DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Therapeutic Risk Management for the Suicidal Patient

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

Presenter:

Bridget Matarazzo, PsyD
Co-director of the VA National Suicide Risk Management Consultation Program
Rocky Mountain Mental Illness, Research, Education and Clinical Center (MIRECC)
Denver, Colorado

Moderator:

Vladimir Nacev, Ph.D., ABPP
Clinical Psychologist, Senior Program Manager
Deployment Health Clinical Center
Silver Spring, Maryland

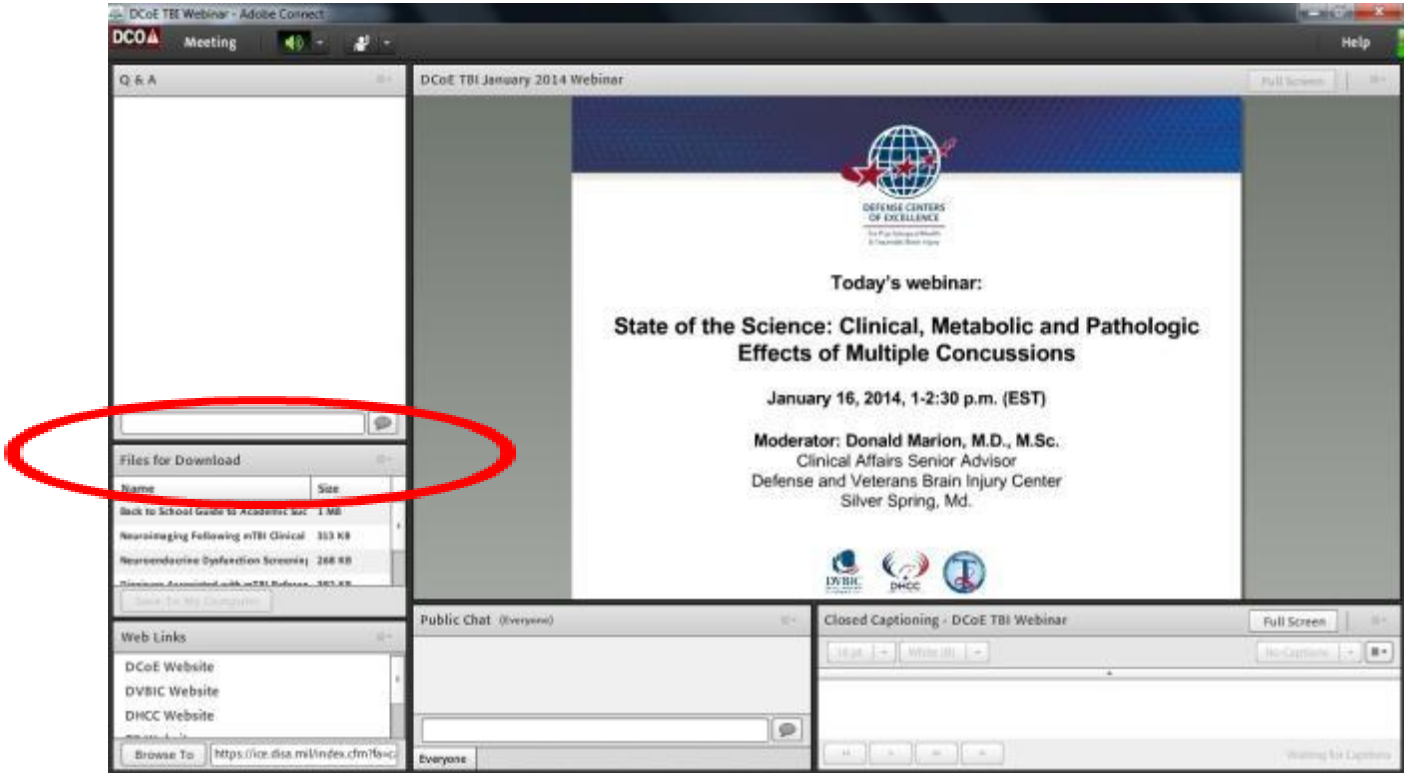
DVBIC
DHCC

Webinar Details

- Live closed captioning is available through Federal Relay Conference Captioning (see the “Closed Captioning” box)
- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: CONUS **800-369-2075;** International **773-799-3736** Use participant pass code: **9942561**
- Question-and-answer (Q&A) session
  - Submit questions via the Q&A box

Resources Available for Download

Today's presentation and resources are available for download in the "Files" box on the screen, or visit **dvbic.dcoe.mil/online-education**



Continuing Education Details

- DCoE's awarding of continuing education (CE) credit is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families.

- The authority for training of contractors is at the discretion of the chief contracting official.
  - Currently, only those contractors with scope of work or with commensurate contract language are permitted in this training.

Continuing Education Accreditation

- This continuing education activity is provided through collaboration between DCoE and Professional Education Services Group (PESG).

- Credit Designations include:
  - 1.5 AMA PRA Category 1 credits
  - 1.5 ANCC nursing contact hours
  - 1.5 APA Division 22 contact hours
  - 1.5 ACCME AMA PRA Category 1 credits
  - 1.5 CRCC continuing hours
  - 0.15 ASHA, Intermediate level continuing hours
  - 1.5 NASW continuing hours

Continuing Education Accreditation

Physicians
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Professional Education Services Group and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE). Professional Education Services Group is accredited by the ACCME to provide continuing medical education for physicians. This activity has been approved for a maximum of 1.5 hours of AMA PRA Category 1 Credits™. Physicians should only claim credit to the extent of their participation.

Psychologists
This activity is approved for up to 1.5 hours of continuing education. APA Division 22 (Rehabilitation Psychology) is approved by the American Psychological Association to sponsor continuing education for psychologists. APA Division 22 maintains responsibility for this program and its content.

Nurses
Nurse CE is provided for this program through collaboration between DCOE and Professional Education Services Group. Professional Education Services Group is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity provides a maximum of 1.5 contact hours of nurse CE credit.

Speech-Language Professionals
This activity will provide 0.15 ASHA CEUs (Intermediate level, Professional area).

Continuing Education Accreditation

Occupational Therapists
(ACCME Non Physician CME Credit) For the purpose of recertification, The National Board for Certification in Occupational Therapy (NBCOT) accepts certificates of participation for educational activities certified for AMA PRA Category 1 Credit ™ from organizations accredited by ACCME. Occupational Therapists may receive a maximum of 1.5 hours for completing this live program.

Physical Therapists
Physical Therapists will be provided a certificate of participation for educational activities certified for AMA PRA Category 1 Credit ™. Physical Therapists may receive a maximum of 1.5 hours for completing this live program.

Rehabilitation Counselors
The Commission on Rehabilitation Counselor Certification (CRCC) has pre-approved this activity for 1.5 clock hours of continuing education credit.

Social Workers
This activity is approved by The National Association of Social Workers (NASW) for 1.5 Social Work continuing education contact hours.

Other Professionals
Other professionals participating in this activity may obtain a General Participation Certificate indicating participation and the number of hours of continuing education credit.

