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Suicide Risk Assessment with Veterans in the Home Environment

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MHICM General Didactic Monthly Call

March 7, 2013

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Disclosure Statement

This presentation is based on work supported, in part, by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

Overview of Presentation

- Facts about Veteran Suicide
- The HOME Program
- In-Home Suicide Risk Assessment
- Safety Planning
- Questions and Comments

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Facts about Veteran Suicide

Facts about Veteran Suicide

- In FY 2009, suicide rate for Veterans utilizing VHA was **35.9 per 100,000**
  (Kemp & Bossarte, 2012)
- In 2009, suicide rate for general population was **13.68 per 100,000**
  (CDC, 2012)
- ~18 deaths from suicide/day are Veterans
  (National Violent Death Reporting System)
- ~ 5 deaths from suicide/day among Veterans receiving care in VHA.
  (VA Serious Mental Illness Treatment, Research and Evaluation Center)

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Severe Mental Illness and Suicide

- Veterans with bipolar disorder are among the highest at risk for death by suicide
  (Desai et al., 2008)
- Higher percentages of OEF/OIF Veterans with psychotic disorders report suicidal ideation
  (Lemaire & Graham, 2011)
- OEF/OIF Veterans with major depressive disorder or PTSD report higher rates of suicidal ideation
  (Jakupcak et al., 2009; Pietrzak et al., 2010)
- Psychotic symptoms reported at Veterans' last visit was associated with death by suicide within one week of the appointment
  (Britton et al., 2012)

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Post-discharge: High Risk Time Period

- The first week following psychiatric inpatient discharge is a particularly high-risk period of time (Hunt et al., 2009)
- 47% of all individuals who died by suicide following discharge did so prior to the date of their first follow-up appointment (Hunt et al., 2009)
- The highest-risk period for death suicide among Veterans is the first 12 weeks post-discharge (Valenstein et al., 2009)

Despite many efforts made by VA, many Veterans do not engage in care, which increases the risk that they will die by suicide.

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Trajectory of Suicide Risk

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Importance of Home Assessment

Sample: Individuals who attempted suicide

Intervention: Home-based re-assessment shortly after discharge

- Patients had significantly lower self-esteem and higher worry (both suicide risk factors) than when in the hospital
- 35% didn't remember discharge plans
- 86% who said they didn't need care post-discharge changed their minds
- Re-assessment may:
  - enhance the accuracy of assessments,
  - improve treatment planning,
  - encourage follow-up care

(Verwey et al., 2010)

