

VA



U.S. Department
of Veterans Affairs



Therapeutic Risk Management

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Disclaimer

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

- **Background**
- **Risk Assessment Components**
 - Assessment + Formulation
 - Assessment Tools
 - Documentation
- **Conceptual Models**
- **Safety Planning**
 - Apps
- **Experiential Exercises**



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 warning signs and modifiable and treatable risk and protective factors that inform treatment and management



We should also assess to...

- **Take good care of ourselves**

- Risk management is a reality of mental health practice
- 15-68% of psychiatrists have experienced a patient suicide
- 33% report these patients' deaths led to irritability at home, decreased ability to deal with routine family problems, poor sleep, low mood, anhedonia, preoccupation with suicide, and decreased self-confidence

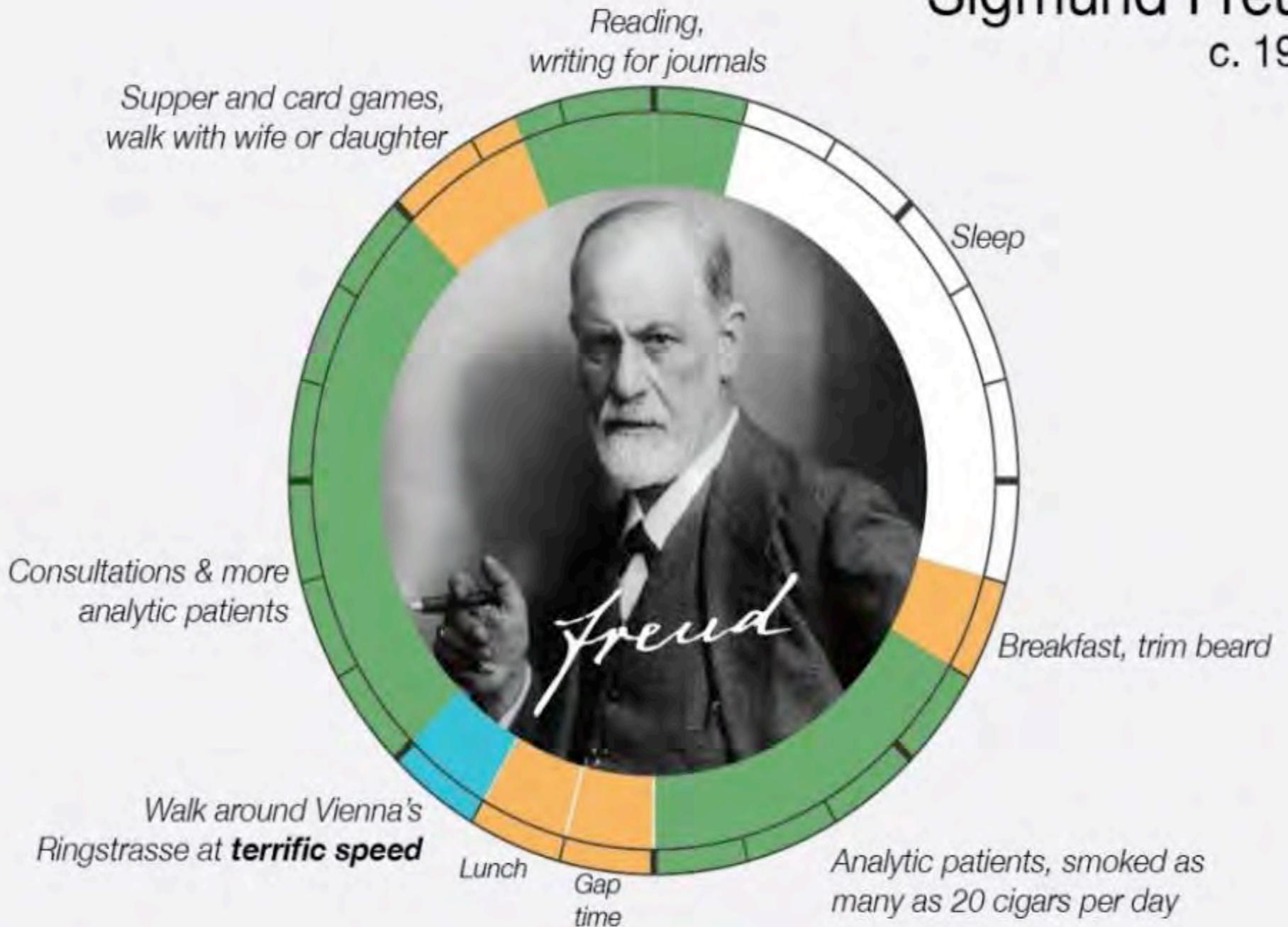


Provider Self-Care



Sigmund Freud

c. 1910



A Self-Care Tool for Clinicians



- Provides tools to guard against burnout and compassion fatigue.
- Videos by service members describing the positive impact health care providers had in their lives are there when you need a reminder of the value of what you do.