Continuing Education Details

- If you wish to obtain a CE certificate or a certificate of attendance, please visit http://dcoe.cds.pesgce.com after the webinar to complete the online CE evaluation.

- The online CE evaluation will be open through **Thursday, October 8, 2015**.

Questions and Chat

- Throughout the webinar, you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. **Please do not submit technical or content-related questions via the chat pod**.
- The Q&A pod is monitored during the webinar; questions will be forwarded to presenters for response during the Q&A session.
- Participants may chat with one another during the webinar using the chat pod.
- The chat function will remain open 10 minutes after the conclusion of the webinar.

Summary and Learning Objectives

The presentation will provide an overview of the Therapeutic Risk Management model, a medicolegally and clinically sound method of conducting suicide risk assessment and management. The session will present suicide risk assessment methods consistent with the VA/DoD Clinical Practice Guideline for the Assessment and Management of Suicide Risk as well as rationale and tips for augmenting the clinical interview with objective assessment measures. The presenter will highlight the importance of stratifying suicide risk with respect to both severity and temporality and share recommendations for documentation. Finally, the presentation will provide an overview of safety planning as an evidence-informed risk management intervention.

Webinar participants will be able to:

- Identify at least two objectives measures that can be used to augment suicide risk assessment
- Describe risk stratification with respect to severity and temporality
- Complete a safety plan with a patient

Bridget Matarazzo, PsyD

Bridget Matarazzo

- Dr. Bridget Matarazzo completed her pre-doctoral internship at the Denver VA Medical Center and obtained a PsyD in clinical psychology from 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 (MIRECC) since 2010 where she currently is co-director of the VA National Suicide Risk Management Consultation Program. She also is an assistant professor in the Department of Psychiatry at the University of Colorado, School of Medicine.
- In the role of co-director 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 multi-site interventional trial aimed at studying the effectiveness of the Home-Based Mental Health Evaluation (HOME) Program, which she developed with her colleagues in the Rocky Mountain MIRECC.

VA | U.S. Department of Veterans Affairs

Therapeutic Risk Management of the Suicidal Patient

Bridget B. Matarazzo, PsyD

Rocky Mountain Mental Illness Research, Education, and Clinical Center (MIRECC);
University of Colorado, School of Medicine, Department of Psychiatry

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Webinar
September 24, 2015

ROCKY MOUNTAIN MIRECC

Poll 01 – Familiarity w/Suicide Risk Management?

- No to little experience
- A few cases a year (monthly)
- Regularly perform suicide risk management (weekly)
- Almost all of my job is dedicated to suicide risk management (almost daily)

Poll 02 – Comfort w/Suicide Risk Management?

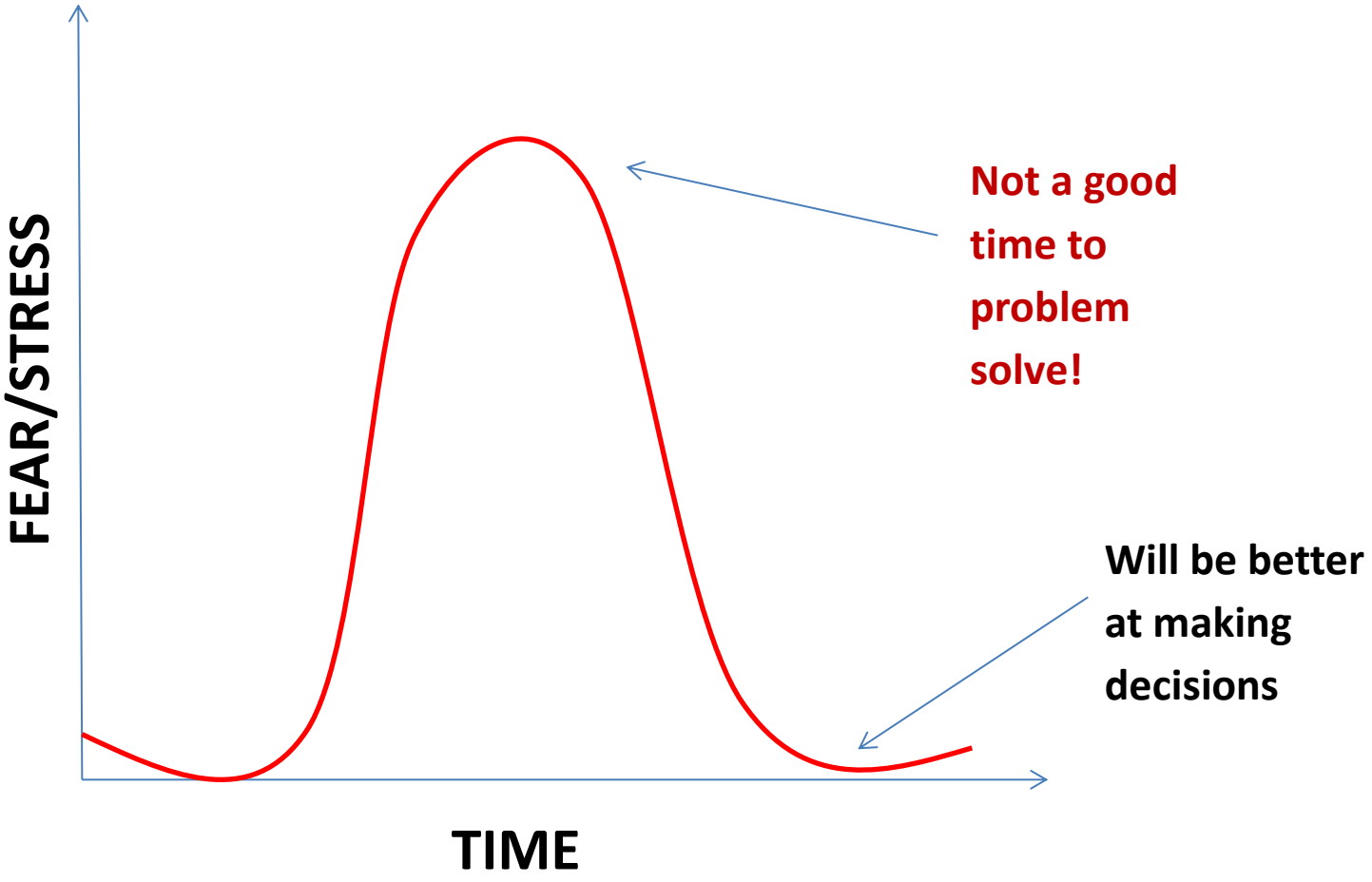
- Not at all comfortable/very anxious
- Some comfort but feel anxious throughout
- Decent level of comfort but occasional cases cause stress
- Quite comfortable – no to little anxiety

Why Assess Risk?

