will you know when the safety plan should be used?”
- Specific and personalized examples

Step 1: Recognizing Warning Signs Examples

- Automatic Thoughts
  - "I am a nobody"
- Images
  - "Flashbacks"
- Mood
  - "Feeling hopeless"
- Behavior
  - "Crying"
  - "Not answering the phone"
  - "Using drugs"

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Step 2: Using Internal Coping Strategies

- Purpose: To take the patient's mind off of problems to prevent escalation of suicidal thoughts
  - **NOT** to solve the patient's problems
- List activities the patient can do without contacting another person
- This step helps patients see that they can cope with their suicidal thoughts on their own, even if only for a brief period of time
- Examples: Go for a walk, listen to inspirational music, take a hot shower, play with a pet

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Step 2: Using Internal Coping Strategies

- *Ask* "How likely do you think you would be able to do this step during a time of crisis?"
- *Ask* "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- Use a collaborative, problem solving approach to address potential roadblocks.

Step 3: People and Social Settings that Provide Distraction

- Purpose: To engage with people and social settings that will provide distraction
- Also increases social connection
- The client is not telling someone they are in distress during this step
- Importance of including phone numbers and multiple options
- Avoid listing any controversial relationships

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Step 3: Socializing with Family Members or Others

- *Ask* "Who helps you take your mind off your problems at least for a little while? You don't have to tell them about your suicidal feelings."
- *Ask* "Who do you enjoy socializing with?"
- *Ask* "Where can you go where you'll have the opportunity to be around people in a safe environment?"
- *Ask* patients to *list* several people, in case they cannot reach the first person on the list.

Step 4: Contacting Family Members or Friends Who May Offer Help

- Purpose: To explicitly tell a family member or friend that he or she is in crisis and needs support
- Can be the same people as Step 3, but different purpose
- If possible, include a family member or friend in the process by sharing the safety plan with them

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Step 4: Contacting Family Members or Friends Who May Offer Help

- Coach patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- *Ask* "Among your family or friends, who do you think you could contact for help during a crisis?" or
- "Who is supportive of you and who do you feel that you can talk with when you're under stress?"

Step 5: Contacting Professionals and Agencies

- Purpose: The client should contact a professional if the previous steps do not work to resolve the crisis

- Include name, phone number and location
  - Primary mental health provider
  - Other providers
  - Urgent care or emergency psychiatric services
  - National Crisis Hotline 800-273-TALK (8255)
  - 911

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Step 6 : Reducing the Potential for Use of Lethal Means

- Complete this step even if the client has not identified a suicide plan
- Eliminate or limit access to any potential lethal means
- Always ask about access to firearms
- Discuss medications and how they are stored and managed
- Consider alcohol and drugs as a conduit to lethal means

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Step 6: Reducing the Potential for Use of Lethal Means

- *Ask* "What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?"
- *Ask* "How can we go about developing a plan to limit your access to these means?"
- The clinician should always ask whether the client has access to a firearm.

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with low lethality, clinicians may ask clients to remove or restrict their access to these methods themselves.
  - For example, if clients are considering overdosing, discuss throwing out any unnecessary medication.

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with high lethality, collaboratively identify ways for a responsible person to secure or limit access.
  - For example, if clients are considering shooting themselves, suggest that they ask a trusted family member to store the gun in a secure place.

Implementation

- Assess how likely it is that the patient will use the safety plan
- Problem-solve around any barriers
- Examples of barriers
  - Difficult to reach out to others
  - Don’t like the name
- Discuss where the patient will keep the safety plan
  - Multiple copies; wallet-size versions
- Review and update the safety plan frequently

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Implementation

- Decide with whom and how to share the safety plan
- Discuss the location of the safety plan
- Discuss how it should be used during a crisis

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It's Always About the Relationship

- Be familiar enough with the Safety Planning steps that you don't have to go through it by rote
- Have a conversation with the patient as you develop the plan
- Recognize strengths and skills and help apply those to the safety plan
- Draw on the patient's history, as he or she is telling it, to support the positive side of the ambivalence

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Most Suicidal People…

- do not want to end their lives, they want an end to their psychological pain and suffering
- tell others that they are thinking about suicide as an option for coping with pain
- have psychological problems, social problems and limited coping skills – all things mental health professionals are usually well trained to tackle

(Jobes, 2006)

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What You Bring to the Relationship

- Degree of comfort in talking about suicide.
- Awareness of the intensity of your own feelings in dealing with suicidal patients.
- Awareness of the role ambivalence is playing.
- Understand and have compassion for the role suicidal thoughts are playing in the person's life.
- Bring options as most suicidal patients are searching for ways to end their pain.
- Familiarity with Warning Signs, Risk and Protective Factors but don't limit yourself to checklists or algorithms or assessment measures alone.