<http://t2health.org/apps/provider-resilience#.UjqbNhaCIII>

Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR

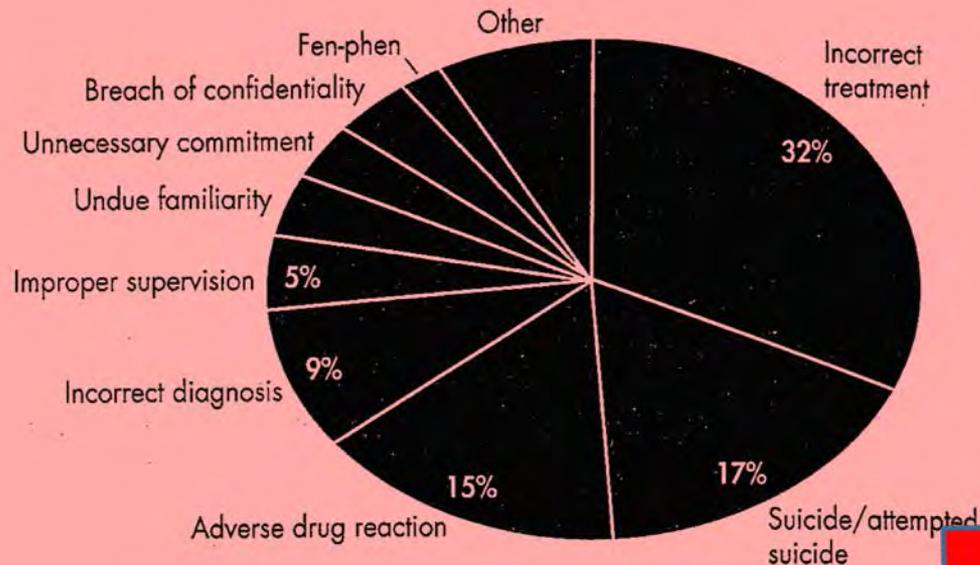


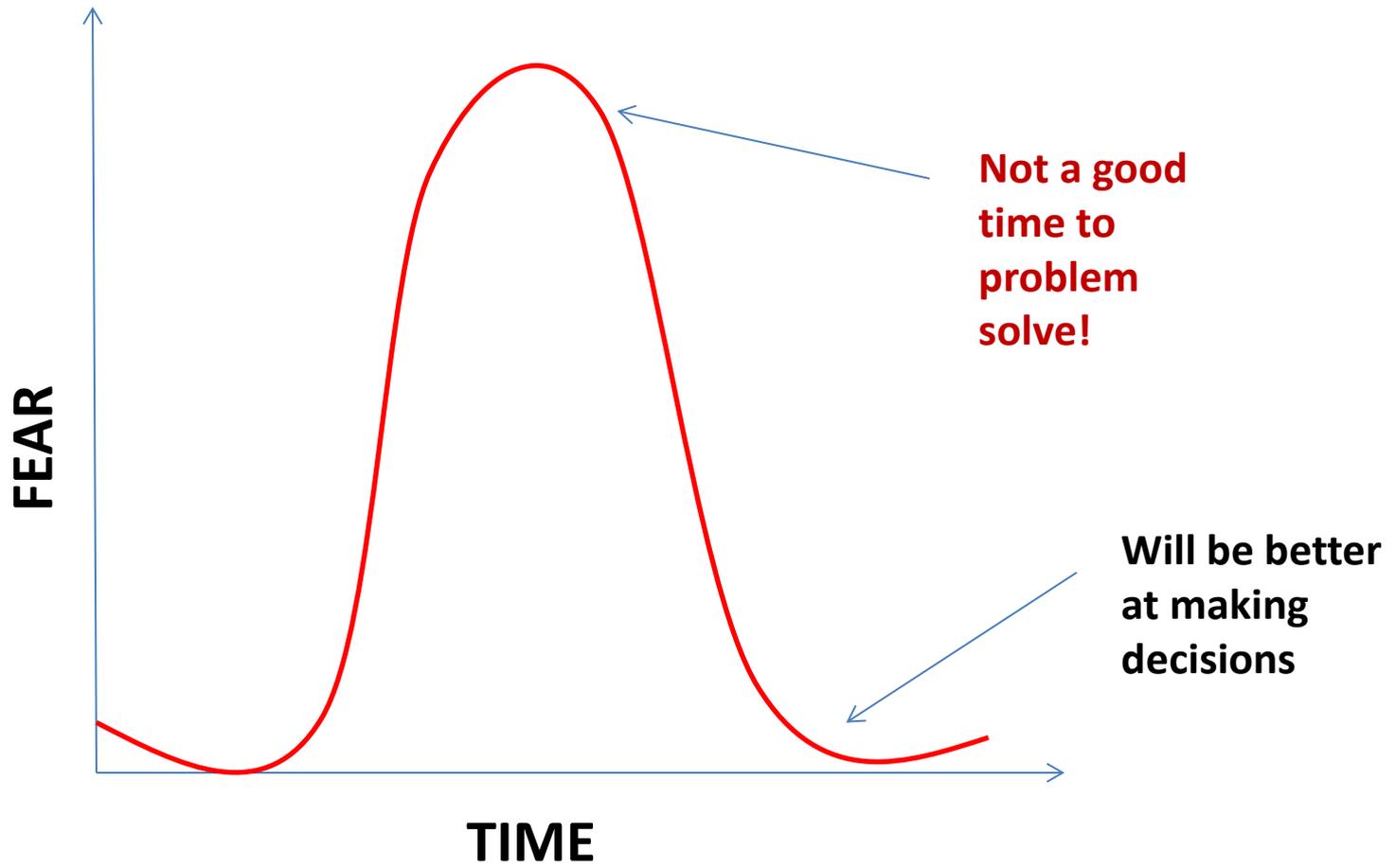
FIGURE 28-1. Most common malpractice claims against psychiatrists: United States, 1999-2003.

Source. The Psychiatrist's Program, the APA-Endorsed Psychiatrists' Liability Insurance Program, 2004.

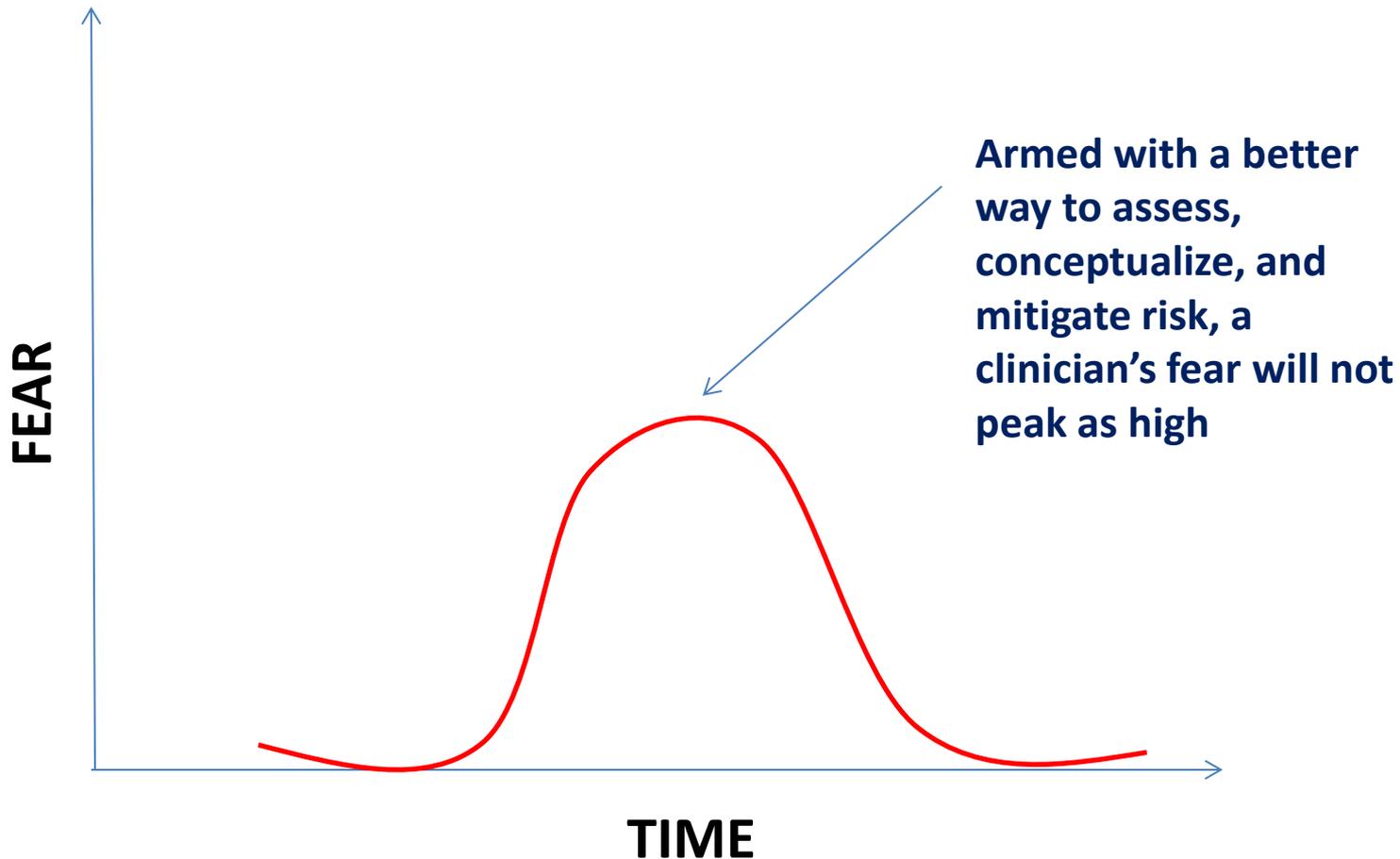




Fear and Clinical Decision Making



Curbing fear should help with decision making





Mitigating Fear

- **The best way to care of potentially suicidal Veterans and ourselves are one in the same**
- **Medico-legally informed practice, that exceeds the standard of care**
- **Clinically based risk management**
 - Patient centered
 - Supports treatment process and therapeutic alliance
- **Good clinical care = best management = good clinical care**



Therapeutic Risk Management

- Affirms the clinician's role in the collaborative treatment of the patient who is suicidal
 - There is a reason that patients are coming to see you – a mental health provider
- Requires working knowledge of the legal regulation of practice to inform appropriate clinical management of legal concerns that frequently arise regarding suicidal patients in crisis



Therapeutic Risk Management

- Supports the therapeutic alliance and treatment plan
- 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
- Seeks to balance the sometimes competing ethical principles of autonomy, non-maleficence, and beneficence



Therapeutic Risk Management

- **Autonomy**

- “personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice.”

- **Non-maleficence**

- “do no harm”

- **Beneficence**

- action that is done for the benefit of others
- beneficent actions can be taken to help prevent or remove harms or simply improve the situation of others



Consequences?

- **Defensive practices may compromise:**
 - Adherence to ethical principals
 - Autonomy (e.g., privacy)
 - Non-maleficence (e.g., 90 day prescription)
 - Beneficence (e.g., means restriction)
 - Clinical/therapeutic relationships
 - Protective factors (e.g., maintaining employment vs. hospitalization)
 - Long-term progress



