Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

September 24, 2015, 1-2:30 p.m. (ET)

"Therapeutic Risk Management of the Suicidal Patient"

Hello, good afternoon, and thank you for joining us today for (technical difficulty) September Webinar.

My name is Dr. Vladimir Nacev. I'm a clinical psychologist and the senior program manager for the Deployment Health Clinical Center. I will be your moderator for today's Webinar.

Before we begin, let us review some Webinar details. Live closed-captioning is available through Federal relay conference captioning. Please see the pod beneath the presentation slides.

Should you experience technical difficulties, please visit dcoe.mill/webinars and click on the troubleshooting link underneath the monthly Webinars heading.

There may be on audio delay as we advance the slides in this presentation. Please be patient as the connection catches up with the speaker's comments.

Today's presentation and resource lists are available for download from the -- from the files pods below.

This continuing education activity is provided thru collaboration between DCoE and Professional Education Services Group. All who wish to obtain continuing education credits or a certificate of attendance and who meet eligible requirements, must complete the online CE evaluation. After the Webinar, please visit dcoe.cds.pesgce.com to complete the online CE evaluation and downloads or print your CE certificate or certificate of attendance. The evaluation will be open through Thursday, October 8, 2015.

Throughout the Webinar you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. All questions will be anonymous. Please do not submit technical or content-related questions via the chat pod.

Participants are encouraged to chat among each other during the Webinar using the chat pods, but please refrain from making or promoting (inaudible) organization or products in the chat pod.

I will now move to today's Webinar topic, the Therapeutic Risk Management for the Suicidal Patient. I would like now to introduce our presenter, Dr. Bridget Matarazzo. Dr. Matarazzo completed her post -- correction, her predoctoral internship at the Denver VA Medical Center and obtained a PsyD degree in Clinical Psychology for the University of Denver in 2010. She is a licensed psychologist in the state of Colorado and has been working in the Rocky Mountain Mental Illness Research Education and Clinical Center since 2010, where she currently is codirector for the VA National Suicide Risk Management Consultation Program.

She is also an assistant professor in the Department of Psychiatry at the University of Colorado School of Medicine. In the role of codirector of the VA National Suicide Risk Management Consultation Program, Dr. Matarazzo provides consultation to VA providers regarding suicide risk assessment and management.

Her primary research interests are related to post-inpatient discharge suicide risk among veterans and military sexual trauma. She is the principal investigator of a military suicide research consortium funded multisite interventional trial aimed at studying the effectiveness of the home-based mental health evaluation program, which she developed with her colleagues in the Rocky Mountain MIRECC.

Welcome, Dr. Matarazzo.

Thank you so much for that introduction. I'll go ahead and get started with the presentation here. So as Dr. Nacev said, I'll be talking today about Therapeutic Risk Management of the Suicidal Patient. And I'll provide a little bit more information during the talk about sort of the development of this model of assessing and managing suicide risks, but it was developed with my colleagues here in the Rocky Mountain MIRECC.

And for those of you who are unfamiliar with MIRECC, there is ten of them across the VA system nationally and they are a Congressionally mandated research centers. And we do research, education and clinical work. And each MIRECC is tasked with a specific topic related to veteran healthcare and ours is related to suicide prevention.

So this model of caring for suicidal patients has really arisen out of a lot of the clinical and research work that has come out of our center on -- as well as a lot of evidence that's also out there in the literature.

So we can go ahead and get moving on -- let's start with a poll question. So it would be helpful for me to hear from the audience on what your level of familiarity with suicide risk management is. So the choices are no to little experience; a few cases a year, maybe monthly, that you regularly perform suicide risk management, like weekly; or almost all of your job is dedicated to risk management.

Just let those responses come in. Okay. So I think we can go ahead and close the poll.

All right, so it looks like it's pretty evenly distributed between a few cases a year to perhaps weekly assessment, so folks are working with suicidal patients on a monthly, weekly, basis. Some a little bit more and some quite a bit less.

So we can go back to the PowerPoint. Thank you. Okay. So that helps me get a sense of your sort of level of experience in your current job setting, but let's also move to the next slide which is another poll question where I want to get a sense of your comfort with suicide risk management. So experience may or may not map on to how comfortable you are doing this work.

So the range is from not at all comfortable; very anxious; to some control but feeling anxious throughout; decent level of comfort but occasional stress related to it; and quite comfortable.

Okay, so it's looking like close to, you know, 88% of folks have some level of anxiety related to doing this kind of a work. And so the level kind of varies and the majority of folks having some, you know, occasional stress related to it, but the vast majority have at least some level of stress.

And if we go back to the PowerPoint, thank you, that's a very sort of common thing. So we certainly see that in the work that we do. And so given the level of anxiety, why is it to important to assess risk? Why do we talk about this? Well, we're all certainly well aware that we do this to take good care of our patients, but it also allows us to take good care of ourselves. So the anxiety that typically comes along with doing this work, there is kind of two different places it comes from. One, the reality of malpractice suits if a very real thing that we deal with as mental health providers. And that causes a lot of anxiety for folks.

In addition to that, there's obviously the very, very tragic loss that's associated with suicide and that we want to do everything we can to prevent that, for the people that we serve, their families, our communities and sort of widespread from there. So there's been a little bit of research done on clinicians as survivors of suicide loss and they find that folks tend to have a similar type of grief reaction that you would expect with, you know, a different kind of a death, but it can be very complicated by guilt, shame, a lot of other factors that can cause folks a lot of distress, so there's certainly reasons why we have a lot of anxiety related to doing this work.

The problem with that is that we know -- and we talk to our patients about this all the time -- is that if we're at kind of the peak of that normal curve there in terms of our anxiety and stress, so we have somebody in the room with us who we're very concerned about from a suicide risk perspective, and we get very, very anxious, that's not the greatest time to be making good clinical decisions, and so we're going to be much better if we're feeling more calm in terms of the way that we're managing -- assessing and managing risks.

So if we're armed with a better way to assess, conceptualize and mitigate risk, our fear is not going to peak as high and we're going to make much better decisions. So my real goal today is to arm you with some of those tools, so you feel like you are more able to do thorough suicide risk assessment and management so that our fear doesn't get quite so high and we can kind of manage this problem among out patients in a much more effective way.

So mitigating fear, so we do this through a medical legally informed practice, such as Therapeutic Risk Management that I'll be talking to you about today, and everything I'll be talking about today, if your practice is consistent with it, you can think of it as really exceeding the standard of care. So if we're doing all the things that we're going to talk about from a medical legal perspective, and you're documenting all that you're doing, which is a key component, you're really going to be protecting yourself from a medical legal perspective, so we can alleviate the anxiety there.

And, fortunately, the best way to care for ourselves and our patients is one and the same, like I said, and it's really nice when those things really line up with one another, and with this model they certainly do.

Clinical based risk management is patient centered, so the way that we're going to do this is really focused on the individual in front of us, which can help us feel less anxious, too, because we're all good at that, we're all good at understanding the people in front of us and this is really consistent with a -- during patient-centered approach.