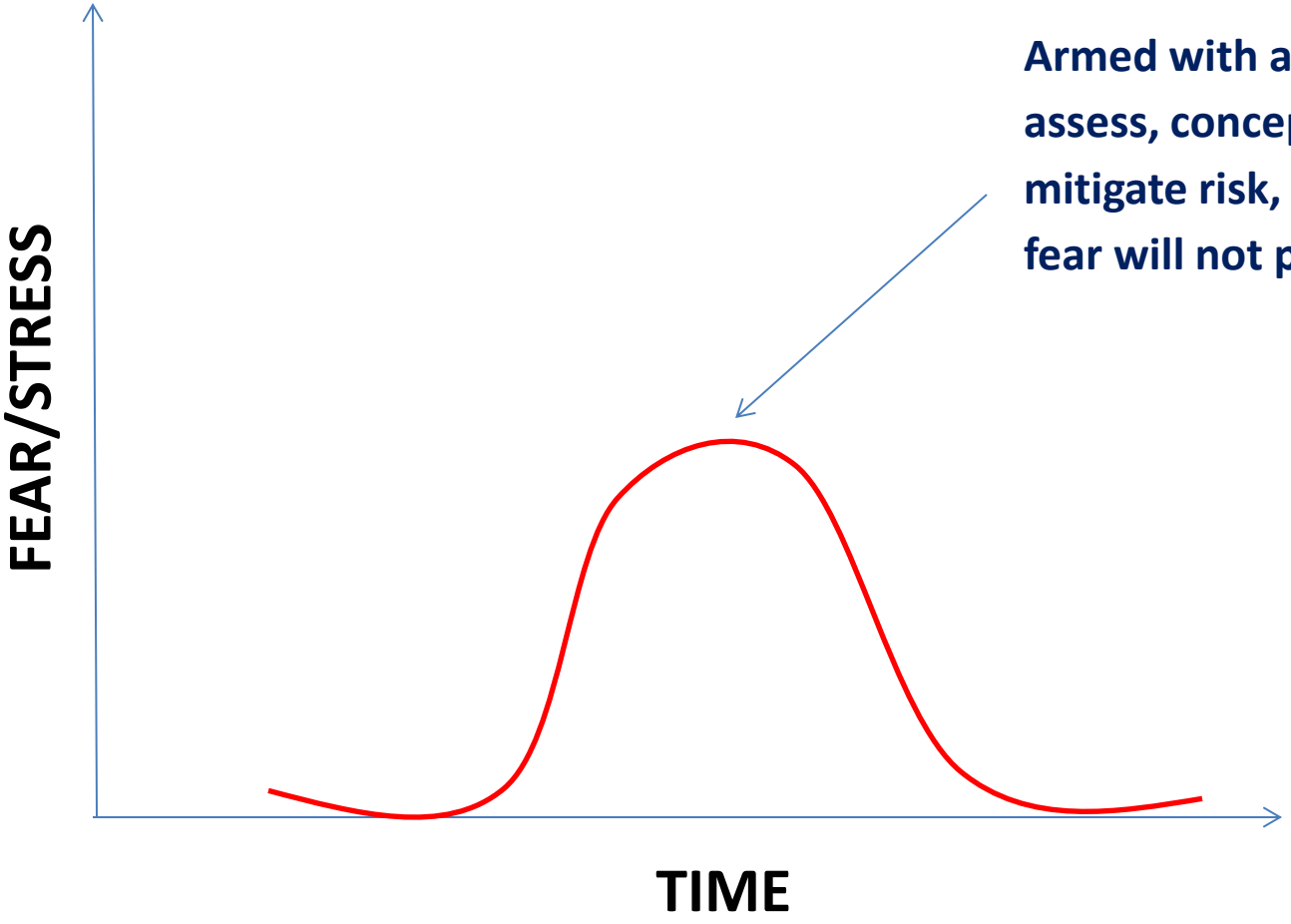
- **Take good care of our patients and to guide our interventions**
- **Take good care of ourselves**
  - Risk management is a reality of psychiatric practice
    - 15-68% of psychiatrists have experienced a patient suicide
    - Suicide/attempted suicide is one of the most common malpractice claim

Alexander, 2000; Chemtob, 1989

Fear/Stress and Clinical Decision Making



Fear/Stress and Clinical Decision Making



Armed with a better way to assess, conceptualize, and mitigate risk, a clinician's fear will not peak as high

Mitigating Fear...

- Via medicolegally informed practice that exceeds the standard of care
- Fortunately, the best way to care for our potentially suicidal patients and ourselves are one in the same
- Clinically based risk management is patient centered
  - Supports treatment process and therapeutic alliance
- Good clinical care = best risk management

Therapeutic Risk Management (TRM) with the Suicidal Patient

1. Conduct and document clinical risk assessment
2. Augment clinical risk assessment with structured instruments
3. Stratify risk in terms of both severity and temporality
4. Develop and document a Safety Plan

The series can be found in *The Journal of Psychiatric Practice*

Acknowledgements:
Hal Wortzel, PhD
Beeta Homaifar, PhD
Bridget Matarazzo, PsyD
Lisa Brenner, PhD, ABPP (Rp)

Therapeutic Risk Management

- Supports the patient's treatment and the therapeutic alliance
- Seeks to balance the sometimes competing ethical principles of autonomy, non-maleficence, and beneficence
- Avoids defensive practices of dubious benefit that, paradoxically, can invite a malpractice suit
- Unduly defensive mindset can distract the clinician from providing good patient care

Simon & Shuman 2009

1. Conduct and document clinical risk assessment

Concepts to be on the same page about

- Suicide is a rare event
- No standard of care for the prediction of suicide
- 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

Overarching Goal

- Gather information related to the patient's intent to engage in suicide-related behavior
- Evaluate factors that elevate or reduce the risk of acting on that intent
- Integrate all available information to determine the level of risk and appropriate care

VA/DoD Clinical Practice Guideline for the Assessment and Management of Suicide Risk

Intent of the guideline

- Reduce current unwarranted practice variation and provide facilities with a structured framework to help prevent suicide and other forms of suicidal self directed violent behavior

- Provide evidence-based recommendations to assist providers and their patients in the decision making process

Annotations are presented in four modules addressing the following components of care

Module A: Assessment and Determination of the Risk for Suicide

Module B: Initial Management of Patient at Risk for Suicide

Module C: Treatment of the Patient at Risk for Suicide

Module D: Follow-up & Monitoring of Patient at Risk for Suicide

Decision point:

- **For whom should suicide risk assessment processes be completed?**

- **Any person who is identified as being at possible suicide risk should be formally assessed for suicide risk**

A. Person Suspected to Have Suicidal Thoughts, a recent Suicide Attempt, or Self-directed Violence Behavior

A1. Any patient with the following conditions should be assessed for suicide risk:

Person reports suicidal thoughts on depression screening tool

Person scores very high on depression screening tool and is identified as having concerns of suicide