Bad Outcomes

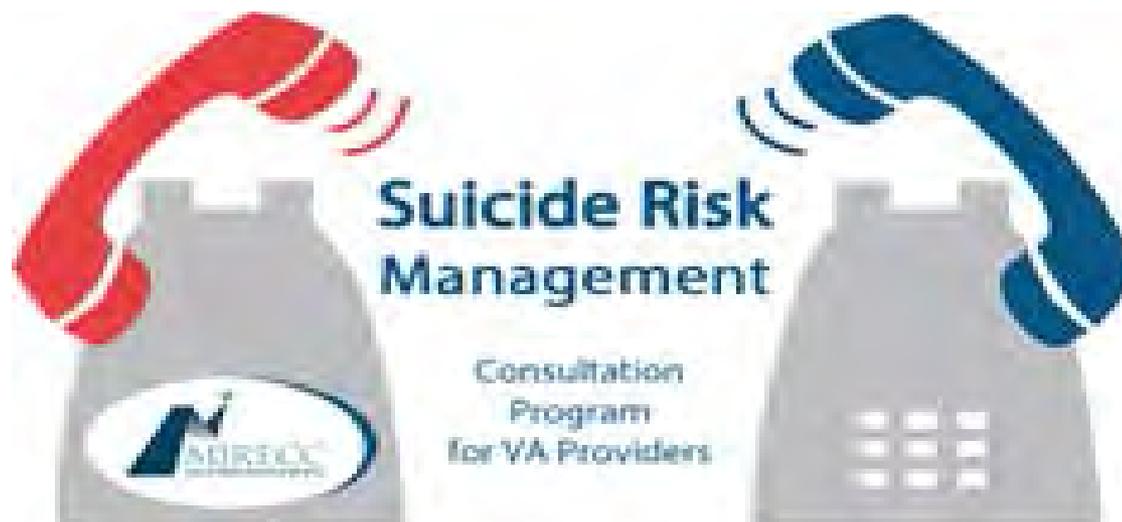
Oncology



Mental Health

- Resistance to treatment
- Patient drop-out
- Hospitalization
- Involvement of leadership
- Grievance
- Legal involvement
- Death

National Suicide Risk Management Consultation Program



Email: srmconsult@va.gov or
Call: (866) 948-7880
to Schedule a Consult

<http://www.mirecc.va.gov/visn19/consult/index.asp>



A Model for Therapeutic Risk Management

- **Suicide risk assessment**
 - Augment with structured instruments
- **Stratify risk in terms of both severity and temporality**
- **Documented clinical risk assessment**
- **Develop and document a Safety Plan**



Suicide Risk Assessment Components

Assessment + Formulation



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**



Guiding Principles

- **Standard of care does require suicide risk assessment whenever indicated**
- **Best assessments will attend to warning signs, and 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



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



Intent of the guidelines

- **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

| <i>Over the past 2 weeks, how often have you been bothered by:</i> | 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 Gibbon.

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.

(4 1 2) 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.
- **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.

C. Assessment of Suicidal Ideation, Intent, and Behavior

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

E. Determine the Level of Risk



Suicide Risk



Not just suicidal ideation



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



Structured Assessments



- **The addition of reliable/valid self-report measures can...**
 - Enhance clinical care
 - Serve an important medicolegal function
 - Help to realize therapeutic risk management of the suicidal patient



Beck Scale for Suicidal Ideation (BSS)

21-item scale used to assess the severity of suicidal ideation within the past week

5 minutes

Beck Hopelessness Scale (BHS)

20-true/false items that assesses hopelessness within the past week

5 minutes

Reasons for Living Inventory (RFL)

48-item scale to assess the reasons for living that may serve a protective function for those at risk

10 minutes



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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
- May reduce unnecessary hospitalizations
- May facilitate life-saving interventions

Wortzel, Homaifar, & Matarazzo, 2013

Go to MH Assistant in CPRS

Click on Instrument Administrator

Citrix Viewer View Keyboard Webcam

Mental Health Assistant in use by BAHRAHBO, NAZAHIN H

Mental Health Assistant Zzaqa, Patient C SSN: xxx-xx-xxxx

Visit: 07/31/14 PRIMARY CARE PROVIDER NOTE, GOL PACT PC FETCHIK, KATHY, Kathy L. Fetchik, D.O. (Jul 31, 14@07)

LOCAL TITLE: PRIMARY CARE PROVIDER NOTE
STANDARD TITLE: PRIMARY CARE OUTPATIENT NOTE
DATE OF NOTE: JUL 31, 2014@07:41 ENTRY DATE: JUL 31, 2014@07:41:27
AUTHOR: FETCHIK, KATHY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

REASON FOR VISIT/CHIEF COMPLAINT:
F/U as previously recommended - 6 month check. Patient is doing very well and is without complain today. He would like refills on his medications.

SOURCE(S) OF HISTORY: Patient
78 year old MALE
SERVICE CONNECTED \$ - NONE FOUND
MyHealthEver Premium account? NO

Active Problems:
Computerized Problem List is the source for the following:
1. Diabetes Mellitus without mention of Complication, type II or unspecified ty
2. Essential Hypertension
3. Chronic airway obstruction, Not Elsewhere Classified
4. Chronic ischemic heart disease
5. Alcohol Dependence * (ICD-9-CM 303.90/303.91)

Lab & Data:
CREATININE SERUM - NONE FOUND
No GLUCOSE (SERUM) in the last 6M ALLEGIES AS DISPLAYED IN
VISTA: CONTRAST MEDIA, PENICILLIN
Patient/family state(s): No new allergies

CURRENT MEDICATIONS: Active Outpatient Medications (including Supplies):
Active Non-VA Medications Status

ESTABLISHED PATIENT Detailed
Diagnosis:
Tinnitus - Tinnitus, unspecified (ICD-9-CM 388.20) (Primary)

May 01, 09 MH GROUP COUNSELING (B), ZZCBOC MHC TEST CLINIC, Jacqueline S. Lopez, R.H.I.A.
Feb 11, 09 MH GROUP COUNSELING (B), ZZPJUE MHC BENAVIDEZ GROUP, PEGGY BENAVIDEZ-LOPEZ, LCSW
Jan 29, 09 FEE BASIS CONSULT REPORT, DEN FEE BASIS, Jacqueline S. Lopez, R.H.I.A.
Jan 09, 09 OUTSIDE RECORDS SCANNED DOCUMENT (T), SCANNED DOCUMENT, Hymie K. Schnepfle
Jan 09, 09 OUTSIDE RECORDS SCANNED DOCUMENT (T), SCANNED DOCUMENT, Hymie K. Schnepfle
Dec 30, 08 SA PSYCHOEDUCATION GROUP, zZDEN SA EMRICK GROUP, Chad D. Emrick, Ph.D.
Dec 05, 08 SCANNED DOCUMENT (T), SCANNED DOCUMENT, Hymie K. Schnepfle
Jul 14, 08 PROVIDER NOTE, DEN S2 VASC/SURG FRI, WARREN D MCDONALD
Jul 08, 08 SA TELEPHONE CONTACT (B), DEN SA TELEPHONE, Chad D. Emrick, Ph.D.

Templates
Encounter
New Note

Cover Sheet Problems Meds Orders Notes Consults Surgery D/C/Summ Labs Reports

Scroll down until you see the BSI

Mental Health Assistant in use by BAHRAINI,NAZANIN H

File Tools Help

 Instrument Administrator Zzaqa, Patient C
SSN: xxx-xx-xxxx

Instruments Ordered By:
BAHRAINI,NAZANIN H

Interviewer:
BAHRAINI,NAZANIN H

Date of Administration:
10/ 1/2014

Visit Location:

Link With Consult (Optional):

Instructions:

If you select someone else as the instrument orderer, that person will be notified by e-mail.

Instruments that are available depends on the instrument orderer.

Available Instruments and Batteries:

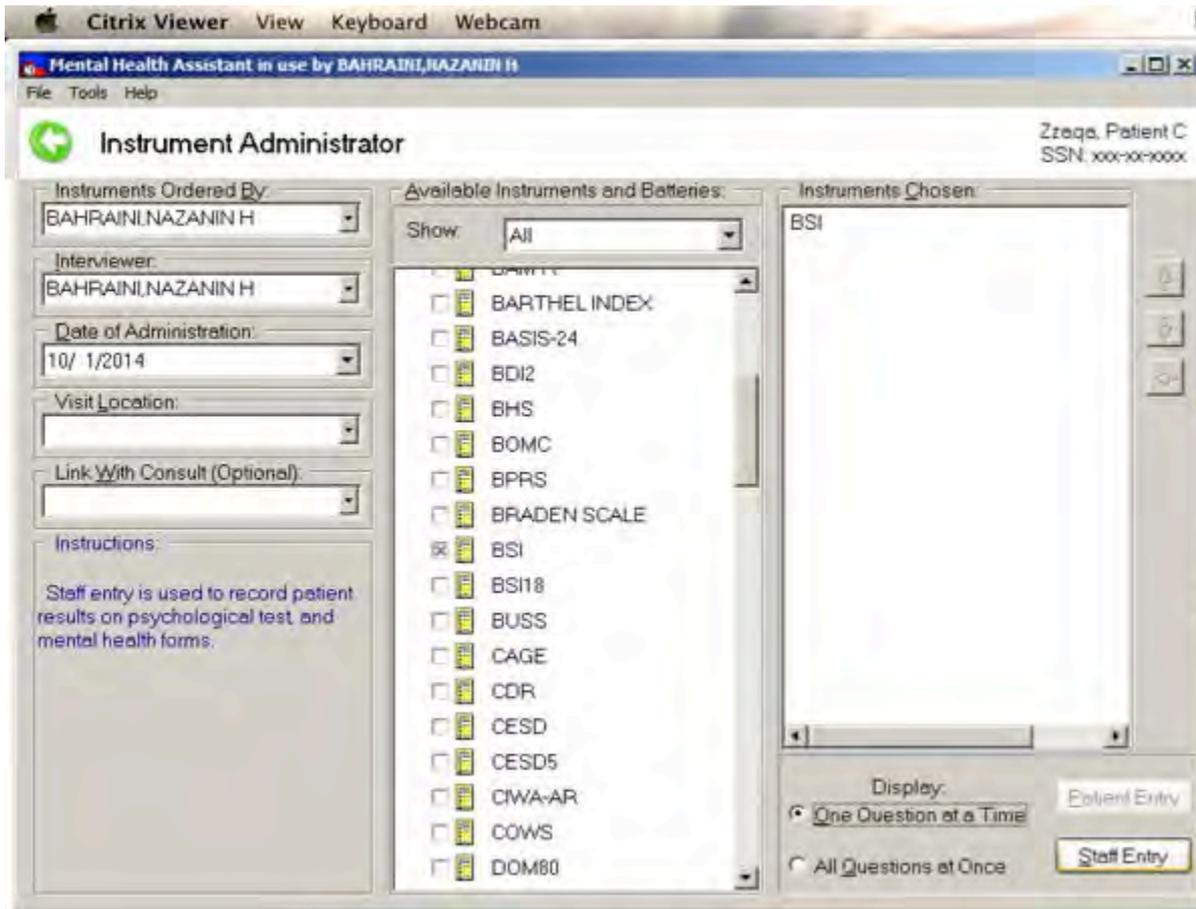
Show: All

-  **My Battery**
-  AAQ-2
-  AIMS
-  ASSIST
-  ATQ
-  AUDC
-  AUDIT
-  AUIR
-  BAI
-  BAM
-  BAM-C
-  BAMHOP
-  BAM-R
-  BARTHEL INDEX
-  BASIS-24
-  BDI2
-  BHS
-  BOMC

Instruments Chosen:

Display:
 One Question at a Time Patient Entry
 All Questions at Once Staff Entry

Select BSI



Select one question at a time and patient entry

Answer each question by selecting a response

Citrix Viewer View Keyboard Webcam 3 Wed 3:06 AM

BSE: ZZAQA, PATIENT C

File View Tools Help

1. Select the one statement in each group that BEST describes how you have been feeling for the PAST WEEK, INCLUDING TODAY.

- 0. I have a moderate to strong wish to live.
- 1. I have a weak wish to live.
- 2. I have no wish to live.

BSE

Next Question Error Question Review Answers Cancel Finish

Use speed tab Hint: Use the number key of the item to speed data entry.

Questions skipped: 1

Save Progress Note to Vista

BSI

This administration has been saved in Vista.

Do you wish to:

Save standard Progress note

Edit then save Progress note

Do not save Progress note



Entered in a separate note with selected responses and total score

The screenshot displays a Citrix Viewer window with the following elements:

- Top Bar:** Citrix Viewer View Keyboard Webcam. System tray shows 11:3, Wed 3:11 AM, and 13% battery.
- Application Title Bar:** Vista CPRS in use by: Bahraini, Nazanin H (VISTA.DOWER.MED.VA.GOV)
- Menu Bar:** File Edit View Action Options Tools Help
- Patient Information:** ZZAQA, PATIENT C (OUTPATIENT), Visit Not Selected, Primary Care Team Unsigned, 615-10-3135P, Oct 31, 1935 (78), Current Provider Not Selected.
- Left Panel (List 50 Signed Notes):**
 - Oct 01 14 MENTAL HEALTH DIAGNOSTIC STUDY NOTE, DEN MENTAL HEALTH RESEARCH-X, Nazanin H Bahraini
 - Jul 31 14 PRIMARY CARE PROVIDER NOTE - GOL PACT PC FETCHIK, KATHY, Kathy L Fetchik, D.O.
 - Jul 30 14 PAIN OPIATE AGREEMENT, "No Location", Kris A Johnson, MD
 - Jul 07 14 INFORMED CONSENT, "No Location", LANANH T NGUYEN DDS
 - Jun 17 14 Adverse React/Allergy, "No Location", CLARISSA S MANZI, PHARM D
 - Jun 17 14 Adverse React/Allergy, "No Location", CLARISSA S MANZI, PHARM D
 - Apr 15 14 HPACT NURSING FOLLOW UP CARE, DEN HPACT SCANLON RN CLINIC, NICHOLAS SARCHET, RN, B
 - Feb 27 14 BLOOD PRESSURE MONITOR EDUCATION CONSULT REPORT (T), DEN A PACT RN CLINIC, LUCY LV
 - Feb 14 12 INFLUENZA VACCINE (D), DEN FLU CLINIC, ANISE L WOODS-ELLISON
 - Jul 25 11 RESEARCH STUDY COORDINATOR, DEN S4 ARTHRITIS RESIDENT, ALYSE D MANN
 - Jul 22 11 RESEARCH STUDY COORDINATOR, DEN S4 ARTHRITIS RESIDENT, ALYSE D MANN
 - Feb 17 11 BLOOD PRESSURE MONITOR EDUCATION CONSULT REPORT (T), DEN B RN CLINIC-X, JOANNA M T
 - Feb 17 11 EKG NOTE, DEN B RN CLINIC-X, JOANNA M THOMPSON
 - Feb 15 11 INJECTION - TESTOSTERONE CYP (T), DEN B INJECTION, JOANNA M THOMPSON
 - Feb 15 11 INJECTION - VIT B12 (T), DEN B INJECTION, JOANNA M THOMPSON
 - Feb 15 11 INFLUENZA VACCINE (D), DEN FLU CLINIC, JOANNA M THOMPSON
 - Nov 04 09 INFORMED CONSENT, "No Location", Michael E. Callahan, PA-C
 - Nov 04 09 INFORMED CONSENT, "No Location", Michael E. Callahan, PA-C
 - Nov 03 09 DEF/DIR TBI 2ND LEVEL EVALUATION CONSULT REPORT, zDEN SA EMRICK IND, Megan B Nelson, I
 - Oct 13 09 INFLUENZA VACCINE (D), DEN FLU CLINIC, ANISE L WOODS-ELLISON
 - Oct 13 09 INFLUENZA VACCINE (D), DEN FLU CLINIC, ANISE L WOODS-ELLISON
 - May 01 09 MH GROUP COUNSELING (B), Z22C0C MHC TEST CLINIC, Jacqueline S. Lopez, R.H.I.A
 - Feb 11 09 MH GROUP COUNSELING (B), Z22PUE MHC BENAVIDEZ GROUP, PEGGY BENAVIDEZ LOPEZ, LCSW
 - Jan 29 09 FEE BASIS CONSULT REPORT, DEN FEE BASIS, Jacqueline S. Lopez, R.H.I.A
 - Jan 09 09 OUTSIDE RECORDS SCANNED DOCUMENT (T), SCANNED DOCUMENT, Hyro K. Schnepfle
 - Jan 09 09 OUTSIDE RECORDS SCANNED DOCUMENT (T), SCANNED DOCUMENT, Hyro K. Schnepfle
 - Dec 30 08 SA PSYCH EDUCATION GROUP, zDEN SA EMRICK GROUP, Chad D. Erick, Ph.D.
 - Dec 05 08 SCANNED DOCUMENT (T), SCANNED DOCUMENT, Hyro K. Schnepfle
- Main Panel (Visit 10/01/14):**
 - TITLE:** MENTAL HEALTH DIAGNOSTIC STUDY NOTE, DEN MENTAL HEALTH RESEARCH-X, Nazanin H Bahraini
 - LOCAL TITLE:** MENTAL HEALTH DIAGNOSTIC STUDY NOTE
 - STANDARD TITLE:** MENTAL HEALTH DIAGNOSTIC STUDY NOTE
 - DATE OF NOTE:** OCT 01, 2014 09:10:47 | **ENTRY DATE:** OCT 01, 2014 09:10:47
 - AUTHOR:** BAHRAINI, NAZANIN H | **EXP COSIGNER:**
 - URGENCY:** | **STATUS:** UNSIGNED
 - Beck Scale for Suicide Ideation**
 - Date Given:** 10/01/2014
 - Clinician:** Bahraini, Nazanin H
 - Location:** Den Mental Health Research-X
 - Veteran:** Isaqs, Patient C
 - SSN:** xxx-xx-xxxx
 - DOB:** Oct 31, 1935 (78)
 - Gender:** Male
 - SSI Score:** 16 indicates low suicidal risk. The overall range is 0 to 42 wit
 - Questions and answers**
 - 1. I have a weak wish to live (1 point)
 - 2. I have a moderate to strong wish to die (2 points)
 - 3. My reasons for living or dying are about equal (1 point)
 - 4. I have a weak desire to kill myself (1 point)
 - 5. I would not take the steps necessary to avoid death if I found myself in a life-
 - 6. I have brief periods of thinking about killing myself which pass quickly (5 point)
 - 7. I rarely or only occasionally think about killing myself (0 point)
 - 8. I neither accept nor reject the idea of killing myself (1 point)
 - 9. I am unsure that I can keep myself from committing suicide (1 point)
 - 10. I would not kill myself because of my family, friends, religion, possible injur
 - 11. My reasons for wanting to commit suicide are primarily based upon escaping from
 - 12. I have considered ways of killing myself, but have not worked out the details (1
 - 13. I do not have access to a method or an opportunity to kill myself (0 point)
 - 14. I am unsure that I have the courage or the ability to commit suicide (1 point)
 - 15. I am unsure that I shall make a suicide attempt (1 point)
 - 16. I have made no preparations for committing suicide (0 point)
- Bottom Panel:** Templates, Encounter, New Note, Cover Sheet, Problems, Meds, Orders, Notes, Consults, Supply, D/C Summ, Labs, Reports