So here's a brief overview of what I'll be talking about today with respect to Therapeutic Risk Management. So we talk about conducting and documenting clinical risk assessment through clinical interviews is what I'll first talk about. Then we talk about augmenting that risk assessment with structured instruments and then a sort of core piece of the Therapeutic Risk Management model is stratifying risk, and with respect to both severity and temporality, which I'll get further into.

And the managing risks through the development and documentation of a safety plan. The Therapeutic Risk Management model we published in a series of articles, four different articles that are in the Journal of Psychiatric Practice. And this was with my colleagues in the MIRECC who I want to acknowledge, Drs. Hal Worsell, Beta Homifar and Lisa Brenner. And those -- the references for those are in the reference list that is under the files area there on your Adobe Connect platform, if you want to reference those.

So Therapeutic Risk Management, the term itself was actually coined by Simon and Schuman in 2009, so the term itself isn't ours, it's been around for a bit. We just sort of have put together a model that's consistent with that term and really reflective of the practice that we have here.

The Therapeutic Risk Management in general supports the patient's treatment, and the Therapeutic Alliance. It seeks to balance the sometimes competing ethical principles of autonomy, nonmaleficence, and beneficence. An example of that that we often run into working with folks who are at risk for suicide

is we want to be really encouraging independence and autonomy and honoring that principle, but at the same time, sometimes we need to do things to limit autonomy, especially in the cases of involuntary hospitalization, for example, to keep somebody safe.

So these principles really compete with one another at times and we hope that this model serves to alleviate some of that tension. It also helps us avoid defensive practices, so in the context of that anxiety that we talked about with doing this work, oftentimes folks can engage in defensive practices such as hospitalizing people, sending welfare checks, doing that sort of thing that may be unnecessary, and it's actually aimed at sort of mitigating our own anxiety, rather than providing the best care. So through the risk stratification process that I'll be reviewing, we hope that it helps avoid some of those practices.

So let's start getting into sort of the meat of the model here. The first piece is conducting and documenting clinical risk assessments.

So before I get into the nuances of that, I want to make sure we're on the same page about a variety of concepts. So first of all, suicide is a rare event. And that's a very important thing to remember in terms of mitigating your own anxiety. So it's an absolutely tragic event when it happens, and that's why we are doing so much to try to prevent it from happening. It is important for us to remember that it is actually a rare event.

In addition to that, it's very important as providers to remember that there is no standard of care for predicting suicide. So as Dr. Nacev mentioned, we run a complicated service out of here, a national VA service, and then we also have a local service, and sometimes we get questions that are kind of aimed at asking us to help predict suicide. And I very much wish that we could, but we can't do that. And it's important for you to know that, and to not put sort of the burden on yourself and expectation that you're able to do that.

What we are able to do is identify modifiable risk and protective factors and sort of develop really sound interventions around that. So that's an important piece to remember.

Some of these other points I'll get through in the talk and so I'm not going to elaborate on right now. An overarching goal of suicide risk assessment in general is that we want to gather information related to the patient's intent to engage in suicide-related behavior. We want to evaluate the factors that elevate or reduce the risk of acting on the intent, and we want to put all this information together to determine the level of risk and appropriate care, given the level of risk. So that's a lot of what we'll get down to today.

So this section is really based on the foundation being in the VA DoD Clinical Practice Guidelines for the Assessment and Management of Suicide Risk. If folks have not seen this resource or you are unaware of it, I want you to know that in about 15 minutes or so, you'll see, on the left side of your screen you'll see an area pop up that gives you different links, and one of those links is to the clinical practice guidelines.

And on that page you will see three different sort of versions of the CPGs. One is the full guidelines, which can be pretty dense, but a very, very good source of information.

Then there is a summary and then there is also a pocket card guide, which I think is the most clinically useful sort of version of this. So certainly recommend that you all check that out, and what I'll be talking about today is consistent with the CPGs.

So the intent of the CPGs is really to reduce current unwanted practice variations and provide facilities with a structured framework to help prevent suicide and other forms of self-directed violence. And we want to provide evidence-based recommendations. So we want our systems of care -- and that being VA and DoD, to be doing consistent practices across our two systems and really be working together in a similar way and a way that's really evidence based. And so everything I'll be talking about today is certainly consistent with that.

So there's four different modules that are sort of presented in the CPGs, but what I'll be focusing on right now is consistent with and drawn from Module A, the assessment and determination of risk.

question comes up of who should I begin assessing? So a lot of folks, especially in high-volume clinics, they're seeing many, many people, and it's hard to know who they should assess.

And so over on the right-hand side of this slide here, it talk about if folks are presenting with any of these conditions, they absolutely should be assessed. And a lot of what this refers to is if a person's making any communication about suicide. So that's kind of a clear rationale for doing a suicide risk assessment. A lot of clinics also do some level of screening. And if somebody screens positive with respect to suicide risk, then they go on to have a full suicide risk assessment.

In our system of care, we see this happening in services such a primary care. So there is a fair amount of research out there that lets us know that folks who die by suicide, make suicide attempts, are more likely to be seen in primary care prior to that behavior than they are mental health. So primary care settings are a really key place to be doing some of these suicide prevention interventions, such as assessment and management. So folks will be using measure such as the PHQU-9 and using that as a screener. And, like I said, if somebody has a positive screen, then they go on to do a full assessment.

So what's included in a full assessment? Well, one thing I want to mention about assessment is that it's a process, it's not an event. So it's a process in which a healthcare provider gathers clinical information in order to determine the patient's risk for suicide. So this piece about it being a process is very important. We don't do a suicide risk assessment and then it's done. So during the course of treatment with somebody we want to be re-evaluating risk over time as we learn more, as things change for the patient, that sort of thing. We really want you to be thinking about this as a process.

So as part of that process, we gather information related to their intent to engage in behavior and then we evaluate the factors that make it more or less likely that they'll engage and actually act on that intent, and we integrate all of that to formulate the level of risk and then the appropriate care.

So when we're assessing suicide risk, we're not just trying to understand the nature of their ideation, but we're also trying to explore risk factors, warning signs and protective factors, each of which I'm going to break down for you.

So when we think about really understanding suicidal ideation, we're going to be looking at all of the factors on this slide here. So starting with ideation, we're going to want to ask specific and direct questions about suicide. So are you having thoughts of killing yourself? I would just be as clear and direct as you possibly can.

There's a myth that certainly still exists out there that if you ask somebody about suicide, you're going to giving them the idea and increase their risk, and there's been a large amount of research that has shown that that is absolutely not true, and that asking about it doesn't sort of give somebody the idea and make it more risky. So err on the side of always asking.

And then in terms of understanding the nature of their ideation, you can ask questions about, you know, tell me what goes through your head when you're thinking about suicide? Literally what thoughts are you having? You want to understand the onset frequency, duration and severity. So when did this start? How long do the thoughts last for? Are you able to stop them if you want to? Do you feel like you can have them without acting? That sort of thing.