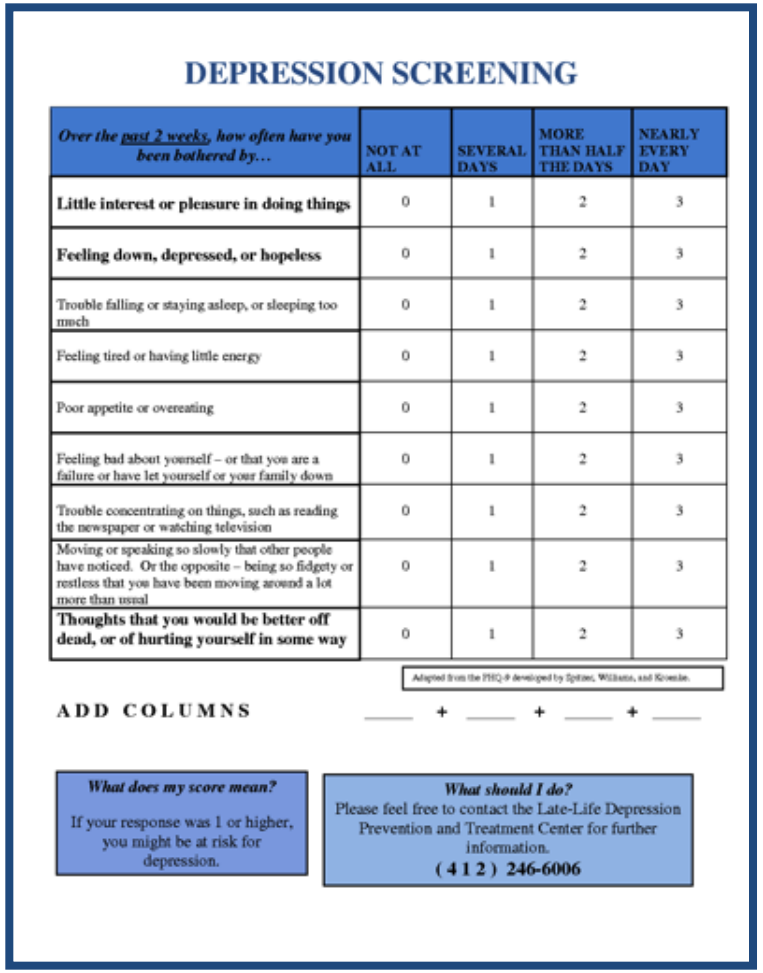
Person is seeking help (self-referral) and reporting suicidal thoughts

Person for whom the provider has concerns about suicide- based on the provider's clinical judgment

Person with history of suicide attempt or recent history of self directed violence.

What About Screening?

- University Screening: routine depression screening as part of regular health maintenance.
- Instruments like the PHQ-9 (which includes a question regarding presence of suicidal ideation) are widely accepted and administered to patients in primary care settings.



DEPRESSION SCREENING

Over the past 2 weeks, how often have you been bothered by…	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Adapted from the PHQ-9 developed by Spitzer, Williams, and Kroenke.

ADD COLUMNS _____ + _____ + _____ + _____

What does my score mean?

If your response was 1 or higher, you might be at risk for depression.

What should I do?

Please feel free to contact the Late-Life Depression Prevention and Treatment Center for further information.

(412) 246-6006

Suicide Risk Assessment

A **process** in which the healthcare provider gathers clinical information in order to determine the patient's risk for suicide.

Assessment and Determination of Risk

- **Gather** information related to the patient's intent to engage in suicide-related behavior.

C. Assessment of Suicidal Ideation, Intent, and Behavior

- **Evaluate** factors that elevate or reduce the risk of acting on that intent.

D. Assessment of Factors that Contribute to the Risk for Suicide

- **Integrate** all available information to determine the level of risk and appropriate care.

E. Determine the Level of Risk

Suicide Risk

Not just suicidal ideation

Current & Past

Risk Factors

Warning Signs

Protective Factors

Indicators of Risk

Ideation → Intent → Plan → Access to Means

Ideation → Intent → Plan → Access to Means

- **Specific & Direct**
  - "Tell me about what you think/what goes through your head"
- **Assess**
  - Onset, frequency, duration, severity

C1. Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior.

C2. Should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following: a. Onset, b. Duration, Intensity, and c. Frequency.

Ideation → **Intent** → Plan → Access to Means

- **Intent**
  - Willingness to act/Reasons for dying
  - How do these size up to barriers to act/reasons for living?

C2. Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

Suicide Intent

Subjective Suicide Intent

Objective Suicide Intent

Ideation → Intent → **Plan → Access to Means**

- **Plan**
  - Preparatory Behaviors?
    - Access to means, letters, rehearsal, research

C3. Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one's death).

Recognize Warning Signs

Precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk

Direct Warning Signs

1. Suicidal communication
2. Preparation for suicide
3. Seeking access or recent use of lethal means

Other Potential Warning Signs

Substance abuse – increasing or excessive substance use
Hopelessness – feels that nothing can be done to improve the situation
Purposelessness –no sense of purpose, no reason for living
Anger – rage, seeking revenge
Recklessness –engaging impulsively in risky behavior
Feeling Trapped –feelings of being trapped with no way out
Social Withdrawal – withdrawing from family, friends, society
Anxiety – agitation, irritability, feeling like wants to "jump out of my skin"
Mood changes – dramatic changes in mood, lack of interest in usual activities
Sleep Disturbances – insomnia, unable to sleep or sleeping all the time
Guilt or Shame – Expressing overwhelming self-blame or remorse

- **Decision point:** How do additional factors contribute to risk?

- **Evaluate** factors that elevate or reduce the risk of acting on that intent.

D1. Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

D2. Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

D3. Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

D5. Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient's home.

Risk vs Protective Factors

- **Risk Factors**
  - Increase the likelihood of suicidal behavior and include modifiable and non-modifiable indicators
- **Protective Factors**
  - Capacities, qualities, environmental and personal resources that increase resilience
  - Drive individuals towards growth, stability, and health
  - Increase coping with different life events
  - Decrease the likelihood of suicidal behavior

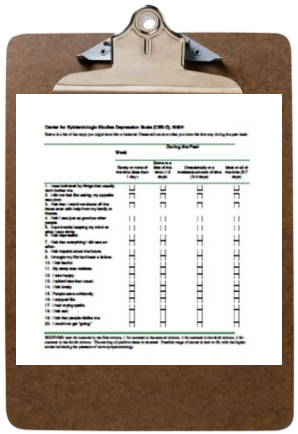
2. Augment clinical risk assessment with structured instruments

Poll 03 – Do you regularly use standardized assessments during suicide risk assessment?

- Yes
- No

Formal Assessment Approaches

- Providers across disciplines generally avoid using formal assessment approaches (e.g., validated tools) in favor of using their own clinical interviews (Jobes, 1995)
- Unstructured clinical interviews have the potential to miss important aspects of risk assessment
- Using both will facilitate a more nuanced, multifaceted approach to suicide risk assessment



The addition of reliable/valid self-report measures can…

- Augment clinical care
- Serve an important medicolegal function
- Help to realize therapeutic risk management of the suicidal patient

A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults

Gregory K. Brown, Ph.D.
University of Pennsylvania

http://www.sprc.org/sites/sprc.org/files/library/BrownReviewAssessmentMeasuresAdultsOlderAdults.pdf

Things to Consider

- Time
- Accessibility
- Credentials/Training of administrator
- How it will inform risk assessment
- Measuring baseline and movement over time

Some Measures Used by Rocky Mountain MIRECC Suicide Prevention Consultation Service

- Beck Hopelessness Scale (BHS)
  - Assesses hopelessness within the past week
  - ~5 minutes

  ➢One of the few measures that has demonstrated an association with death by suicide

- Reasons for Living Inventory (RFL)
  - Assesses reasons for living that may serve a protective function for someone considering suicide
  - ~10 minutes

- Beck Scale for Suicidal Ideation (BSS)
  - ~5 minutes

  ➢One of the few measures that has shown an association with death by suicide

What if I am unfamiliar with how to incorporate these tools into practice?