Note total score, but do not rely on self-report measures alone to determine level of risk

Beck Scale for Suicide Ideation

Date Given: 10/01/2014

Clinician: Bahraini, Nazanin H

Location: Den Mental Health Research-X

Veteran: Zzaqa, Patient C

SSN: xxx-xx-xxxx

DOB: Oct 31, 1935 (78)

Gender: Male

BSI Score: 15 indicates low suicidal risk. The overall range is 0 to 42 with low suicidal risk between 0 - 21

Questions and answers

1. I have a weak wish to live (1 point)
2. I have a moderate to strong wish to die (2 points)
3. My reasons for living or dying are about equal (1 point)
4. I have a weak desire to kill myself (1 point)
5. I would not take the steps necessary to avoid death if I found myself in a life-threatening situation (2 points)
6. I have brief periods of thinking about killing myself which pass quickly (0 point)
7. I rarely or only occasionally think about killing myself (0 point)
8. I neither accept nor reject the idea of killing myself (1 point)
9. I am unsure that I can keep myself from committing suicide (1 point)
10. I would not kill myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc (2 points)
11. My reasons for wanting to commit suicide are primarily based upon escaping from my problems (2 points)
12. I have considered ways of killing myself, but have not worked out the details (1 point)
13. I do not have access to a method or an opportunity to kill myself (0 point)
14. I am unsure that I have the courage or the ability to commit suicide (1 point)
15. I am unsure that I shall make a suicide attempt (1 point)
16. I have made no preparations for committing suicide (0 point)
17. I have not written a suicide note (0 point)
18. I have made no arrangements for what will happen after I have committed suicide (0 point)
19. I have not hidden my desire to kill myself from people (0 point)
20. I have never attempted suicide (0 point)
21. My wish to die during the last suicide attempt was moderate (1 point)

Identify concerning items and follow up with the patient to further assess



Case Example



Image from DoD: www.defense.gov



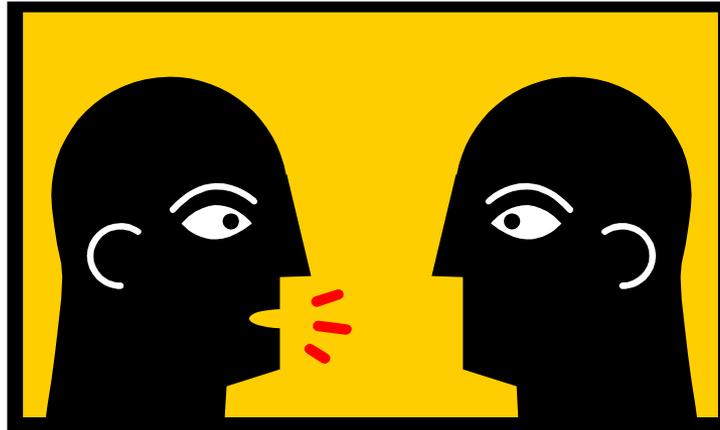
What's the Risk?

- **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**



What's the Risk?

- Risk factors?
- Warning signs?
- Protective factors?
- Assessment instruments?





Suicide Risk Assessment Components

Assessment + **Formulation**



Severity

Low

Intermediate

High



Severity

Low

Intermediate

High





Stratify Risk – Severity & Temporality

Low

Intermediate

High

Acute

Chronic

Integrate different sources of information to determine level of risk

| Risk of Suicide Attempt | Indicators of Suicide Risk | Contributing Factors † | Initial Action Based on Level of Risk |
|-------------------------|---|---|--|
| High Acute Risk | <ul style="list-style-type: none"> Persistent suicidal ideation or thoughts Strong intention to act or plan Not able to control impulse OR Recent suicide attempt or preparatory behavior †† | <ul style="list-style-type: none"> Acute state of mental disorder or acute psychiatric symptoms Acute precipitating event(s) Inadequate protective factors | <ul style="list-style-type: none"> Maintain direct observational control of the patient. Limit access to lethal means Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization |
| Intermediate Acute Risk | <ul style="list-style-type: none"> Current suicidal ideation or thoughts No intention to act Able to control the impulse No recent attempt or preparatory behavior or rehearsal of act | <ul style="list-style-type: none"> Existence of warning signs or risk factors †† AND Limited protective factor | <ul style="list-style-type: none"> Refer to Behavioral Health provider for complete evaluation and interventions Contact Behavioral Health provider to determine acuity of referral Limit access to lethal means |
| Low Acute Risk | <ul style="list-style-type: none"> Recent suicidal ideation or thoughts No intention to act or plan Able to control the impulse No planning or rehearsing a suicide act No previous attempt | <ul style="list-style-type: none"> Existence of protective factors AND Limited risk factors | <ul style="list-style-type: none"> Consider consultation with Behavioral Health to determine: <ul style="list-style-type: none"> - Need for referral - Treatment Treat presenting problems Address safety issues Document care and rationale for action |