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Bring Hope to the Relationship

"It is clear that the capacity to think about the future with a sense of hope is absolutely protective against suicide. It follows that a sense of hopefulness within our future thinking and key beliefs help us weather the rough spots that we invariably encounter in life. Alternatively, the absence of hopefulness-particularly in the absolute sense of hopelessness- is an extremely pernicious risk factor for suicide… there is perhaps no single construct that has been more highly correlated with completed suicide than hopelessness".

(Beck, 1986; Brown, Beck, Steer ,& Grisham, 2000)

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Resources

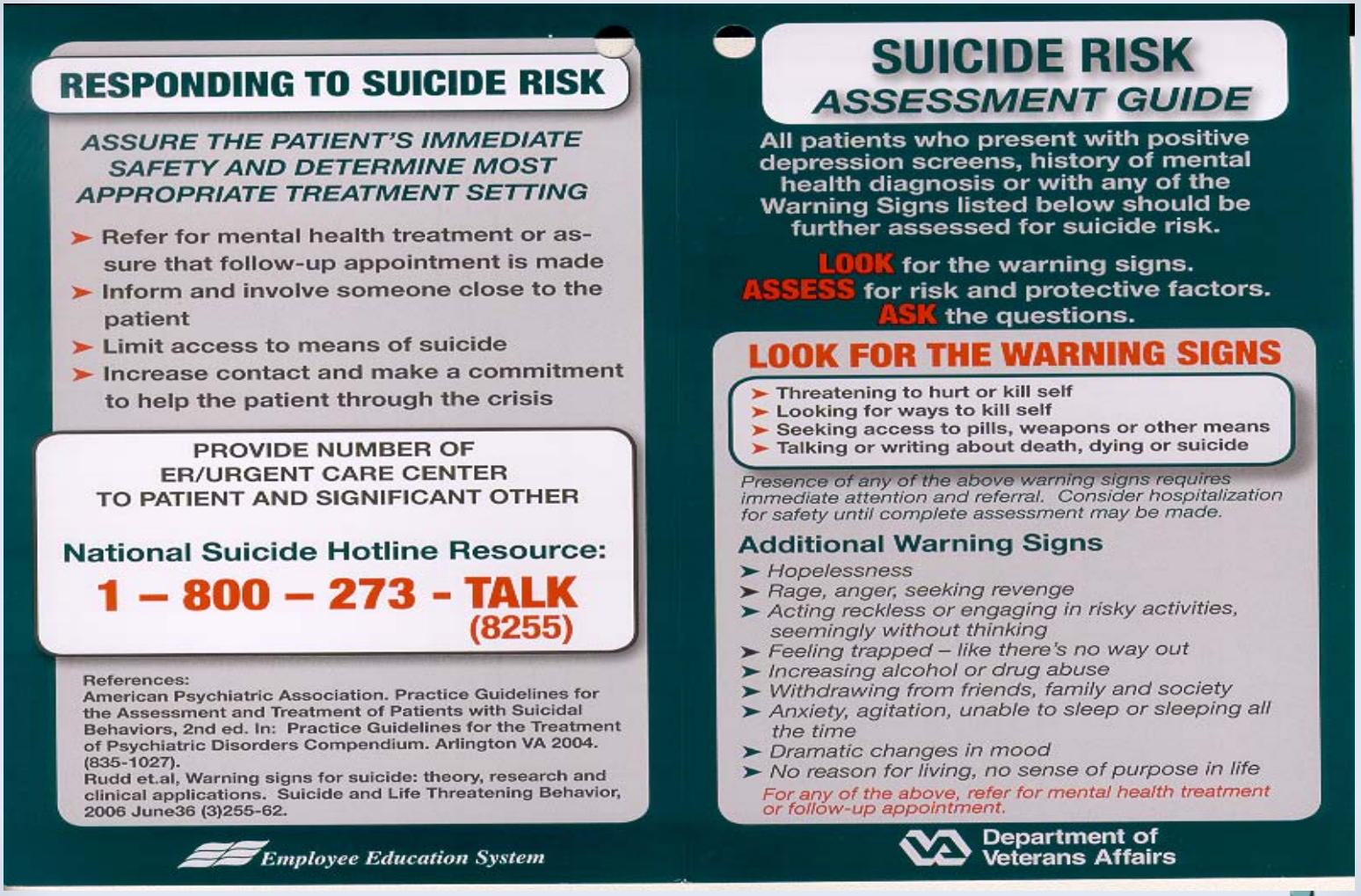
- VISN 19 MIRECC

http://www.mirecc.va.gov/visn19/

- VA Safety Planning Manual

www.mentalhealth.**va**.gov/docs/**VA_Safety_planning**_manual.doc

VA Risk Assessment Pocket Card



RESPONDING TO SUICIDE RISK

ASSURE THE PATIENT'S IMMEDIATE SAFETY AND DETERMINE MOST APPROPRIATE TREATMENT SETTING

- Refer for mental health treatment or assure that follow-up appointment is made
- Inform and involve someone close to the patient
- Limit access to means of suicide
- Increase contact and make a commitment to help the patient through the crisis

PROVIDE NUMBER OF
ER/URGENT CARE CENTER
TO PATIENT AND SIGNIFICANT OTHER

National Suicide Hotline Resource:

1 – 800 – 273 - TALK (8255)

References:
American Psychiatric Association. Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, 2nd ed. In: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium. Arlington VA 2004. (835-1027).
Rudd et.al, Warning signs for suicide: theory, research and clinical applications. Suicide and Life Threatening Behavior, 2006 June36 (3)255-62.

Employee Education System

SUICIDE RISK ASSESSMENT GUIDE

All patients who present with positive depression screens, history of mental health diagnosis or with any of the Warning Signs listed below should be further assessed for suicide risk.

LOOK for the warning signs.
ASSESS for risk and protective factors.
ASK the questions.

LOOK FOR THE WARNING SIGNS

- Threatening to hurt or kill self
- Looking for ways to kill self
- Seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide

Presence of any of the above warning signs requires immediate attention and referral. Consider hospitalization for safety until complete assessment may be made.

Additional Warning Signs

- *Hopelessness*
- *Rage, anger, seeking revenge*
- *Acting reckless or engaging in risky activities, seemingly without thinking*
- *Feeling trapped – like there's no way out*
- *Increasing alcohol or drug abuse*
- *Withdrawing from friends, family and society*
- *Anxiety, agitation, unable to sleep or sleeping all the time*
- *Dramatic changes in mood*
- *No reason for living, no sense of purpose in life*

For any of the above, refer for mental health treatment or follow-up appointment.