BSS

- During the first appointment, the BSS is used to establish a baseline regarding an individual's level of suicidal ideation
- Due to the transient nature of suicidal ideation, the BSS is also administered at the beginning of subsequent appointments
- Any changes in the score and/or composition of responses are then discussed with the patient, and this information is used to augment the assessment of the patient's acute risk for suicide

If a patient endorses the BSS item indicating uncertainty about whether he or she will make a suicide attempt, and this is a different response than that given in the previous appointment, the provider will then follow-up with questions aimed at further understanding this change in response.

Rationale for use

The inclusion of instruments such as the BSS in the patient's medical record helps to establish a baseline regarding suicidal ideation

- Facilitates subsequent risk assessments, including those performed by providers with less familiarity with the patient
- May reduce unnecessary hospitalizations (as may occur when baseline levels of suicidal ideation are misidentified as suicidal crisis)
- May facilitate life-saving interventions (when spikes in suicide risk are more readily apparent because of a well documented baseline)

Advantages:

- Require little time to administer
- Relatively easy to administer and therefore conducive to settings where time constraints are heavy
- Provide a modality in which patients may feel more comfortable disclosing sensitive information, such as suicidal ideation and behaviors
- Provide a quantitative measure of suicide risk

Potential Challenges:

- Time needed to familiarize themselves with the administration/scoring/interpretation of such measures
- Potential for over-reliance on a quantitative score of suicide risk which, if used in the absence of clinical judgment, is not capable of capturing the gestalt of the drivers of suicide risk
- Tendency to focus on suicide risk assessment as an event, rather than a process

Caveat

While suicide-specific assessment instruments can assist providers in the clinical assessment of suicidal ideation and behavior, such instruments are not a substitute for clinical judgment

No single assessment or series of assessments is able to accurately predict the emergence of a suicidal crisis

3. Stratification of Risk

What's the Risk?

- 29 y/o female
- 18 suicide attempts and chronic SI
  - Currently reports below baseline SI & stable mood
- Numerous psychiatric admissions
- Family history of suicide
- Owns a gun
- Intermittent homelessness
  - Currently reports having stable housing
- Alcohol dependence
  - Has sustained sobriety for 6 months
- Borderline Personality Disorder

Poll 04 – What's your risk estimation?

- Low
- Intermediate
- High

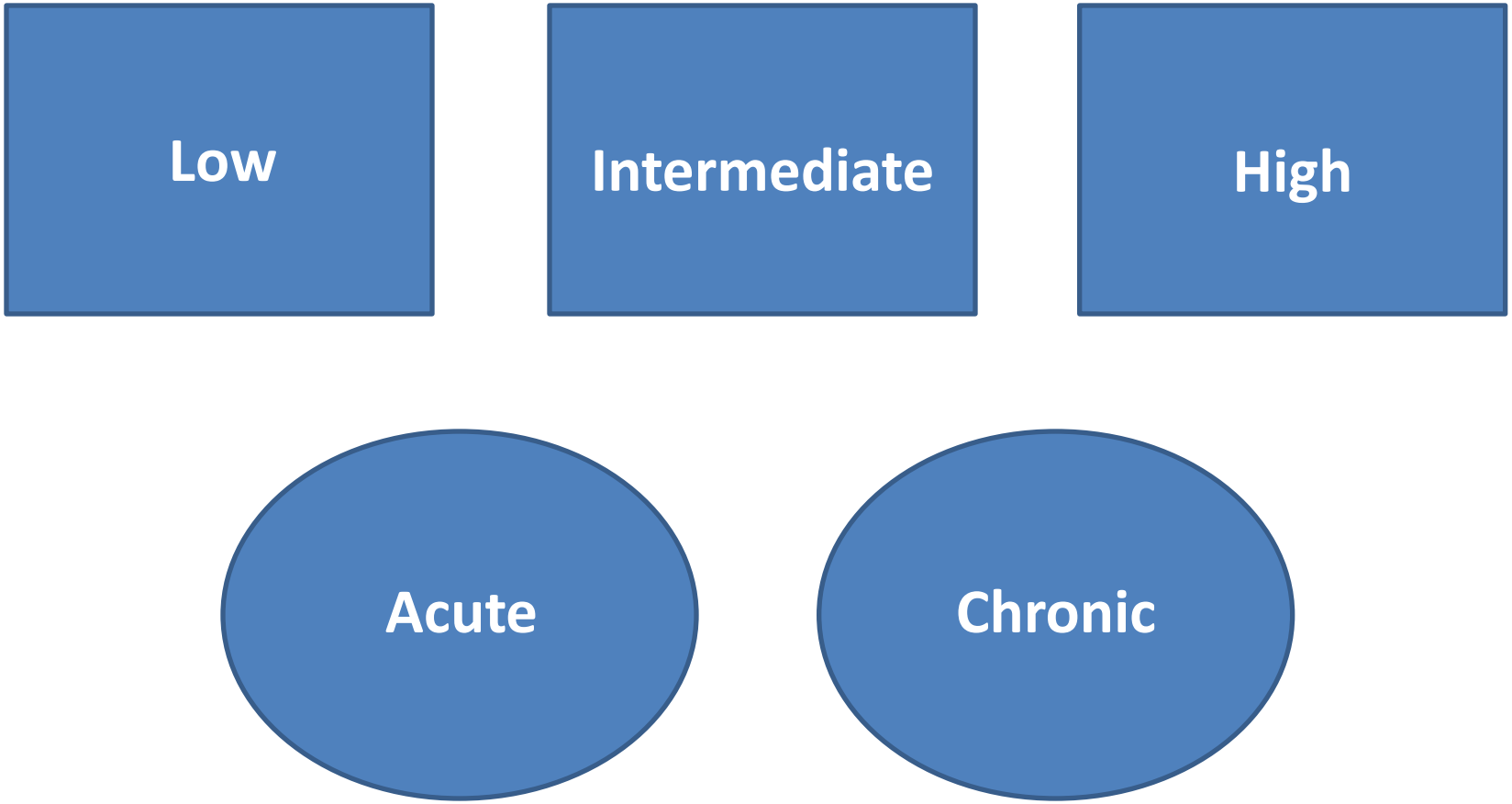
Severity

Low

Intermediate

High

Stratify Risk – Severity & Temporality



High Acute Risk

- **Essential features:**
  - SI with intent to die by suicide AND
  - Inability to maintain safety independent of external support/help
- **Likely to be present:**
  - Plan
  - Access to means
  - Recent/ongoing preparatory behaviors and/or SA
  - Acute Axis I illness (e.g., MDD episode, acute mania, acute psychosis, drug relapse)
  - Exacerbation of Axis II condition
  - Acute psychosocial stressor (e.g., job loss, relationship change)
- **Action:**
  - Psychiatric hospitalization