Which leads me into the next piece of assessing ideation, which is intent. So you want to get to the willingness to act on the thoughts. Intent is really, really the crux of doing a good suicide risk assessment. So certainly here, with the population that we serve, we see a lot of folks who have chronic ideation, that their intent is what I'm really trying to get a nuanced assessment of. And so you can do that in a yes/no way. Do you have intent to act on thoughts or not? I find that it's helpful for folks who have

chronic ideation to also have them rate their level of intent. So I'll say, From a zero to ten, where are you today? Zero meaning you have absolutely no intent of acting on the thoughts that you're having, and a ten being you're going to leave the office and make a suicide attempt. Where are you today?

It helps you establish a baseline, and you can see a sort of -- folks are fluctuating over time. It can be a nice way to do that.

One other piece about intent is that there's subjective intent and objective intent, and sometimes those are consistent; sometimes they're not. So a subjective intent is what the patient's telling you. So what they're telling you about their intent. And then sometimes the objective intent is going to be consistent with that and sometimes it's not. And a case in which it might not could be something like the patient is telling you, Nope, I have absolutely no intent to act on the suicidal thoughts. I don't know why everybody is so concerned about me. I would never do that, that sort of a thing. But you have family members telling you, Well, when they were intoxicated last night, they were sending me texts that they were going to kill themselves. Then I went into their room and found that they had started to write a suicide note. I found that they have a stockpile of medications and so you have more of this objective evaluated that there likely is intent there.

And as a clinician, it's part of your job, that you are absolutely entitled to infer intent. And so that's part of the decision-making that we do. You're weighing all of the pieces of evidence together.

Okay, so then the next pieces that you want to be assessing, plan and access to means. So do you have a plan for how to kill yourself? What would you do and do you have access to those methods. A critical piece of this is talking about firearms. So certainly with veteran and military populations and anybody, really, but especially in those populations, we always want to be asking about firearms, even if that's not the plan that they say that they have, I would always, always ask about access to firearms.

And there is a lot that can be done in terms of safety with firearms. It's sort of beyond the scope of today for me to get a lot into that, but I did want to point you to one of the websites that's on the web link area of the Adobe Platform today. It's called Firearm Safety. If you scroll down, you'll see it. Firearm Safety. It's a PSA that was put out by the VA about firearm safety and I strongly, strongly recommend that you check that out and share it with folks.

Okay. So now let's move on to warning signs. So you've done a very thorough assessment of ideation and you've gotten a good sense of the nature of their ideation and what they've been thinking about, how often, that kind of thing. And now we need to start looking a little bit more into warning signs, risk factors and protective factors.

So what are warning signs? Warning signs are precipitating emotions, thoughts or behaviors that are most proximally associated with a suicidal act and reflect high risk. So there's different types of warning signs. The ones on this side can be thought of as direct warning signs. So suicidal communication, preparation for suicide, seeking access, or recent use of lethal means.

So if any of these things are present, I would be very, very concerned about somebody and you are thinking about really assessing their acute risk and management with respect to that. So that's what some direct warning signs are.

This next slide provides some other potential warning signs, and there is quite a list here. And, again, these are consistent with the CPGs. And what I want folks to know about warning signs is that they are -- they are personal and meaningful warning signs for that -- for an individual patient. So everybody has their own warning signs, so you could have two people who are experiencing the same sort of stressor. For one of them that puts them at elevated suicide risk; another person it doesn't. Financial stress for somebody might make them suicidal; for somebody else, it might not, since the warning sign's for the first person, not the second.

And then, at the same time, you can have somebody who -- you know, folks who make attempts and very different things led up to those attempts. And so your job, when you're doing your suicide risk assessment, is to understand what the individual's warning signs are.

The best way to do this that I have found is by really exploring the most recent suicidal crisis. So, okay, the last time you were feeling really suicidal, let's kind of back things up, almost doing like a chain analysis, and figure out what led up to that. Okay, so you're having some financial stress, that was going on. And then your PTSD symptoms were starting to kick up a little bit, you had some bad nightmares. And then on top of all that, you got into a fight with your girlfriend, and that's when you became acutely suicidal. So if you're identifying different warning signs through that kind of questioning, and that's going to be a critical component in terms of helping somebody manage their risk and we'll get to that more towards the end.

Okay. So after warning signs, you also want to understand a lot about risk factors and protective factors and protective factors. So the question here is how do these factors contribute to risk? So what elevates and what reduces risk? So risk factors are those that are -- have been found -- sort of demonstrated in research, these things are consistently found to be more common amongst folks who have made a suicide attempt or died by suicide than those who have not, whereas protective factors are capacities, qualities, environmental and personal resources that increase resilience, that drive individuals towards growth and stability, they are associated with increased coping, decreased likelihood of suicidal behavior.

And your job is to identify the factors that are present and then, on a more nuanced level, identify the ones that are modifiable, because again this is going to inform the management that you do.

So something being an older adult whose Caucasian and male, those things we can't change. Those are not modifiable. But the fact that they've had a recent exacerbation and depressive symptoms, we absolutely can have some intervention targeted at that. So your job is to really figure out what we can modify, and that's the critical part of that piece of the assessment.

Okay. So once you have done a very thorough suicide risk assessment in terms of the clinical interview in the ways that I talked about, one thing that you can do, start augmenting that with structured instruments.

So let's get into that a little bit here. So here's another polling question. So we'd like to know from the audience, Do you regularly use standardized assessments during suicide risk assessment, yes or no?

Okay. So looks like it's shaking out to be about 55/45. So with a few more folks saying that they do regularly use standardized assessments, which is great. That's wonderful to hear. And we'll talk about some reasons why that can really help augment your assessment.

So for the folks that you don't use those, that's certainly not an uncommon thing. So David Job did so research looking into this and found that providers across disciplines often avoid using formal assessment approaches, because they just want to use their own clinical interview.

And do a very important point I want to make before we get into this is that we're certainly not saying one's better than the other, or that one should be used in -- you know, and not using the other. So we're really talking about augmenting here. So we certainly want to use clinical interview in the way that I just suggested and augment it through objective assessment.

And so I'll talk a little bit more about the reasons why we might want to do that. We find that it can really augment clinical care. So sometimes using a structured assessment, particularly with a reliable and valid assessment measure, can really help get you a more nuanced understanding of somebody's suicide risk.

So, for example, I might ask somebody about frequency and intensity, something like that. And then I give them a measure that actually breaks down different levels of frequency, intensity, so I can get a severity score. That gives me even more data about their suicide risk. It also serves as an important

medical legal function. So, again, from a documentation standpoint, if you're able to say that the subjective assessment lined up with what they endorsed on a reliable and valid measure, it's just going to be even stronger documentation in terms of the rationale, why you're saying somebody is at a certain level of risk, and it really helps to realize Therapeutic Risk Management of the patient.

And so the -- the reference that's on here is a really nice resource that Greg Brown put together. The link for that is on the web links portion of the Connect Platform here, over on the left. It's the one that's called Review of Assessment Measures. And if you click on that, it provides a whole variety of assessment measures that you could consider for use.

Some things to consider when you're choosing which assessment measures you want to use are time. So how long does this measure take to administer? You want to look at accessibility, so does this cost money? Do I have funding for this? Is it available in the Center that I work for, that sort of a thing?

You want to look at credentials. So what kind of training or what kind of professionals are limited and in terms of the use of the measure. How exactly is it going to augment and inform the risk? So what do I feel like I'm kind of missing out on in my assessment and what can I get from different measures?