Department of Veterans Affairs

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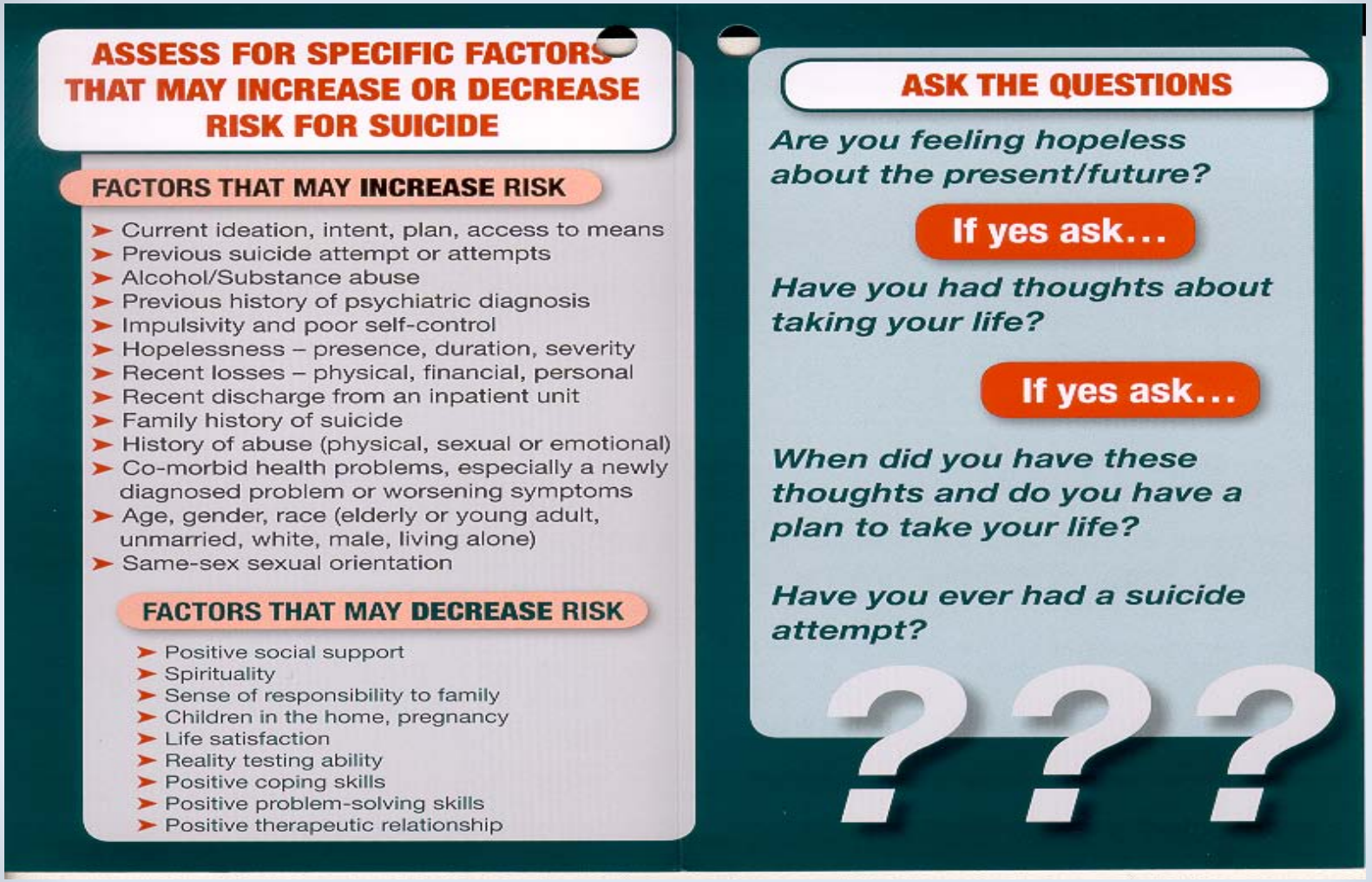