Intermediate Acute Risk

- **Essential features:**
  - Ability to maintain safety independent of external support/help
- **Likely to be present:**
  - May present similarly to those at high acute risk except for:
    - Lack of intent or preparatory behaviors
    - Reasons for living
    - Ability/desire to abide by Safety Plan
- **Action:**
  - Consider psychiatric hospitalization
  - Intensive outpatient management

Low Acute Risk

- **Essential features:**
  - No current intent AND
  - No suicidal plan AND
  - No preparatory behaviors AND
  - Collective high confidence (e.g., patient, care providers, family members) in the ability of the patient to independently maintain safety
- **Likely to be present:**
  - May have SI but without intent/plan
  - If plan is present, it is likely vague with no preparatory behaviors
  - Capable of using appropriate coping strategies
    - Willing/able to use Safety Plan
- **Action:**
  - Can be managed in primary care
  - Mental health treatment may be indicated

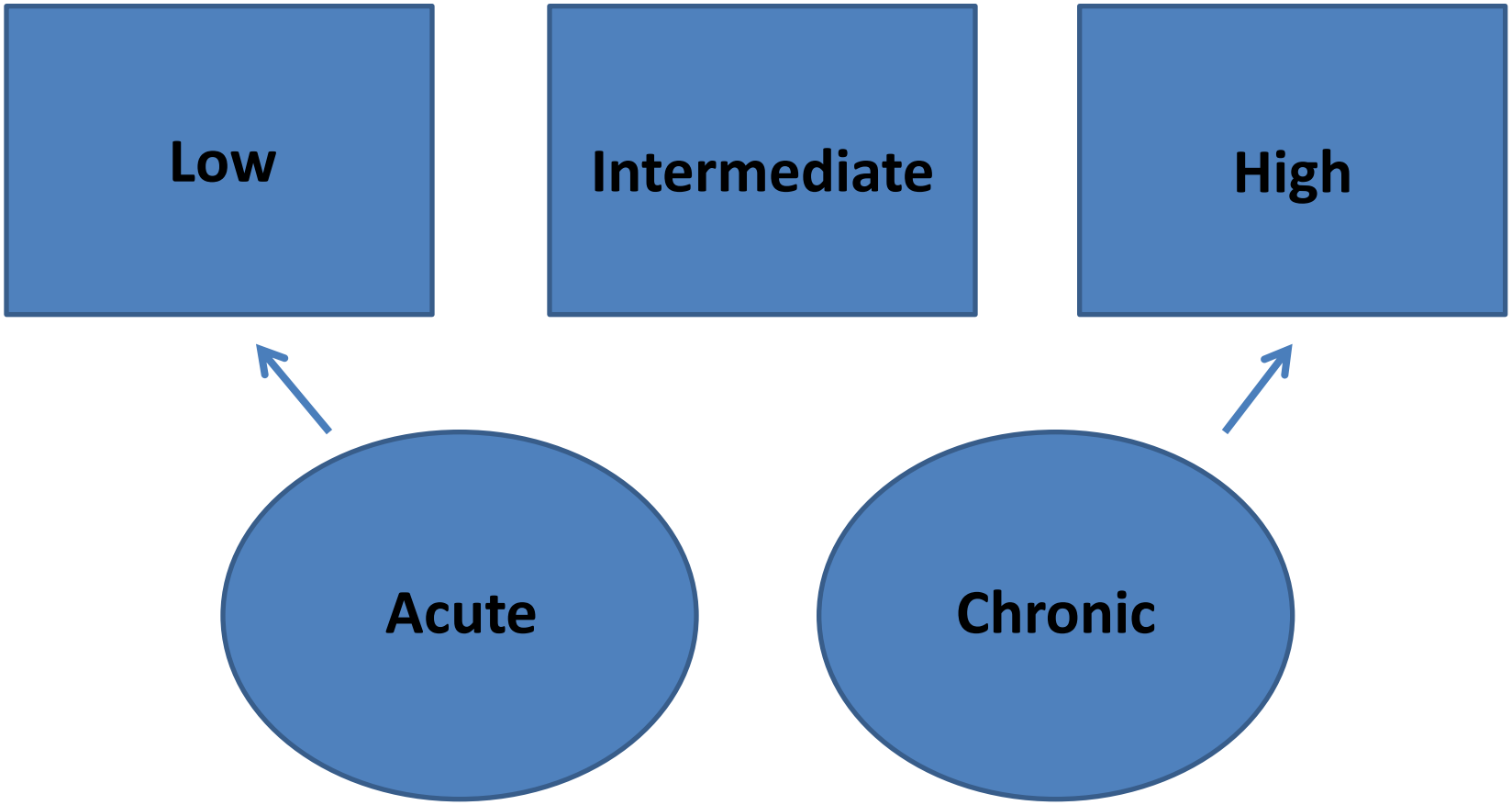
Chronic Risk

- **High**
  - Prior SA, chronic conditions (diagnoses, pain, substance use), limited coping skills, unstable/erratic psychosocial status (housing, rltp), limited reasons for living
  - Can become acutely suicidal, often in the context of unpredictable situational contingencies
  - Routine mental health f/up, safety plan, routine screening, means restriction, intervention work on coping skills/augmenting protective factors
- **Intermediate**
  - BALANCE of protective factors, coping skills, reasons for living, and stability suggests ENHANCED ability to endure crises without resorting to SDV
  - Routine mental health care to monitor conditions and maintain/enhance coping skills/protective factors, safety plan
- **Low**
  - History of managing stressors without resorting to SI
  - Typically absent: history of SDV, chronic SI, tendency toward impulsive/risky behaviors, severe/persistent mental illness, marginal psychosocial functioning

What's the Risk?