And then you also want to think about how you are going to use it. So do you want it to be able to capture a baseline and sort of track that over time? And I'll get into an example of that. So those are some things to consider.

So here are some example measures. And like I said, there is many of them that might be of better use for the system of care that you work in. I'm going to highlight a few of them that we use here in our local suicide consultation service and talk about those.

So we use the (inaudible) scale. It's one of the few measures that's demonstrated an association with death by suicide. It's a fairly quick measure and hopelessness is a very, very strong predictor of suicide, so that's why we tend to include that. We also are very, very commonly including the Reasons for Living Inventory. So this is put out by Marsha Linnehan and it asks folks to rate a whole list of reasons why they wouldn't want to kill themselves. So really helps you get at protective factors. And this is one of those cases where I find that I can get at a lot more nuanced information than I can in clinical interview.

So oftentimes if you're working with somebody who is really, really depressed and you are saying, you know, Tell me your reasons for living. And you're trying to get at protective factors. Part of the symptom of their depression is that they're having trouble generating those things, they're feeling pretty disconnected from those things. I've had plenty of times where then I've administered the Reasons for Living Inventory to somebody, and there is -- I believe it's six different domains on the RFL, and it looks like, Oh, wow, there is reasons you wouldn't want to kill yourself because you have a sense of responsibility to your family or you have moral objections, or you can kind of see a more nuanced assessment in that way. Or it might even be item level. Give us one reason that you rated really strongly. So then you have ideas for intervention. I'm going to continue to really beef that up and make sure we're doing things to protect that Reasons for Living. So we find that one particularly helpful.

Then the best scale for suicidal ideation, I'm going to get into using more of an example on the next slide here. So a lot of folks who haven't done this before will say, Okay, sounds like a great idea, but I don't know exactly how I would use it in practice. So I'll use the example of the BEK. So what we often do, we'll administer the BEK the first time that we meet with somebody, and it allows us to get a baseline score of their level of ideation.

And then during each subsequent appointment, we're administering it again. It's pretty quick. Takes about five minutes. It's nice because it sort of can be used as a screening measure. So if they don't sort of pop positive on the first five questions, you don't administer the whole measure. So it can be really quick is somebody's doing okay. But it's a nice way to see if there is any variation over time.

So you may notice, Oh, your score's changed a little bit. Then clinically what I do is look at the item level data and say -- notice what has changed. So, for example, let's say one week somebody came in and they endorsed on the fact that they were sure that they would not make a suicide attempt in the future. And then the next week that has changed and now they're unsure. That's a very nuanced sort of change that you might not pick up on in clinical interview, but can be a big springboard for discussion. Wow, I notice that now you're a little unsure if you're going to make a suicide attempt. What has changed? What's going on? And you can get a very sort of -- a nuanced understand of what's going on. So that's one way that you can use a measure such as the BEK.

In terms of establishing a baseline, this can be really, really helpful -- going back to what I said in the beginning about balancing some of the ethical principles. So if somebody has a baseline established in their chart, it can really help avoid unnecessary hospitalization. I can -- and it can also, on the other end, sort of flag times in which we really need to facilitate lifesaving intervention.

So let's say I've been administering the BEK to somebody for quite a while. They consistently score around a 20. Then they come into Urgent Care because they've been having difficult sleeping and they want some help with that. While they're in Urgent Care, they administer the BEK also, and they see, Whoa, this person is scoring way, way higher now. I know that their sleep is a problem, but they're also probably feeling much more suicidal, because I can tell by their other -- you know, the baseline that's sort of established in the medical record that they're not doing so well. And so that's really good sort of objective information.

On the other side, let's say that same person comes in, they say, I'm really not sleeping well. You have well-trained staff that knows insomnia is a huge warning sign, very commonly for suicide. Then they administer the BEK and they're right at their baseline. They're having trouble sleeping, but maybe they're catching it early enough before it turns into elevated risk. So then you might not be moving towards, you know, hospitalization or something that's unnecessary. So it can really help -- particularly in a situation of care and communications amongst providers.

So with respect to advantages of using structured assessment tools, they require little time to administer. They're relatively easy to administer. So they are conducive to high-volume clinics, you have somebody fill these out in the waiting room, and then we'll get them once they're back in the room, that sort of a thing.

They sometimes can be a modality that patients feel much more comfortable disclosing their ideation on, so certainly in VA, DoD populations – I mean, this is a problem everywhere, but certainly with our population stigma, it's a huge, huge issue when we're talking about suicide risk assessment and some folks might feel more comfortable answering questions on a measure than they do in the interpersonal context of actually talking to you.

I've had folks I've started interviewing, kind of not getting anywhere despite everything I'm doing to try to build rapport and make them feel more comfortable. So I kind of just throw the interview out for that time being and administer some measures. And then their responses that they're giving me on the measures, I can really use as a springboard for further discussion. And so that's one way that they can be used.

And then they also provide a quantitative measure of suicide risk. And, again, like I talked about, that can be advantageous for sort of tracking over time.

So let's think about potential challenges. So why maybe you might not want to use measures or things just to be aware of. So they do take some time to familiarize yourself with them in their scoring and how to interpret that, so that takes a little bit of time. We do want to warn against over-relying on a quantitative score. That score is helpful, but we want to make sure that folks aren't sort of overinterpreting that. Again, if we think about the whole anxiety thing and how much anxiety can drive what we're doing when we're working with suicidal patients, it would be really nice if a number could just be the answer. And so we could over-rely on that. So we want to be really cautious about that and, again, say that it really

needs to be put into the context of everything else that you're doing in the clinical interview that you're doing.

And it can cause us to focus on suicide risk assessment as an event. Okay, great, I administered all those measures, I did my risk assessment, I'm done. And, again, I -- you know, I suppose I can't say it enough, we really want to think of this as a process over time.

Okay. So this caveat slide is sort of saying all of that again. It's absolutely not a substitute when you're using the structured instruments, just to really think of it as augmenting what you're already doing in clinical interview.

Okay. So now I'm going to move on to talking about stratification of risk. And this is really a core, core component of the Therapeutic Risk Management model. And so let's start to get into it with a case.

So you have a 29-year-old female who has a history of many attempts, chronic ideation, when they come in to -- oh, say this is for an intake appointment. They report that their current ideation is below baseline. Their mood's been stable. They tell you they have a history of many psychiatric hospitalizations. They have a family history of suicide. They own a firearm. They have intermittent homelessness, although they have stable housing right now. They have a history of alcohol dependence. They've been sober for about six months and they have a diagnosis of borderline personality disorder.

So if we go to the next polling question, what would you all say that their risk is? Would you say that they're at low, intermediate, or high risk for suicide?

Okay, so it looks like the vast majority of folks are thinking intermediate or high. So they're about equal. 47 – 50, okay. Intermediate. Folks are saying -- about 50% of folks are saying that and about 44% are saying high. So if we go back to the slide -- perfect.