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

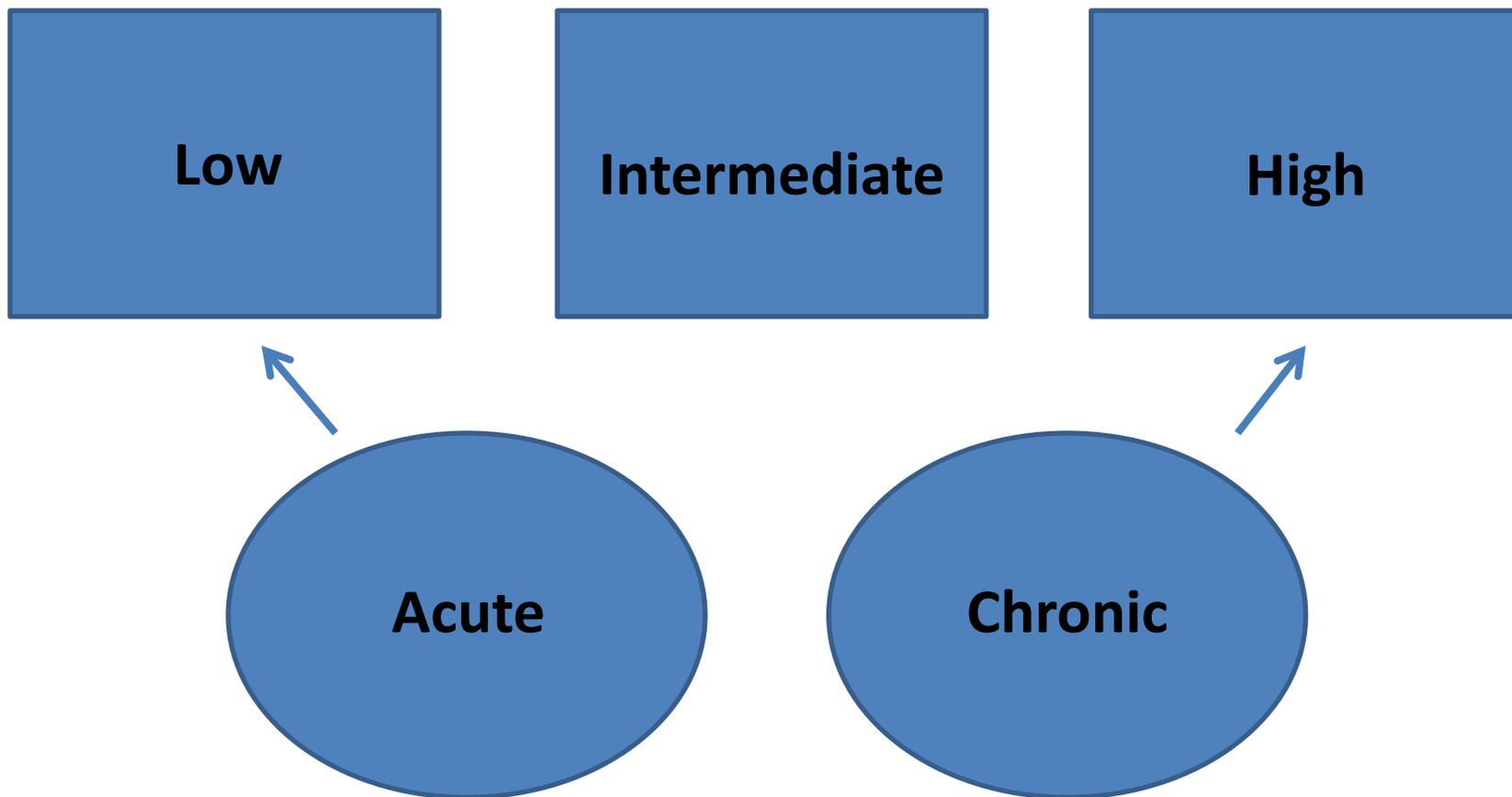


What's the Risk?

- **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





Documentation

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

Ideation → Intent → Plan → Access to Means

Conceptual Models





Fluid Vulnerability Theory

Rudd, 2006



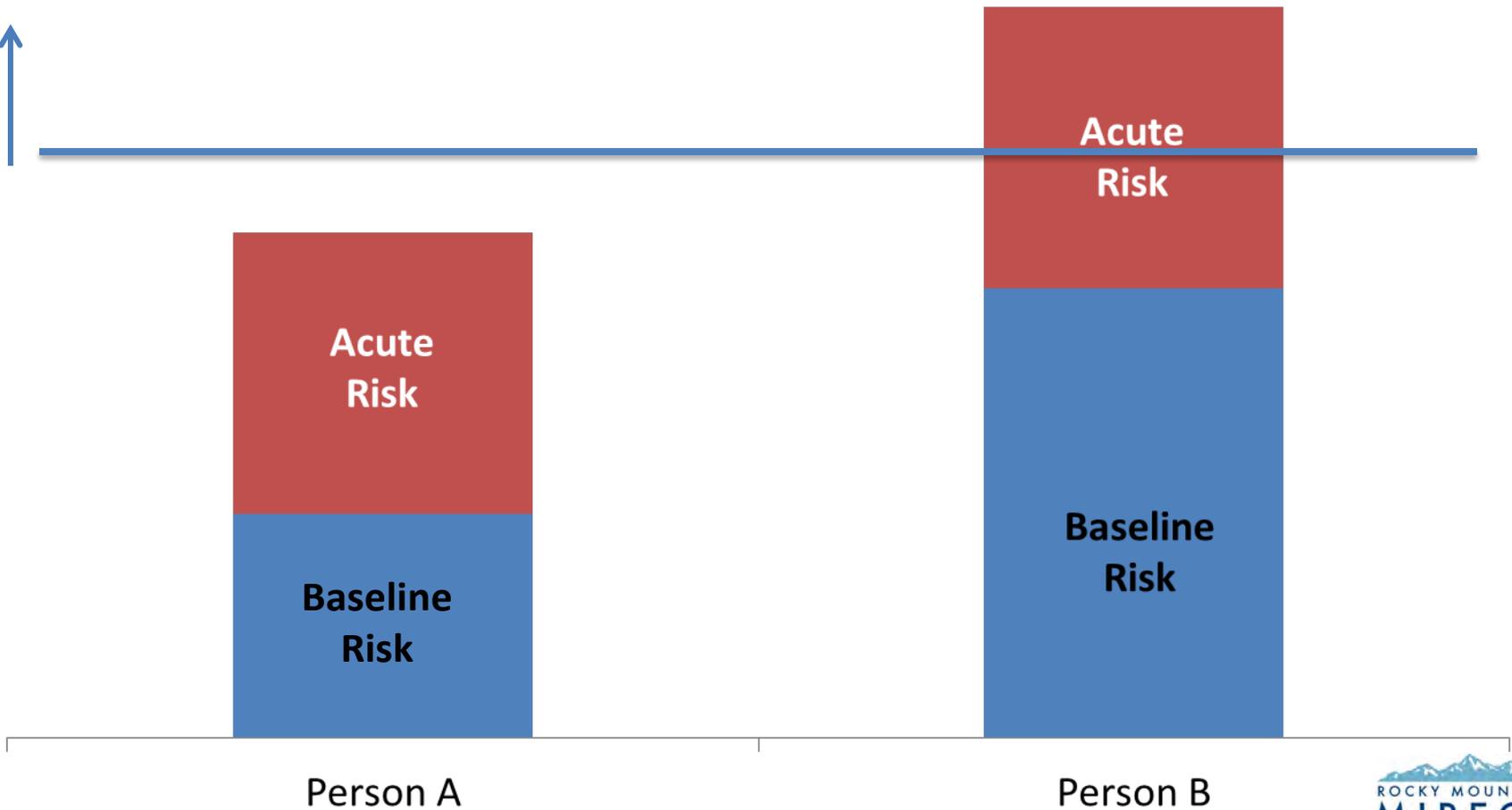
Core Concepts

- **Suicidal episodes are time limited**
- **Factors that trigger an episode and determine the duration are fluid**
- **Baseline risk varies from person to person**



...what does this look like?

Suicidal Mode





...what does this look like?