- 29 y/o female
- 18 suicide attempts and chronic SI
  - Currently reports below baseline SI & stable mood
- Numerous psychiatric admissions
- Family history of suicide
- Owns a gun
- Intermittent homelessness
  - Currently reports having stable housing
- Alcohol dependence
  - Has sustained sobriety for 6 months
- Borderline Personality Disorder

Stratify Risk – Severity & Temporality



Risk Assessment and Formulation: Documentation

Ideation → Intent → Plan → Access to Means

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 and no current intent suggest *low acute/imminent risk* for suicidal behavior

4. Develop and Document a Safety Plan

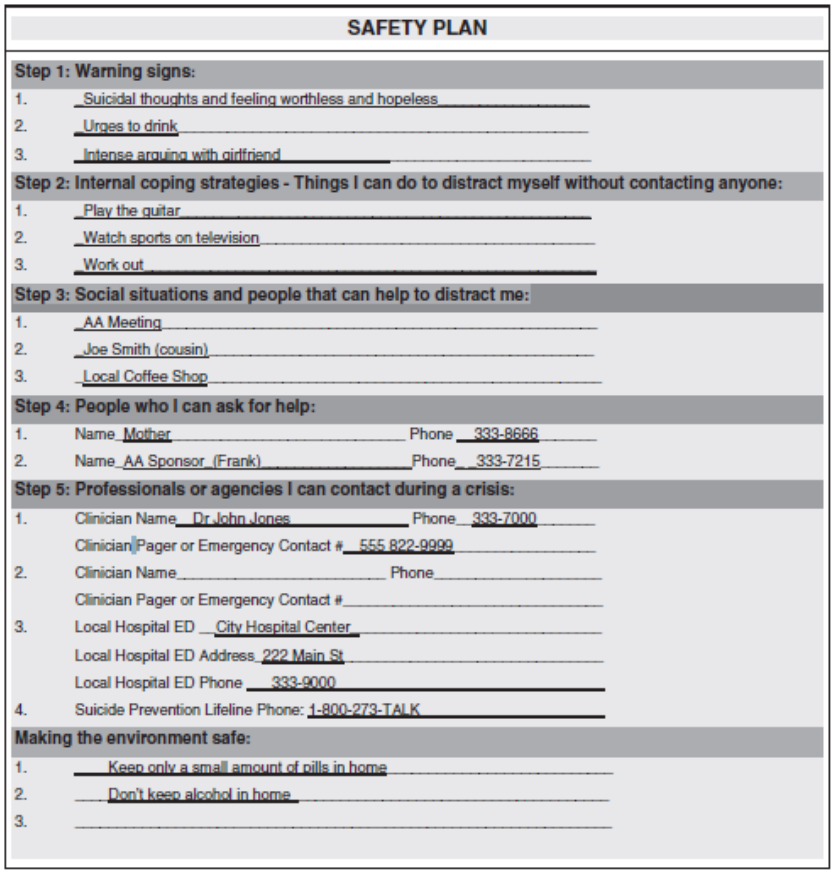
"No-Suicide Contracts"

- Typically entails a patient agreeing to not harm themselves
- Despite a lack of empirical support, commonly used (up to 79%) by mental health professionals
- Not recommended for multiple reasons
  - No medicolegal protection
  - Negatively influences provider behavior
  - Not patient-centered

Drew, 1999; Range et al., 2002; Rudd et al., 2006; Simon, 1999

Safety Planning

- Brief clinical intervention
- Follows risk assessment
- Hierarchical and prioritized list of strategies
- Used preceding or during a suicidal crisis
- Involves collaboration between the client and clinician



SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

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

1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3.

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.*

Tips for Developing a Safety Plan Collaboratively

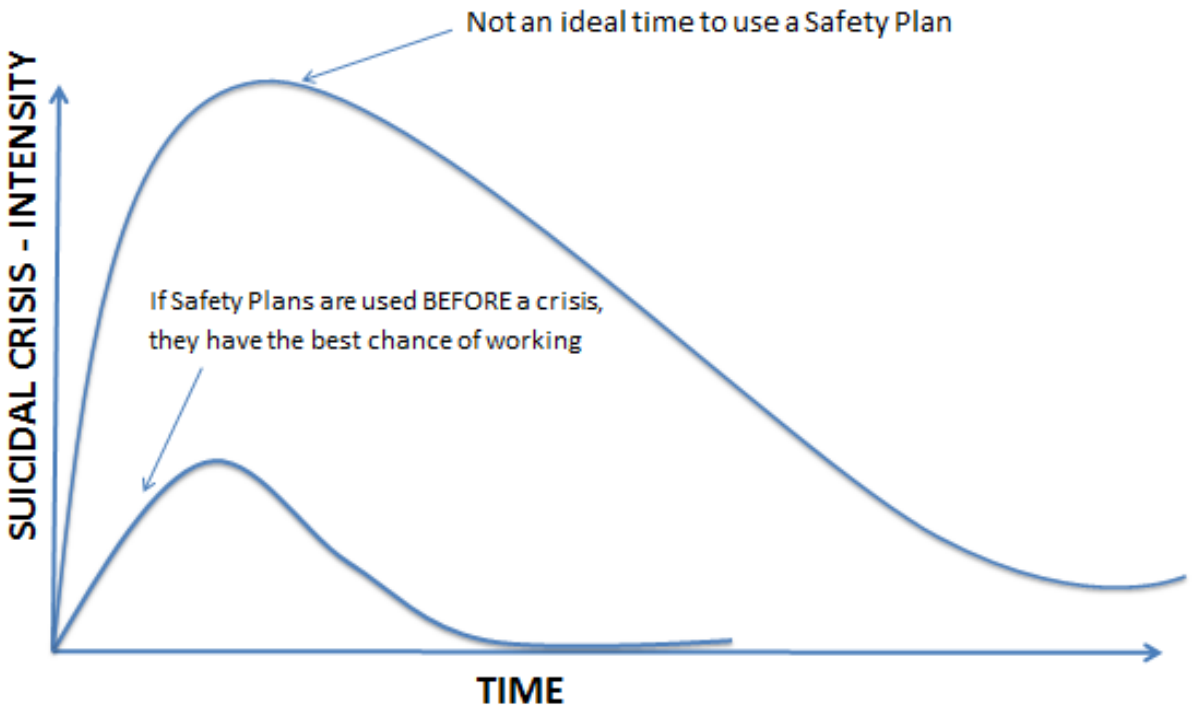
- Collaboration essential when working with individuals who are suicidal

- Ways to increase collaboration
  - Sit side-by-side
  - Use a paper form
  - Have the individual write
  - Provide brief instructions using client's words
  - Conversational approach
  - Jointly address barriers and use problem-solving

Ellis, 2004; Rudd, 2006; Jobes, 2006

Provide Rationale

- Ask: What's your thinking like in a crisis?
- Stop, Drop, & Roll analogy
- Catch it early!



Step 1: Warning Signs

- Purpose: Identify and attend to warning signs for suicidal ideation/behavior

- List specific and personalized examples in patient's own words
  - Thoughts
  - Emotions
  - Behaviors
  - Physical sensations

Ask:

"How will you know when to use your safety plan?"

"What are your personal red flags?"

Step 2: Internal Coping Strategies

- Purpose: Take the individual's mind off of problems to prevent escalation of suicidal thoughts

- List activities client can do <u>without contacting another person</u>
  - Take a hot shower
  - Listen to my "chill out" play list
  - Pet my dog

- Encourage patient to build "coping memory"

Ask:

"What can you do on your own to prevent yourself from acting on suicidal thoughts or urges?"

"How likely would you be able to do this during a time of crisis?"

Step 3: Social Contacts and Settings for Distraction

- Purpose: Engage with people and social settings that provide distraction

- List people or safe places that offer distraction
  - Important to include phone numbers and multiple options
  - Avoid listing any contentious relationships
  - Examples of places: park, coffee shops, places of worship

Ask:

"Who helps you feel better when you socialize with them?"