So what you all were rating there is the severity. So you were thinking of the severity of their risk: low, intermediate or high. And most folks were thinking intermediate or high. So what we really want to encourage you to do -- and I'll talk you through this -- is stratifying risk. So severity, low, intermediate or high, but we want to also encourage you to think about temporality. So acute and chronic risk.

So we're going to think about acute and chronic risk. So for the patient that we just talked about, you may estimate the severity of risk differently if we're talking about acute versus chronic. And so I'm going to get into a little bit of the features of those.

Before I do so, I want to point you to another resource. So if you look over on the web links again, towards the bottom there's a link for Therapeutic Risk Management. So we recently launched a website devoted to the Therapeutic Risk Management model and we will be continuing to update it over time, but right now one resource that you'll see on there is a table that is a much more sort of clinical useful way to get this information then in the articles that we wrote, which I think are pretty clinically useful, but a tool's always nice to have in the room with you in session.

And so one side of the tool talks about acute risk and the other side talks about chronic. And it breaks down -- on the left side of the tool you'll see the essential features of that risk category and then you'll see the associated action that we recommend in terms of managing the risk.

And so I'm not going to go into a ton of detail of the six different categories, because if we're thinking about acute and chronic, we're falling into six different categories here. I don't go into all of them, but all of that's really laid out on the table. What I really want you to think about is thinking about both the acute and the chronic.

So for acute risk, I'm thinking about imminent. So right now, when you're sitting in session with me, and then maybe in the next 24 or 48 hours, what am I thinking about your risk, with respect to chronic risk, which is on a much longer timeline.

So let's think about high acute risk. So if somebody's at high acute risk, they likely will have suicide ideations, suicidal ideations with intent to die by suicide and the inability to maintain safety independent of external support. There's a variety of things that will likely be present, such as plan, access to means, there's a whole list here.

And in terms of action, you're really going to considering psychiatric hospitalization. If somebody is at high acute risk, they're probably requiring psychiatric hospitalization.

Then let's think about intermediate risk. I think this is the category that folks seem to have the most difficulty with. So the big difference here is that they may have a lot of features that are associated with high acute risk. The big difference is that there are reasons for living or protective factors, things in place, why they currently are not going to act on those thoughts. So they might need a lot in place to help them manage their risk so that they don't make a suicide attempt, but right now they're not intending on doing it.

And so in this case, sometimes you're considering psychiatric hospitalization. That might be required to sort of help manage and maybe beef up some of the modifiable protective factors and address sort of the modifiable risk factors. But a lot of times folks can be maintained outpatient if they're at moderate acute risk. They're just going to need sort of amped-up services. So they might need to be checked in with every day. They might need resources such as the veteran's crisis line, different things in place to help mitigate their risk.

So I always think of, if I'm placing somebody at moderate acute risk, then I also better be documenting what I'm doing to sort of amp up their level of care, even if it's not to the level of hospitalization.

So then low acute risk is -- they might still have ideation, but they definitely don't have intent, no plan, no preparatory behaviors, that kind of thing, and these folks can be managed in whatever outpatient setting that they're currently being managed in.

This slide breaks down the chronic risk. So high, intermediate and low. So really the thing to think about when you're stratifying chronic risk is how the level of protective factors and risk factors are sort of balancing out. What I want to say about high chronic risk is that we think of it as folks who are at high chronic risk of becoming acutely suicidal. So on a long-enough timeline, it's likely that, if the factors shift in such a way, they'll become acutely suicidal. That sort of thing. So that's how we think about that.

So let's move back to our case example. So now -- and I don't have a polling question for this, but I want you all to just think about it in your minds. So look at this case again and think about acute risk and chronic risk. And what are the factors you would consider to stratify both, because we really want you to be doing both.

Let's take a moment to think about that. Okay. So for the first person we were going to think about low acute risk and high chronic risk. And a note about documentation. When you're documenting those two levels of risk, you really want to be providing evidence for why you said they're at low acute and high chronic. Here's an example of how you can do that.

So although the patient carries many static risk factors, placing her at a high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety and FI below baseline and no current intent suggests low acute or imminent risk for suicidal behavior.

So what we find -- and I would say this comes up on almost all of our national consultation calls, is that clinicians are often stuck in this sort of dilemma of I'm working with a chronically suicidal person and I'm letting them go home every time after I meet with them. In my documentation, I want to say that they're at high risk, but I want to have documentation for why I wasn't hospitalizing them and how do I sort of get around that in my documentation?

So this is really sort of the answer and this tends to provide folks with a lot of relief. So what you'll be doing is saying they're at high chronic risk and saying all the risk factors and the reasons why, but then you're going to be saying, But today in session they denied intent, they demonstrated ability to utilize a safety plan, for example, in the past and they haven't had any recent preparatory behavior. So today, they're at low acute risk. And then it's clear why you're not sort of amping up their level of care in that session.

So, again, it's a way that we are mapping on the risk level to management in such a way that's really serving our patient in the best way and meeting their needs most appropriately in terms of level of care, which is really consistent with a recovery model of care in terms of least restrictive sort of interventions.

And then also you're really, really protecting yourself from a medical legal perspective in terms of providing thorough documentation about your clinical decision-making.

So -- oh, and one other thing I wanted to say is that this is one example of sort of how you can document risk. We also have a template with some different language, consistent language, but just a different way of saying it, that we use here often. And if folks are interested in that resource, you can always shoot me an email and I'm happy to share that template with you all.

Okay. So in the remaining ten minutes or so that we have, I want to talk about developing and documenting a safety plan. This is sort of a last component of TRM. And before I get into that, I want to say I could, you know, certainly present an hour alone on TRM -- I'm sorry, on safety planning.

And it looks like the slide's already started. Is there a way to get back to the slide I was on? Thank you.

Okay. It's the one that will have a number four on it. So what I was going to say is that I can do an hour-long talk just on safety planning, so this is really going to be an overview of safety planning. There is a resource on the reference page that's one of the files that you can download that is the link to the safety planning manual online. You can also just Google CA Safety Plan and it will come up. And the manual goes into further details than what I'll go into today. Thanks for getting those back.

Okay. So let's get into safety planning. One other thing I wanted to say actually before I launch in there, is that safety planning is one way that somebody can manage suicide risk. So there is interventions that are specifically aimed at mitigating risk, like cognitive therapy for suicide prevention. Different things can help target and really modify risk factors. But I certainly believe in it -- a mandate in the VA that anybody that's at high chronic risk should have a safety plan. So this is certainly something that we certainly strongly advocate as a core component to suicide risk management.

I want to make a note about no-suicide contracts. So when I talk about no-suicide contracts, I'm referring to a patient and a provider making an agreement with one another or a contract that they patient will not harm themselves. So that's what is typically involved in a contract. They could be as formal as actually writing something up, both parties signing it, getting that in the medical record. Or, more commonly nowadays, I tend to see it in medical records with language such as the patient would or would not contract for safety. So more so, the concept being alluded to. And we strongly recommend not using that language. So the way you can think about it is kind of contracting is out and safety planning is in. And we really recommend that. So contracting for safety has been around for a very long time and despite that, there is no empirical support for it.