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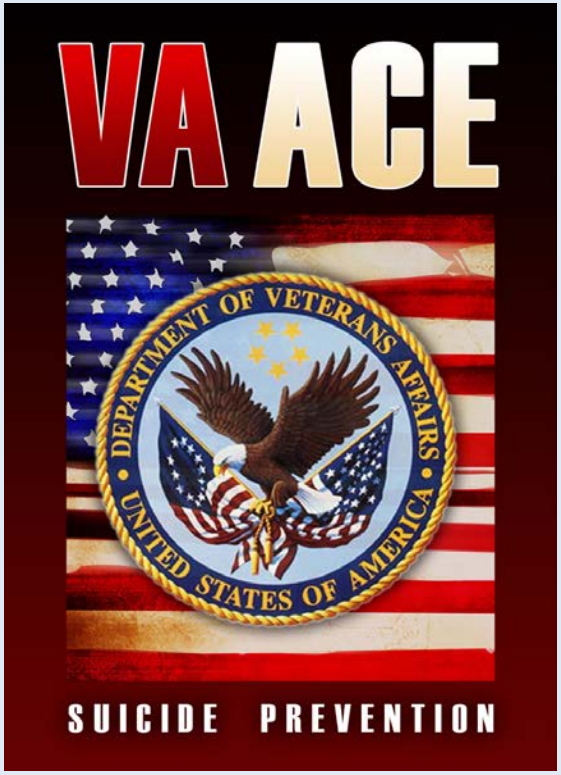
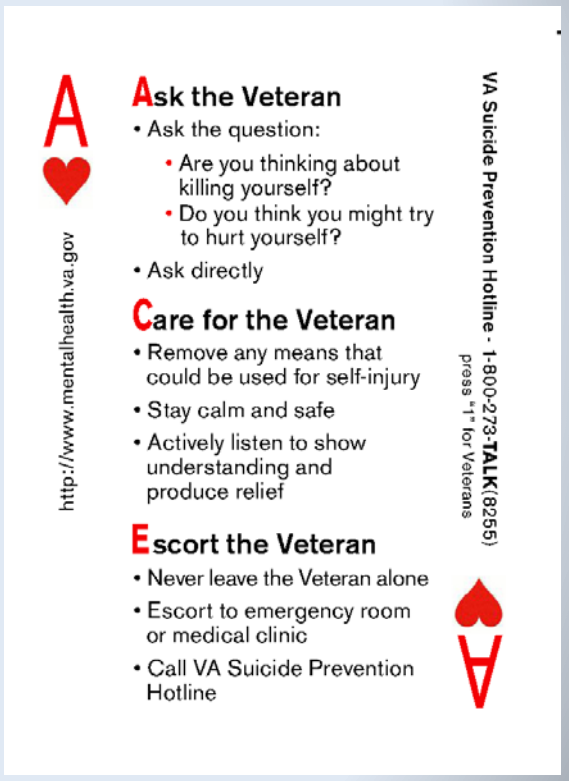
VA ACE CARDS

- These are wallet-sized, easily-accessible, and portable tools on which the steps for being an active and valuable participant in suicide prevention are summarized
- The accompanying brochure discusses warning signs of suicide, and provides safety guidelines for each step



Front view



Back view

Ask your VA provider for an ACE card to carry with you

Recognizing Suicide Warning Signs

Warning signs are early indicators of heightened risk

These signs require immediate attention

- Thinking about hurting or killing self
- Looking for ways to kill self
- Seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide

What Veterans and Their Family Members and Friends Should Know about Suicide

- Asking a Veteran about suicide does not create suicidal thoughts any more than asking about chest pain causes a heart attack
    - The act of asking may give the Veteran permission to talk about thoughts or feelings
- Many people who die by suicide have communicated some intent, wish, or desire to kill themselves
    - Someone who talks about suicide gives you an opportunity to intervene before suicidal behaviors occur
- Many suicidal ideas are associated with the presence of underlying treatable conditions
    - Providing treatment for an underlying condition can save a life
    - Helping the person survive the immediate crisis so that they can seek such treatment is vital
- Suicidal thinking can overwhelm even the most rational person
    - Protective factors may not provide a sufficient buffer during periods of crisis
- Anyone experiencing serious suicidal thoughts should be referred to a health care provider who can evaluate their conditions and provide treatment as appropriate

Additional Warning Signs

The presence of these signs requires contact with a professional

- Inability to sleep or sleeping all the time
- Withdrawing from friends, family and/or society
- Increasing alcohol or drug use
- Acting recklessly or engaging in risky activities
- Rage, anger, seeking revenge
- Avoiding things or reliving past experiences
- Anxiety, agitation
- Dramatic changes in mood
- No reason for living – no sense of purpose in life
- Feeling trapped – like there is no way out
- Hopelessness

Protective Factors

Factors that can protect one from suicidal behavior

Protective factors include:

- Family, friends, social support, close relationships, battle buddy
- Coping/problem-solving skills
- Ongoing health and mental health care relationships
- Reasons for living
- Cultural and religious beliefs that discourage suicide and support living

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IT
TAKES
THE
COURAGE AND STRENGTH
OF A WARRIOR
TO ASK FOR HELP.....
If you're in an emotional crisis
call 1-800-273-TALK "Press 1 for Veterans"
www.suicidepreventionlifeline.org
NATIONAL SUICIDE PREVENTION LIFELINE
Department of Veterans Affairs

Use Your Smartphone to Visit the VISN 19 MIRECC Website

Requirements:

1. Smartphone with a camera
2. QR scanning software (available for free download just look at your phones marketplace)

www.mirecc.va.gov/visn19