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The HOME Program

Program Description

Risk assessment over the phone within **1 business day**

Home visit within **first week** of discharge

-Risk assessment

-Review and revise discharge plan and safety plan

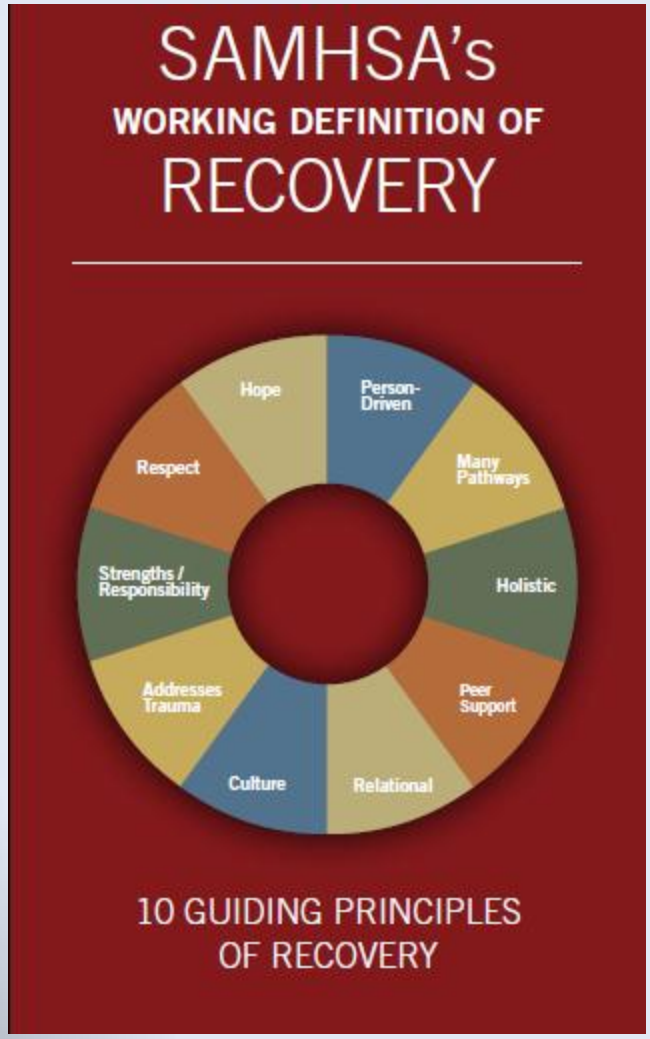
-Meet with support system

-Review upcoming appointments

-Completed assessment measures

Follow-up until engaged in care

Recovery-Oriented Care



VHA Directive 1163 mandates that mental health services must be recovery-oriented

(SAHMSA, 2012; US Dept of Veterans Affairs, 2011)

Recovery and the HOME Program

- Hope
- Person-driven
- Many pathways
- Holistic
- Relational
- Strengths/responsibility
- Respect

Suicide Risk Assessment

We assess risk to…

- Take good care of our patients and to guide our interventions
- The purpose of systematic suicide risk assessment is to identify modifiable and treatable risk factors that inform the patient's overall treatment and management requirements (Simon 2001)
- Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)

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Risk Assessment & Management

- Risk assessment and management is:
  - Person-driven
  - Strengths-based
  - Holistic
  - Provides hope
- Supports treatment process and therapeutic alliance (Simon, 2006)
- Good clinical care = best risk management (Simon, 2006)

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Suicide Risk Assessment

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

Good Clinical Practice is the Best Medicine

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

"Never worry alone." (Gutheil 2002)

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Suicide Risk Assessment

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

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Suicide Risk Assessment

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

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APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors

http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_14.aspx

- Quick Reference Guide
- Indications
- Risk/protective factors
- Helpful questions to uncover suicidality
- And more

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Important Domains of a Suicide-Focused Psychiatric Interview

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

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Thorough Psychiatric Evaluation

- Identify psychiatric signs and symptoms
  - In particular, sx's that might influence risk: aggression, violence, impulsivity, insomnia, hopelessness, etc.
- Assess past suicidal and self-injurious behavior
  - For each attempt document details: precipitant, timing, intent, consequences, and medical severity
  - Substances involved?
  - Investigate pt's thoughts about attempt: perception of lethality, ambivalence about living, degree of premeditation, rehearsal
- Review past treatment history and relationships
  - Gauge strength of therapeutic alliance

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Thorough Psychiatric Evaluation

- Indentify family history of suicide, mental illness, and dysfunction
- Investigate current psychosocial situation and nature of any current crisis
  - Acute crisis or chronic stressors may augment risk: financial, legal, interpersonal conflict or loss, housing, employment, etc.
- Investigate strengths!
  - Coping skills, personality traits, thinking style, supportive relationships, etc

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Specific Inquiry of Thoughts, Plans, and Behaviors

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

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Specific Inquiry of Thoughts, Plans, and Behaviors

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

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Identify Suicide Risk Factors

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

Warning Signs

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

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Risk Factors vs. Warning Signs

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

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Risk Factors vs. Warning Signs

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

Determine if factors are modifiable

Non-modifiable Risk Factors

- Family History
- Past history
- Demographics

Modifiable Risk Factors

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

Don’t Neglect Modifiable Protective Factors

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

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Establish Diagnosis and Risk

- Axis I, II, III, and IV all extremely pertinent to informed determination of risk
- In estimating risk, combine all elements:
  - Psychiatric illness
  - Medical illness
  - Acute stressors
  - Risk factors and patient-specific warning signs
  - Protective factors
  - Nature, intensity, frequency of suicidal thoughts, plans, and behaviors

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Acute v. Chronic Risk

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

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

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

Acute v. Chronic Risk

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

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

Psychiatric Management

- Establish/Maintain therapeutic alliance
  - Taking responsibility for patient's care is not the same as taking responsibility for the patient's life
- Attend to safety and determine treatment setting
  - Level of observation, frequency of sessions
  - Restricting access to means
  - Consider safety needs, optimal treatment setting, and patient's ability to benefit from such

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Develop a Treatment Plan

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

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HOME Program
Home Visit Risk Assessment

Mood reported as:

Suicidal Ideation at time of contact:

Suicidal Behavior reported since last visit:

Veteran modifications to safety plan were made as follows:
Step 1 (warning signs):
Step 2 (internal coping strategies):
Step 3 (ppl and places for distraction):
Step 4 (ppl I can ask for help from):
Step 5 (professional help):
Step 6 (making environment safe):

Risk Factors: recent discharge from inpatient hospital treatment,

Warning Signs:

Protective Factors/Reasons for Living:

Due to the dynamic nature of some warning signs and risk and protective factors, suicide risk should be routinely re-assessed.