And in addition to that, I think that there is medical legal provider focused and patient centered sort of reasons to not contract for safety, so -- and we go into this a little bit more in the article that's written about this, but from a medical legal perspective, it's not actually legally binding. So we use the term contract, but it's not legally binding. And the use of the term contract, I think from the provider perspective could provide a false sense of security. So, okay, they agreed to this contract. They're not going to do it. I'm kind of done with the work I need to do, and that can be really, really problematic, especially when we

think about this whole trying to do things as a process, not an event. Somebody could feel like they're done once they've done a contract.

From the patient's perspective, there is some research that this can really just feel like a CYA thing to patients. It's not reflective of the therapeutic process. They -- it can feel like a disruption in the alliance and, additionally, the sort of -- biggest thing that I always remember about this is that with a contract, you're telling the patient what not do do. You're telling them to not kill themselves, but you're not giving them alternatives.

And so that's really where the safety planning comes in. So the safety planning is a whole list of things to do instead of killing yourself. So it's a brief clinical intervention. It follows risk assessment. If you've done a really thorough suicide risk assessment in the way that we've talked about today, you're going to be well-armed to go ahead and do a safety plan, and we'll go through the steps of it here in just a moment. It's a hierarchical and prioritized list of strategies. They can be used ideally proceeding a crisis. So ideally you're going to get -- work with your patients so that they really get to know their own warning signs, so they can see what's leading up to a crisis and catch it early.

But it can be certainly used during a crisis if somebody just sort of finds themselves in the midst of one. It also can be used as a standalone intervention, so you think about, you know, psych emergency services kind of setting. And even if that patient's coming in just during a one-time thing because they're in crisis, you can do a safety plan with them that they'll then carry forward with them. But then you can also use it in the context of an ongoing therapy relationship.

So it certainly involves a lot of collaboration between the client and the clinician, which I'll get into in a moment. The reference is also on here for the safety planning manual.

Okay, so tips for developing a plan collaboratively. So the manual gets into a lot of these details and this is, again, sort of a discussion that's based in a lot of work that's been done by some other folks in the field of suicide (technical difficulty) in terms of ways to increase collaboration. So some of this is based in the CAMs model and it's the idea of sitting side by side with a patient. So when I create a safety plan with one of my patients, I'm actually sitting down next to them. I give them the paper to write on, so it's in their writing. They're really taking ownership of it. I'm kind of coaching them through it, but it's really theirs and I want them to feel like they own it. It's in their language, not mine. We do it really conversationally. We address barriers as we go, and use a problem-solving approach.

So a critical piece of doing safety planning well is providing a rationale at the onset. So you want to tell your folks why this matters. I mean, safety planning is -- like I said, it's mandated in the VA for folks who are determined to be at high risk. And I can't tell you how many veterans I've come across that say that they have a safety plan and they're just not really in the practice of using it.

So I'm trying to do a lot to increase buy-in with my patients and have them understand why this can be such a critical component of their risk management plan.

So there's a couple analogies I want to go over briefly that I tend to use to present the safety plan. One is stop, drop and roll. So no matter where you work, this analogy works with most folks. So most of us when we were little, we learned for fire safety, you do stop, drop and roll, right? The natural sort of inclination, if you were to catch on fire, would be to run. And that's the worst thing you should do. You need to stop, drop and roll. Well, what do we do as little kids? In kindergarten, you're on the ground, you're rolling around, you're practicing this when you're not on fire, right?

Well, safety plan is very similar. Your first impulse, instead of running when you're on fire is going to be towards suicidal behavior or other potentially self-destructive behavior. We need to do a lot of practice to override that instinct or that habit of going to suicidal behavior, so we want to practice your safety plan and we want to practice it when you're calm and you're doing well.

And so that analogy you can really kind of carry forward, which I like and another analogy that we often use here with military veteran populations is likening this to military SOP. So you would never go into a dangerous situation, you would never go into a combat situation without a plan in place. You would have an SOP for what to do. This is the exact same thing. So you have the skills for this. You know how to think this way. We're just encouraging you to apply it to your emotional life now and that's sort of how we talk about it.

So I'm going to go through the steps, like I said, fairly quickly. There's a lot of other resources out there for how to really learn how to do safety planning if you aren't familiar with it. On our MIRECC website, we have links to safety planning presentations that are more of like an hour-long- presentation just about safety planning, so there's certainly resources out there for you.

But let's just do an overview of the steps. So the first step is warning signs. Talked a lot about those earlier in the Webinar. Good thing to remember here is that we want these to be really specific and personalized and concrete.

So I won't let patients get away with just putting depression as a warning sign on their safety plan. Michael, what does that mean? Depression means a million things to a million different people. So what is it like when you're depressed? Oh, well, I tend to isolate. Okay, what does that look like? Well, I stop answering the phone.

Okay, so write that down on your safety plan. So instead of writing this sort of abstract thing of depression on their safety plan, they're writing stop answering the phone. So in the future when I have encouraged them to look at their safety plan every day and to check in about their warning signs, they say, Oh, not answering the phone. Yeah, I kind of stopped answering the phone a couple days ago. Maybe I need to be doing some things to get myself some help. Much more concrete; makes it much more likely they're going to use it.

So if that's the case, they know some of the warning signs are going on, then they start doing things to help themselves. Step two is things that they do for distraction to prevent escalation of thoughts. And this is about contacting another person. So these are some internal coping strategies.

If that's not working, then we encourage them to start reaching out. During Step three, they're going to be engaging with people or social settings, again, to provide distractions. They're not yet telling folks that something's going on and they really need help. They're just getting outside of themselves and their environment for the purposes of distraction. And so there are some tips of the slides here about nuanced ways to do this. But the big thing is go for things that works, that they are familiar with, that sort of a thing.

Step four, this is when they're reaching out to people in their personal life for support. So, hey, I'm having a hard time and I need some help. And this is when they're involving people in helping to manage their crisis, but they're not yet asking professionals for help.

That's in Step five. So this is where they're going to be listing you as their provider. We want them to have the veterans crisis line on there if they're a veteran, a military service member. If they're not, the National Suicide Crisis line is the same number. They just don't press one when they call it.

I often do a lot of discussion around barriers and problem-solve around those barriers to calling a crisis line. Our folks have a lot of misconceptions about the crisis line that we come across, so we can do a lot to provide education.

And then Step six is making the environment safe. So this is where we are really going to get into mean safety. Again, I already commented somewhat on this in terms of the firearm safety and making sure that, if folks do have access to a firearm, that they're counseled on sort of the risks associated with that.

You come up with a good plan to safely deal with that issue, and then you're going to be talking about other access to means.

In addition to that, we think about not only taking away things that elevate their risk, but adding things in that could protect them. So if they've mentioned earlier that their grandchildren why they're still alive, put pictures of your grandchildren in your house.

You have a gun lockbox, put a picture of your grandchildren on the box. You're reminded of them before you go to reach for that firearm, things like that.