"What social settings help you take your mind off your problems at least for a little while?"

Step 4: People Who I can Ask for Help

- Purpose: Tell a family member or friend that he/she is in crisis and needs support

- List names and phone numbers of supportive others
  - Can be same people as Step 3, but different purpose
  - Include multiple options and prioritize list
  - If possible, share safety plan with the family member or friend

Ask:

"Among your family or friends, who do you think you could contact for help during a crisis?"

"Who is supportive of you and who do you feel that you can talk with when you're under stress?"

Step 5: Professionals and Agencies to Contact for Help

- Purpose: List professionals/services to reach out to if previous steps did not resolve the crisis

- List name, phone number and location of
  - Primary mental health provider and other providers
  - Emergency psychiatric services
- National Suicide Prevention Line: 1-800-273-TALK (8255)
- Veterans Crisis Line: 1-800-273-TALK (8255), press 1
- 911

Ask:

Who are the mental health professionals that we should identify to be on your safety plan?"

Step 6: Making the Environment Safe

- Purpose: Eliminate or limit access to lethal means
- Bonus purpose: Increase reminders of reasons for living

- Means-restriction counseling
  - Always ask about access to a firearm
  - Assess access to other means
    - Example: Discuss medications and how they are stored/managed
  - Consider alcohol and drugs as a conduit to lethal means
- Reminders of reasons for living may include photos of loved ones, inspirational quotes, etc.

Ask:

"What means do you have access to and are likely to use to make a suicide attempt?"

"How can we develop a plan to limit your access to these means?"

Enhancing Patient Use of the Safety Plan

- Increase access
- Personalize
- Encourage regular practice
- Share with others
- Update regularly
- Use technology

Thank you!

Bridget Matarazzo, PsyD
Bridget.Matarazzo@va.gov

www.mirecc.va.gov/visn19

References

Alexander DA, Klein S, Gray NM, et al. Suicide by patients: Questionnaire study of its effects on consultant psychiatrists. BMJ 2000;320:1571–4.

Beck AT, Steer RA, Ranieri WF. Scale for suicidal ideation: Psychometric properties of a self-report version. J Clin Psychol 1988;44:499–505

Brown, GK. A review of suicide assessment measures for intervention research with adults and older adults. Retrieved from http://www.sprc.org/sites/sprc.org/files/library/BrownReviewAssessment MeasuresAdultsOlderAdults.pdf

Brown GK, Beck AT, Steer RA, et al. Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. J Consult Clin Psychol 2000;68:371–7.

Chemtob CM, Bauer GB, Hamada RS, Pelowski SR, Muraoka MY. Patient suicide: Occupational hazard for psychologists and psychiatrists. Prof Psychol Res and Practice 1989;20(5):294-300.

Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide. 2013. Retrieved from http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf

Drew BL. No-suicide contracts to prevent suicidal behavior in inpatient psychiatric settings. J Am Psychiatric Nurses Assoc 1999;5:23–8.

Ellis TE. Collaboration and a self-help orientation in therapy with suicidal clients. J Contemp Psychother 2004;34(1):41-57.

Homaifar B, Matarazzo B, Wortzel HS. Therapeutic risk management of the suicidal patient: Augmenting clinical suicide risk assessment with structured instruments. J Psychiatr Pract 2013;19:406–9.

Jobes DA. Managing suicidal risk: A collaborative approach. New York: Guilford; 2006.

Jobes DA, Eryman JR, Yufit RI. How clinicians assess suicide risk in adolescents and adults. Crisis Intervention & Time-Limited Treatment 1995;2:1–12.

References

Linehan M.M., Goodstein JL, Nielsen SL, et al. Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. J Consult Clin Psychol 1983; 51:276–86.

Matarazzo B., Homaifar B., Wortzel, H.S., Therapeutic risk management of the suicidal patient: Safety planning. J Psychiatr Pract 2014;20:220–224.

Range LM, Campbell C, Kovac SH, et al. No-suicide contracts: An overview and recommendations. Death Studies 2002;26:51–74.

Rudd, M.D. (2006). *The assessment and management of suicidality.* Sarasota, FL: Professional Resource Press.

Rudd MD, Madrusiak M, Joiner TE. The case against no suicide contracts: The commitment to treatment statement as a practice alternative. J Clin Psychol 2006;62:243–51.

Simon RI. The suicide prevention contract: Clinical, legal, and risk management issues. J Am Acad Psychiatry Law 1999;27:245–50.

Simon RI, Shuman DW. Therapeutic risk management of clinical-legal dilemmas: Should it be a core competency? J Am Acad Psychiatry Law 2009;37:155–61.

Stanley B, Brown GK (with Karlin B, Kemp JE, & VonBergen HA). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.* 2008.

Wortzel HS, Matarazzo B, Homaifar B. A model for therapeutic risk management of the suicidal patient. J Psychiatr Pract 2013;19:323–6.

Wortzel HS, Matarazzo B, Homaifar B, et al. Therapeutic risk management of the suicidal patient: Stratifying risk in terms of severity and temporality. J Psychiatr Pract 2014;20:63–7.

Questions?

- Submit questions via the Q&A box located on the screen.
- The Q&A box is monitored and questions will be forwarded to our presenters for response.
- We will respond to as many questions as time permits.

How to Obtain CE Credit

1. Go to URL http://dcoe.cds.pesgce.com
2. Select the activity: **24 September 2015 Psychological Health Webinar**
3. This will take you to the log in page. Please enter your e-mail address and password. If this is your first time visiting the site, enter a password you would like to use to create your account. Select Continue.
4. Verify, correct, or add your information AND Select your profession(s).
5. Proceed and complete the activity evaluation
6. Upon completing the evaluation you can print your CE Certificate. You may also e-mail your CE Certificate. Your CE record will also be stored here for later retrieval.
7. The website is open for completing your evaluation for 14 days.
8. After the website has closed, you can come back to the site at any time to print your certificate, but you will not be able to add any evaluations.

Webinar Evaluation/Feedback

We want your feedback!

- Please complete the Interactive Customer Evaluation which will open in a new browser window after the webinar, or visit: https://ice.disa.mil/index.cfm?fa=card&sp=134218&s=1019&dep=*DoD&sc=11

- Or send comments to usarmy.ncr.medcom-usamrmc-dcoe.mbx.dcoe-monthly@mail.mil

Chat and Networking

Chat function will remain open 10 minutes after the conclusion of the webinar to permit webinar attendees to continue to network with each other.

Save the Date

Next DCoE Psychological Health Webinar:
Pharmacology in the Treatment of Behavioral Health Conditions

October 22, 2015; 1-2:30 p.m. (ET)

Next DCoE Traumatic Brain Injury Webinar:
Effects of Chronic Mild Traumatic Brain Injury: Caregiver Perspectives and Knowledge Gaps

October 8, 2015; 1-2:30 p.m. (ET)

DCoE Contact Info

DCoE Outreach Center

866-966-1020 (toll-free)

dcoe.mil

resources@dcoeoutreach.org