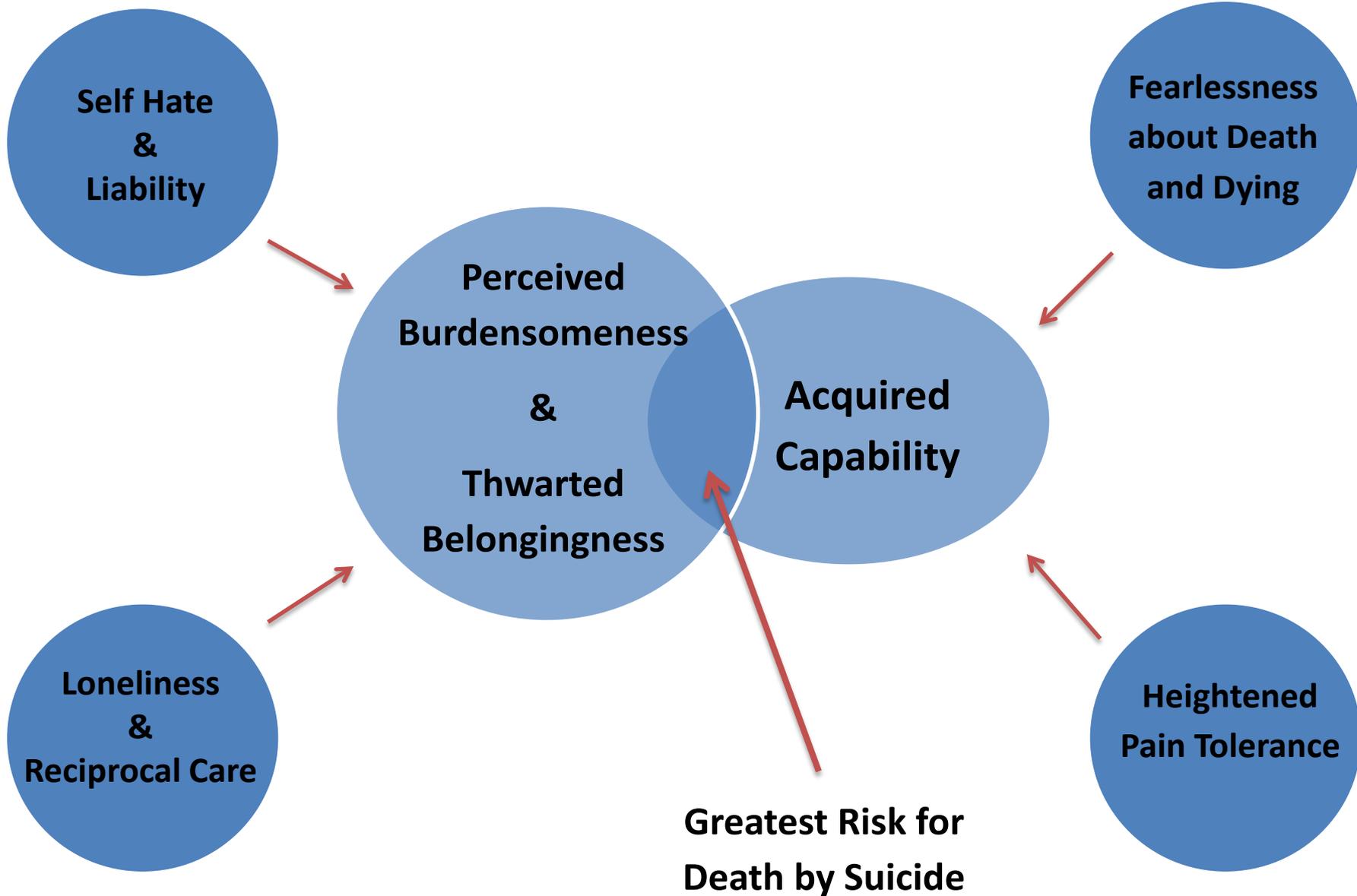
Suicidal Mode

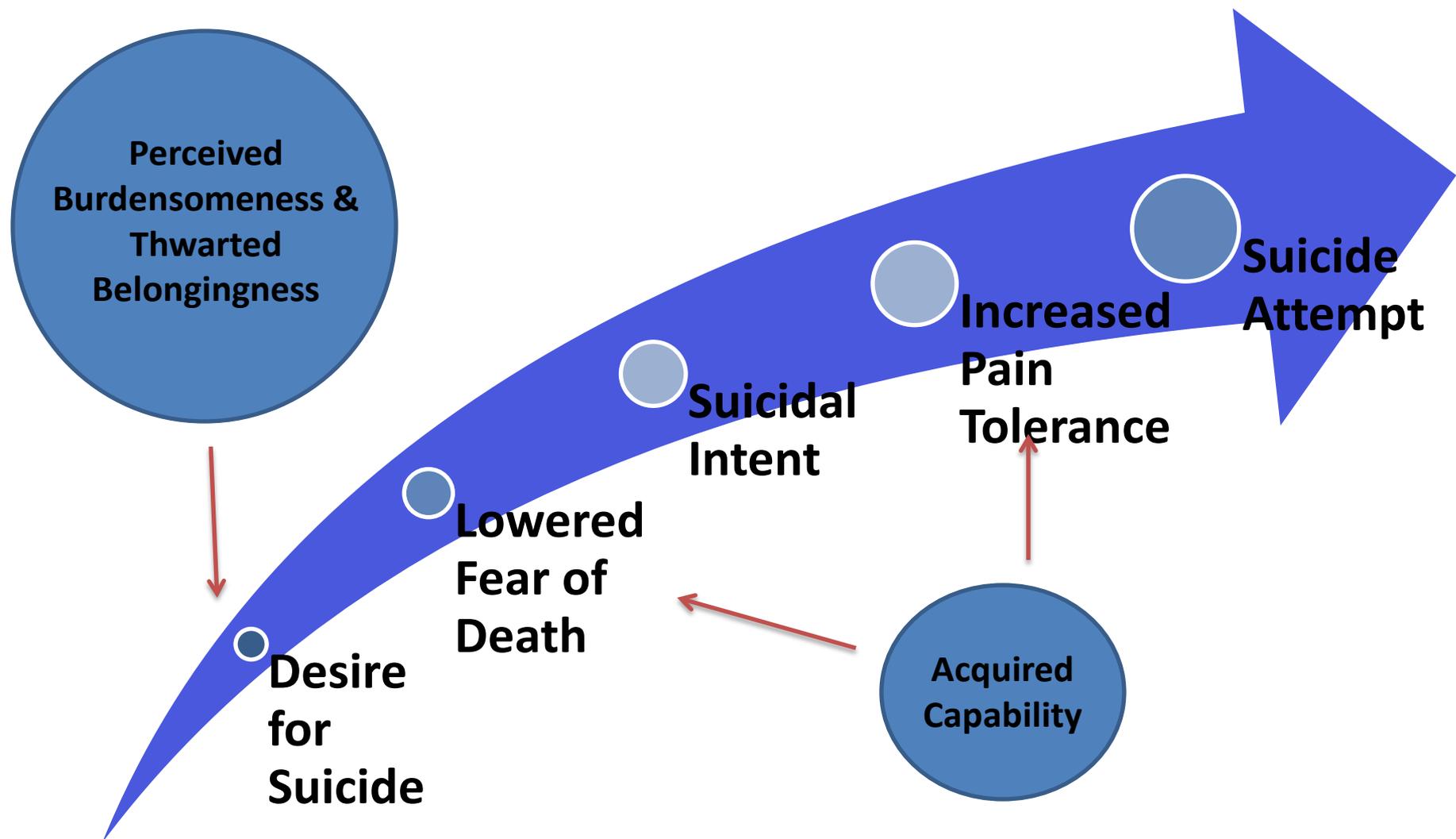




Interpersonal Theory of Suicide

Joiner, 2005; Van Orden et al., 2008; Van Orden et al., 2010







Safety Planning: A Stand Alone Intervention



Learning Objectives

- 1. Summarize the rationale behind safety planning**
- 2. Discuss safety planning as a collaborative experience**
- 3. Review available apps that can be used in conjunction with safety planning**



How can this presentation be helpful?

- **Determine the rationale for safety planning**
- **Familiarize yourself with the safety planning process**
- **Feel empowered to help your patients overcome barriers to safety plan creation or use**
- **Mirror our method of teaching the safety planning process when instructing your own staff about safety planning**



Safety Planning Rationale



Safety Plan vs. Suicide Contract

- **No-Suicide Contracts**

- Typically entails a patient agreeing to not harm themselves
- Sometimes includes what to do if they can no longer abide by the contract

- **Up to 79% of mental health professionals report using them despite there being no empirical support regarding their effectiveness (Drew, 1999; Rudd et al., 2006)**



No-Suicide Contracts - Reasons to Not Use Them

- **Medicolegal**

- Not legally binding; no protection against malpractice (Stanford et al., 1994; Simon, 1999)
- Erroneous to believe it can prevent suicide (Simon, 1999)

- **Provider-specific**

- False sense of security (Simon, 1999)
- Absence of therapeutic relationship (Simon, 1999)

- **Patient-centered**

- Concern that provider only worried about legal protection (Range et al., 2002)
- Could discourage open disclosure of thoughts, plan, etc. (Range et al., 2002)



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 (ideally) preceding a suicidal crisis
- Involves collaboration between the client and clinician

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



Safety Planning

- **Components grounded in...**
 - Cognitive Therapy
 - Collaborative Assessment and Management of Suicidality
 - Recovery-Oriented Approach



Collaboration

- **Key factor in working with individuals who are suicidal**
 - Suicide risk assessment can strain the therapeutic alliance
- **“Ownership” of the therapeutic relationship**
 - Shared responsibility
 - Teaching problem-solving vs suggested solutions
 - Cultivation of self-efficacy
 - Meeting needs for connection & acceptance



Tips for Developing a Safety Plan Collaboratively

- **Ways to increase collaboration**
 - Sit side-by-side
 - Use a paper form
 - Have the client to write
- **Brief instructions using the client's own words**
- **Easy to read**
- **Conversational approach**
- **Jointly address barriers and use a problem-solving approach**
 - Share responsibility



It's Always About the Relationship

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



The Safety Planning Process



Provide Rationale

- **What's your thinking like in a crisis?**
 - Fight or flight response
- **Stop, drop, and roll**
- **Military SOP**
- **Catch it early!**



SUICIDAL CRISIS - INTENSITY

Not an ideal time to use a Safety Plan

If Safety Plans are used BEFORE a crisis,
they have the best chance of working

TIME



6 Steps of Safety Planning

- **Step 1: Recognizing Warning Signs**
- **Step 2: Using Internal Coping Strategies**
- **Step 3: People and Social Settings that Provide Distraction**
- **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**



Step 1: Recognize Warning Signs

- **Purpose: To help the client identify and pay attention to his or her warning signs for suicidal ideation/behavior**
- **What to ask: “How will you know when the safety plan should be used?”**
- **What to include in the safety plan: Specific and personalized examples**
 - Physical sensations
 - Thoughts
 - Emotions
 - Behaviors



Step 1: Recognizing Warning Signs

Example of Barriers

- **Patient: “I don’t know what I think or feel when I’m not doing well.”**
- **Clinician: “Okay, let’s focus on your behaviors. What do you do when you are not doing well?”**
- **Patient: “Oh, I stop showering and don’t talk to anyone.”**



Step 2: Using Internal Coping Strategies

- **Purpose: To take the client's mind off of problems to prevent escalation of suicidal thoughts**
 - NOT to solve the client's problems
- **What to include in the safety plan: List activities the client can do without contacting another person**
 - Examples?