Okay. So on this last slide here, this is about just enhancing the use. So you want to increase access to the safety plan. I give people multiple copies. I encourage them to use technology, take a picture of it, have it on your Smartphone. There is apps, such as the Virtual Hope Box and safety planning apps that can be helpful with this. Really personalize, like I talked about. We want to encourage regular practice with the safety plan, so, again, you can get back to that stop, drop and roll analogy. Encourage them to share it with others, so I typically will talk to them about the folks that they've put on Step four of their plan and ask them if the feel comfortable sharing a copy of their safety plan with those people and then encourage them to update it regularly. And that's something that you can be on top of with them in session.

So that concludes the presentation for today. I have the references here. Like we said, they are also available in the downloadable file. So website on this slide is for the Rocky Mountain MIRECC where we have a number of educational products and clinical resources and information about the research that we're doing in our Center. So encourage you to check that out. And my email address is there if you have any questions beyond the (inaudible) Q and A that we'll do today.

Outstanding. Thank you very much for the presentation, Dr. Matarazzo. We have a number of questions that came in.

In no particular order or importance, but one question I would ask is if you suspect a patient may have suicidal ideations and thoughts would you ask them directly, Have you thought about killing yourself or would you be more subtle about -- or differently or passive about it?

Was the question if you suspected that they had suicidal thoughts?

Yes, ma'am.

Okay. But they weren't being particularly forthcoming?

Correct. So would you ask them more directly about, Have you thought about killing yourself specifically and focusing on using the actual words?

Yeah, so there's a couple ways that you could go about that. One way that you could sort of lead into it more subtly, if I felt more comfortable, would be, you know, if you're suspecting that they have suicidal ideation, there's a reason for that. So I'm really transparent with that about folks. So, Hey, you know, you told me -- and I'm, of course, just making up this example. But, hey, you know, you told me that you've -- your chronic pain's been really bothering you lately, you're not sleeping, you've been fighting with your girlfriend a lot. Sometimes when folks have a whole host of things going on like that, they start having thoughts about ending their life, because they kind of can't manage anymore. So are you having any thoughts like that? And that can be sort of a more gentle way of easing into it.

But I -- you know, so I think regardless of if you're using the words, you know, are you going to kill yourself, there's ways that you can sort of draw from the information they've already given you and make a nice link to those questions.

Are there any other questions that we wanted to go through?

I'm sorry. Didn't realize we were on mute here.

That's okay.

My apologies. The question I had was, Do you follow up with a patient or do you have the patient follow up with you after you do their risk assessment?

I'm not sure what that means. Do you think it means after that session or --

Right. After the session, do you call the patient or do you have the patient call you in a day or two to check in with you, or what -- do you have a protocol for that?

Yeah, good question. So that will really depend on what you've done in terms of the risk formulation. So depending on how you've stratified their risk. So your follow-up plan should really map onto that. If they're at -- let's say, they're at moderate acute risk. You're pretty concerned about them. I would be sort of working it out with them and certainly kind of working from a recovery and patient-centered standpoint.

If they want to be the one initiating the call the next day, let's say you agree there should be a call to check in the next day, I would say, Yeah, why don't you call me at this time. And then I would be clear with that. If I don't hear from you -- say it's 1 o'clock. If I don't hear from you by 1:15, I'm going to be calling you, so I'd make a really clear plan with folks around that.

In terms of returning to the clinic for assessment, I would just make that sort of based, again, on the need. If they're at low acute risk, you know, maybe you're just seeing them -- whatever, you know, how frequently you tend to see folks in your clinic.

So I really would just kind of work it out on a case-by-case basis, but I always -- like I said, I'm really transparent with folks that, If I'm not hearing from you, then I'm going to start contacting you and calling you a bunch to make sure you're doing okay, so . . .

Great, yeah. Another question was can you talk a little bit about the legal obligations associated with suicide -- suicide risk assessments? (Overlapping speakers).

Just sort of generally?

Yeah.

Yeah, I mean, I think the thing that comes up the most is that oftentimes folks are -- a couple of things come to mind. One is that sometimes folks, because they are feeling so anxious, they are not asking the questions. And, again, they fear from sort of a clinical and legal standpoint that if they're not asking and they don't have to put anything in the record and then they're okay.

Well, the standard of practice absolutely is that you're asking the questions, so you're really doing yourself a disservice if you're not asking and you're not documenting. The documentation is the other piece. We'll talk to folks and say, You know, we found the documentation, it looks like these things weren't addressed. Oh, no, we did, but nothing was going on, so I didn't say anything about it.

Well, from a legal standpoint, you absolutely want to document that. You asked or did a screen, even if it was negative, because then, if something were to happen in the future, then it's clear that you were thinking of that and you covered your bases.

So I guess the biggest thing with doing this work is really thorough documentation. Like I said, one thing that can really help is having clear evidence for the risk stratification. So if you're doing both the acute and chronic risk, really providing the evaluated for why you were thinking that, why that was your clinical impression, and the sort of management things that you considered and why you chose what you chose. So just really transparent documentation, I think, is the key to sort of the legal piece of this.

Yeah, I think that's a good point. And it's also, I think as you highlighted briefly, the idea of you can't really ignore suicidal ideations, no matter how small they might be or vague they might be, they need to be followed through, because ultimately it is the provider's obligation to do that.

Yeah.

So another question is how do you balance other people's agenda as sources of information against the patient's -- their own narrative where a family member may have a particular agenda or being frustrated or angry with their adolescent child and make accusations -- Oh, yeah, they're constantly suicidal or they've done all these things and not necessarily quite true.

Yeah.

So you have -- on the one side you have the patient says no. On the other side you have external information that says, Oh, yeah, they're doing it quite a bit. How do you balance that in terms of the risk assessment?

Yeah, I think it's a good question. Oftentimes we have -- you know, it's a beautiful thing when all of our data sources line up and it's really clear what's going on with somebody. But oftentimes we have this conflicting data and that gets a little bit into what I was talking about earlier with the objective and subjective intent.

And I think a big piece of that is our job as the provider is to use our clinical judgment and our skills to really integrate all the pieces of information and make the best judgments that we can when there is just clearly different -- differing information, I mean, what I would do clinically in that circumstance is clearly have everybody in the same room and point out the dilemma and have them help me flesh it out.

So saying to the patient, Hey, you're telling me X, Y and Z, but your family has, you know, talked about these other claims that you've made. And if it wasn't true, then tell me why you said those things. Was it for a different reason? Were you trying to get other needs met? That sort of thing. So really trying to dig down with folks to understand sort of the reason why there is conflicting evidence.

And, you know, if in some cases you can't do that, then certainly you want to be more sort of conservative in terms of managing somebody's risk and taking things really seriously when sort of those statements or threats are made. So . . .

Yeah, I think you bring up a very good point in terms of be safe rather than sorry later.

Yeah, and it demonstrates to folks -- you know, I've worked with plenty of folks who might make statements about being suicidal for other reasons, not because they're actually feeling suicidal. And it just really quickly shows them that you're going to take that really seriously. So you send a welfare check and they may get really pissed at you, but that's the consequence for saying things like that. If you're, you know, trying to get a different need met, then tell me what that is and we'll talk about it. Otherwise, we're kind of going to have to go through this whole thing because I need to take that really seriously. So I think you can use sort of a DVT approach in this case.

Okay. Great. Another question. Would you provide some examples of barriers for patients calling a suicide prevention line?