Veteran is presently considered to be at _____ acute risk for suicide based upon _____.
Veteran is considered to be at _____ chronic risk for suicide based upon _____.
*Risk stratification can be low, moderate, moderate-high, or high.**

Safety Planning: A Stand Alone Intervention

Major Challenges

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

What is Safety Planning?

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

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

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“No-Suicide Contracts”

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

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

- DON’T USE THEM!

SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 4: People whom I can ask for help:

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

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

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

Step 6: Making the environment safe:

1. _____
2. _____

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

6 Steps of Safety Planning

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

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Resources

- VISN 19 MIRECC

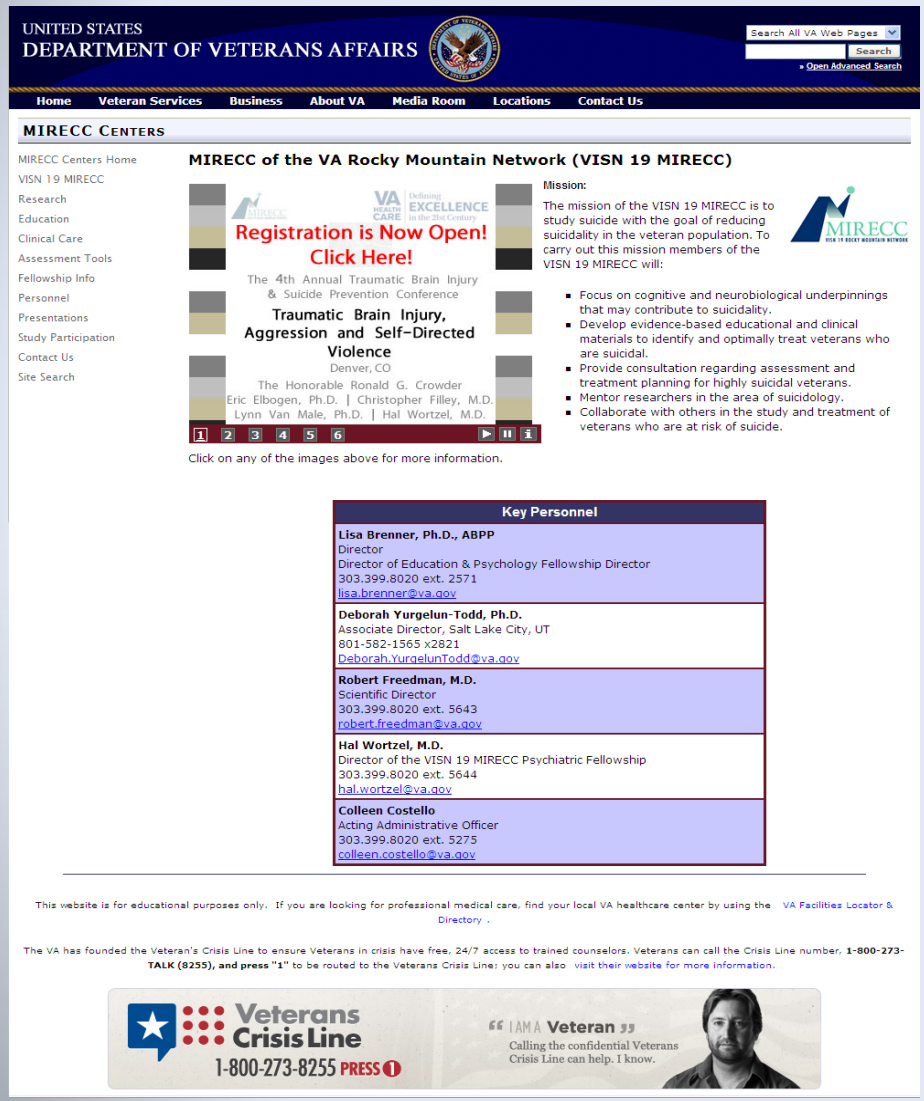
http://www.mirecc.va.gov/visn19/

- VA Safety Planning Manual

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


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

VISN 19 MIRECC Website



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

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Use Your Smartphone to Visit the VISN 19 MIRECC Website

Requirements:

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

www.mirecc.va.gov/visn19

Thank you!

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