Step 2: Using Internal Coping Strategies

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



Step 2: Using Internal Coping Strategies

Example of Barriers

- **Patient: “I don’t have any coping skills- that’s why I am here.”**
- **Draw from past successes**
 - “Has there been any time in your life when you were having a hard time and coped with it?”
- **Build on recent experiences**
 - “Tell me what happened before this most recent crisis.”



Building “coping memory”

- **The importance of rehearsing and practicing internal coping skills**
 - The more you practice the internal coping strategies, the more these become automatic and likely to be used when needed the most



Step 3: People and Social Settings that Provide Distraction

- **Purpose: To engage with people and social settings that will provide distraction**
- **What to include on the safety plan: Importance of including phone numbers and multiple options**
- **What not to include: Avoid listing any controversial relationships**



Step 3: People and Social Settings that Provide Distraction

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



Step 3: People and Social Settings that Provide Distraction

Example of Barriers

- **Patient: “When I am having a hard time, the last thing I should do is be out around people.”**
 - (Patient has PTSD)
- **Clinician: “That can certainly be hard when your PTSD symptoms are triggered. How about...”**
 - Library (quiet, yet still around people)
 - Park/mountains (outside and likely not many people)



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

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



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

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



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

Example of Barriers

- **Patient: “I don’t have anyone to call. That is part of the problem.”**
- **Clinician**
 - Explore the validity of this, keeping in mind that the Veteran may have inaccurate beliefs regarding being a burden to others
 - Other patients truly may have no one to call. Assure them that a safety plan can still work for them.
 - Reassure them that this is something they can work on in treatment (building relationships and support systems)



Step 5: Contacting Professionals and Agencies

- **Purpose: The client should contact a professional if the previous steps do not work to resolve the crisis**
- **Include name, phone number and location**
 - Primary mental health provider
 - Other providers
 - Urgent care or emergency psychiatric services
 - National Suicide Prevention Line
 - 1-800-273-TALK (8255), press 1
 - 911



Step 5: Contacting Professionals and Agencies

Example of Barriers

- **Patient: “I’m not going to call that Crisis Line. I heard they’ll just bring you right to the hospital or jail or something.”**
- **Clinician**
 - Explain that only 5% of all calls made to the Crisis Line result in a “rescue”
 - Explain the circumstances in which they may initiate an emergency response
 - Add in that they can call the Crisis Line when in any distress- not just suicidal (remind them of the graph depicting preventing a crisis)



Step 6 : Reducing the Potential for Use of Lethal Means

- **Complete this step even if the client has not identified a suicide plan**
- **Ask “What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?”**
- **Ask “How can we go about developing a plan to limit your access to these means?”**



Step 6: Reducing the Potential for Use of Lethal Means

- Always ask whether the client has access to a firearm
- Discuss medications and how they are stored and managed
- Consider alcohol and drugs as a conduit to lethal means
- Also include ways to increase safety of environment
 - Reasons for living



Step 6: Reducing the Potential for Use of Lethal Means

Example of Barriers

- **Patient: “I’m not giving up my guns.”**
- **Clinician**
 - As appropriate, recommend that guns are given to a person they trust (perhaps another Veteran) only while they are not doing well
 - Recommend other options, such as gun locks (free from VA!), gun safes, separating ammunition from the gun, storing the gun (even if not locked up) in a difficult to access spot, pasting a picture of their reasons for living on gun case

Implementation





Implementation

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



Implementation

- **Assess how likely it is that the client will use the safety plan**
- **Discuss where the client will keep the safety plan**
 - Multiple copies; wallet-size versions; mobile phone or other device
- **Review and update the safety plan frequently**



Barriers to Implementation

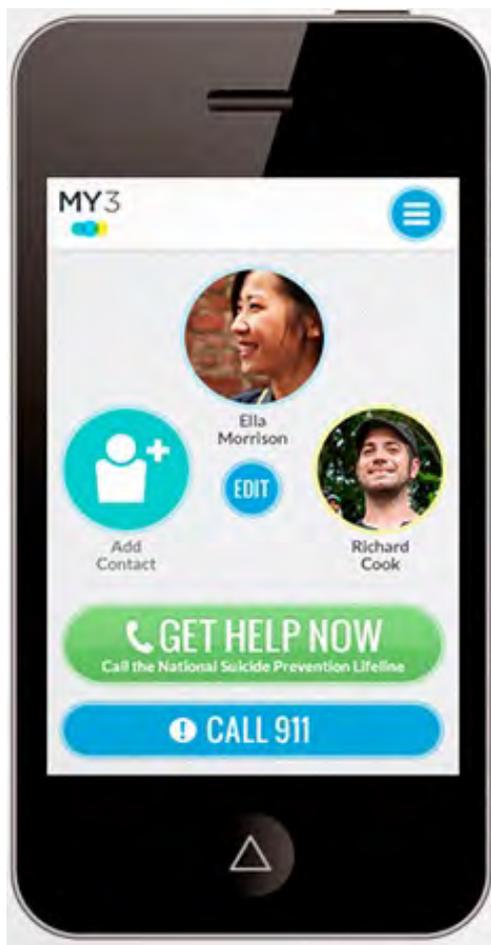
- **Problem-solve around any additional barriers, for example:**
 - Difficult to reach out to others
 - Don't like the name (Safety Plan)
 - Don't remember to use it
 - Change in home setting

Mobile Apps





Mobile Safety Planning



MY3

- Includes: A safety plan page where users can customize a step-by-step plan that they can refer to when they are experiencing thoughts of suicide.
- The My3 plan is modeled after a plan originally developed by Drs. Barbara Stanley and Gregory Brown.



Mobile Safety Planning



Virtual Hope Box

- VHB contains simple tools to help patients with coping, relaxation, distraction and positive thinking



Mobile Safety Planning Virtual Hope Box



Mobile Applications



Breathe2Relax

- Breathe2Relax is a portable stress management tool--hands-on diaphragmatic breathing exercise.
- Users can record their stress level on a 'visual analogue scale' by simply swiping a small bar to the left or to the right.

<http://t2health.org/apps/breathe2relax#.UjqUbxaCIII>

Mobile Applications



LifeArmor

- Brief self-assessments help the user measure and track their symptoms, and tools are available to assist with managing specific problems, including sleep, depression, relationship issues, and post-traumatic stress.

Mobile Applications



Positive Activity Jackpot

- Uses augmented reality technology to combine a phone's GPS and camera to find nearby enjoyable activities or pleasant diversions.

Clinician's guide available for download

http://www.t2health.org/sites/default/files/mobile_apps_PositiveActivityJackpot_Clinicians_Guide.pdf



Resources

VISN 19 MIRECC

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

VA Safety Planning Manual

www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc

Experiential Exercises





Vignette A

- 24, male, OIF Vet, admitted to in-patient psychiatric unit
- Told GF he was going to kill himself during argument
- Refused to participate in evaluation (“I don’t need to be here”)
- Observed to be calm, engaging with other Vets, eating/sleeping well, no signs of acute major mental illness
- Denies SI but denies being suicidal leading to admission
- 2 suicide attempts (also in context of rltp discord)
- Superficially invested in developing safety plan and plans for aftercare



Vignette B

- **30, female, OEF Vet, presents to outpatient appt**
- **Depression worsened over the last few weeks w/impending anniversary of trauma**
 - Not eating or sleeping much
- **Thinking about killing self w/pistol (kept in safe in closet)**
- **Support (best friend) will be out of town**
- **Internal coping strategies not working recently**
 - Only talking to friend and looking at pictures of children have been helpful
- **You are considering hospitalization but are concerned because she has 3 young children**
 - No other support available to take care of children



Vignette C

- **63, male, widowed, Vietnam Vet, presents to outpatient visit**
- **Endorses SI**
 - “Yeah, I have thought about suicide in the past week...I still wonder if things would be better if I was dead”
- **1 suicide attempt**
 - Overdose which required hospitalization 10 years ago
- **Regularly attending outpatient visits**
 - Only miss in past 3 months was due to flu
- **Has recently reengaged contact w/daughter**
 - Desires to improve physical and psychological health because of this
- **Denies current plan for suicide; denies intent**
 - Cannot guarantee that he will never act on his thoughts again in the future if “things get worse”



Questions?



Thank you!

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If you'd like to keep the discussion going and/or leave comments and questions, please feel free to do so within GoSoapBox