Yeah, absolutely, good question. So the one that I most commonly hear is, Oh, I'm not calling that number because as soon as I call, the cops are going to show up at my house. So that's, I would say, the most common one that I hear.

So I provide them with some education about that. That the research coming out of the crisis line shows that the calls result in a rescue, as they call them, only ten percent of the time. So actually it might be even closer to five percent. I'd have to double-check it, but the vast majority of times, that's not what's

happening. And I give them education about what happens instead. So the crisis line responder's going to be getting a good sense of what's going on with you, they're going to talk to you to try to give you some coping skills in the moment to help calm down. They're going to make sure you're linked up with care, provide you with resources, that sort of a thing. It's much more rare that it results in what we call rescue.

I'm really transparent with folks about what would result in a rescue or a hospitalization and then as compared to what wouldn't, so they're really clear on that, because people have a lot of misconceptions about that.

The other -- another barrier that I tend to hear is, Well, I don't want to call and talk to some stranger. So I let them know that if they are a -- you know, this is easier in the VA system. If they're a veteran and they press one, they go to a VA responder and they can pull up their medical record and learn a lot about them.

But I'll also just sort of talk to folks about, well, in that moment, if you're in crisis, anybody can help you and these folks are trained to sort of get to know you quick and figure out what you need and I usually, in those cases, draw from any previous experiences that I know they've had. So let's say I recently just met them. Then I'll say, Well, you know -- or even, you know, when we started out our relationship, there was a point where you didn't know me either and we were able to figure it out and, you know, kind of get your needs met and so they'll be able to do that too.

Those are some of the main barriers I hear. Sometimes folks don't want to provide their name, they want to call anonymously. I'd much rather have them call anonymously than not call, so I tell them they can do that. Let them know that they can also, if they don't like doing this over the phone. There's also a text feature and a chat feature. So if they go to the veterans' crisis line website, that information's on there. So I would say those are some of the most common barriers that come up.

Okay. Another question, Would you please talk a little bit about family members and the role in suicide risk assessment and safety planning.

Yeah, absolutely. So it's another big theme that comes up, I would say, in a lot of the work we do and on the consultation service, is the need to get collateral information. So when things aren't just lining up or we're really concerned about somebody and we're having a hard time getting in touch with them, so whether it's the assessment piece or the management piece, I think family members are a critical piece of that.

So, you know, having them sort of provide information about what they're seeing, why they're concerned about the patient, they can be really helpful with safety planning, and developing a safety plan. They can really help provide insight into warning signs that maybe the veteran themselves isn't aware of, or the patient. And so that's one place I find it critical.

And then in terms of the support, I've had, you know, family members have copies of the safety plan so they can help remind the patient when they're crisis of the resources that are available to them.

So, Hey, you know, you have going for a walk on here. Why don't we get out of the house and go for a walk together, that kind of a thing. And one big piece of that is that if you work with patients who are really uncomfortable sharing their safety plan or involving family members in the assessment process, what I'll often say to them -- usually that's because of burdensomeness. They feel like they've already been such a burden to their family, they don't want to include them in this way. So I'll usually have the patient talk to me about somebody they've been really concerned about before and what was the worst part of that? Well, it's usually that they don't know how to help. Well, do you think your family member might be feeling the same way? Well, maybe. So maybe you could tell them how to help you, and they can be involved in this process that will actually, you know, alleviate some of that burden, that sort of a thing. So that's one way you can get everybody on the same page about including family.

And last question, for the few minutes we have left, would you please talk a little bit about self-care. We're dealing with a difficult topic and we often forget ourselves, and I would like you to address a little bit of that, if you will.

Yeah, thanks so much for bringing that up. I think, you know, our whole philosophy here in the MIRECC and certainly with our consultation service, our philosophy is never worry alone. And, again, it's not a phrase that we coin, so we kind of took from somebody. And we -- I mean, I think that is the biggest piece of self-care over doing this work is consulting with your colleagues and talking about this.

And that could be from the logistics of it. So, hey, let me run this case by you, this is how I was thinking of their level of risk, this is what I'm doing to help manage it, would you suggest anything else?

Or on the other end of it, which can just be, like, post passing, Wow, that was really intense or that was really sad or I feel really hopeless working with this person, and just really sharing that experience with your colleagues or, as it's appropriate, with other support in your life. I think that's a big piece of just talking about this stuff.

The stigma associated even with doing the work can be really intense. I mean, I tell people what I do and -- you know, if you're in a social setting, sometimes you just kind of get this quiet like, Oh, okay. And people are really uncomfortable talking about this stuff. So just really talking about it with your colleagues and support is a big, big piece.

And then all the, you know, typical things you would do to recommend to your patients for self-care: Taking breaks. If you had a really intense sessions with somebody, taking a minute to kind of, you know, alleviate your own anxiety and calm down and get yourself in a good place and really kind of being balanced with things.

In terms of really kind of catching yourself, if you've noticed that maybe you're starting to be really hypervigilant about your patients, because you're really freaked out about them, you're starting to sense more welfare checks then you normally would or hospitalize more people, you know, those are some cues that you might need to catch yourself if you're doing a lot of this work and really check in. And, again, the best way to do that is through just leaning on each other who are doing this work.

Yeah, I think those are great comments and thoughts. And as I was thinking through it, having been working in a crisis center at early years, processing every day at the end of the day to process how the day went and what went well, as well as what went bad, so to speak --

Yeah.

-- it's important to do so.

One last question, and my producers tell me I have a little bit of time. Are there are any professional groups with higher suicide risks than others that you can --

You know, I've certainly heard over the years a lot of that data sort of alluded to. I haven't actually read it myself, so I don't want to speak to it because I'm not sure exactly what is out there. But I do think there is research out there that does say that there is certain occupations that are at higher risk. I'm just not totally clear on what those are, so . . .

Okay. Very well. Well, thank you so much for a wonderful presentation and a great topic. We'll continue on with -- after the presentation here.

After the Webinar, please visit dcoe.cds.pesgce.com for -- to complete the online CE evaluation and download or print out your CE certificate or certificate of attendance. The online CE evaluation will be open through Thursday, October 8, 2015.

Thank you again to our presenter, Dr. Matarazzo. Today's presentation will be archived in the monthly Webinar section of DCoE websites. To help us improve future Webinars, we encourage you to complete the feedback tool that will open in a separate browser on your computer. To assess the presentation -- to access the presentation and resource list for this Webinar, visit DCoE website at dcoe.mail/webinars.

A downloadable audio podcast and edited transcript of the closed captioning text will be posted to that link as well.

The chat function will remain open for an additional ten minutes after the conclusion of the Webinar to permit attendees to continue to network with each other.

The next DCoE psychological health webinar topic, Pharmacology and the Treatment of Behavioral Health Conditions is scheduled for October 22, 2015, again, at 1 p.m. Eastern Standard Time. The next DCoE TBI webinar topic, Effects of Chronic Mild Traumatic Brain Injury: Caregiver Perspectives and Knowledge Gaps, is scheduled for October 8, 2015, from 1 to 2:30 p.m. Eastern Time.

Thank you again for attending and have a great day.