

# PTSD and Suicide Risk: Assessment and Intervention

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VA VISN 19 MIRECC

Mental Illness Research, Education  
& Clinical Center

[www.mirecc.va.gov/visn19](http://www.mirecc.va.gov/visn19)

Boulder MHC

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## MIRECC CENTERS

### Useful Links

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## MIRECC of the VA Rocky Mountain Network (VISN 19)



VA ACE Cards - How you can talk to a Vet about suicide information.

### Mission:

The mission of the VISN 19 MIRECC is to study suicide with the goal of reducing suicidality in the veteran population. To carry out this mission members of the VISN 19 MIRECC will:



- Focus on cognitive and neurobiological underpinnings that may contribute to suicidality.
- Develop evidence-based educational and clinical materials to identify and optimally treat veterans who are suicidal.
- Provide consultation regarding assessment and treatment planning for highly suicidal veterans.
- Mentor researchers in the area of suicidology.
- Collaborate with others in the study and treatment of veterans who are at risk of suicide.

### Key Personnel

#### Lawrence Adler, M.D.

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[Larry.Adler@va.gov](mailto:Larry.Adler@va.gov)

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# Objectives

- Discuss 3 Essential Cluster Symptoms of PTSD
- Discuss key elements of Suicide Assessment
- Introduce Safety Planning
- Identify Resources

# What is PTSD?

“An anxiety disorder resulting from exposure to an experience involving direct or indirect threat of serious harm or death; may be experienced alone (rape/assault) or in company of others (military combat)”





# Types of Trauma

- War
- Terrorism/Mass Violence
- Accidents
- Natural Disasters
- Violence & Abuse
  - Sexual Assault
  - Community Violence
  - Domestic Violence
  - Child Sexual Abuse

# Those with PTSD at Increased Risk for Suicidal Behavior

14.9 times more likely to attempt  
suicide than those without PTSD  
(community sample)

# DSM-IV Criteria



## Essential Clusters of PTSD:

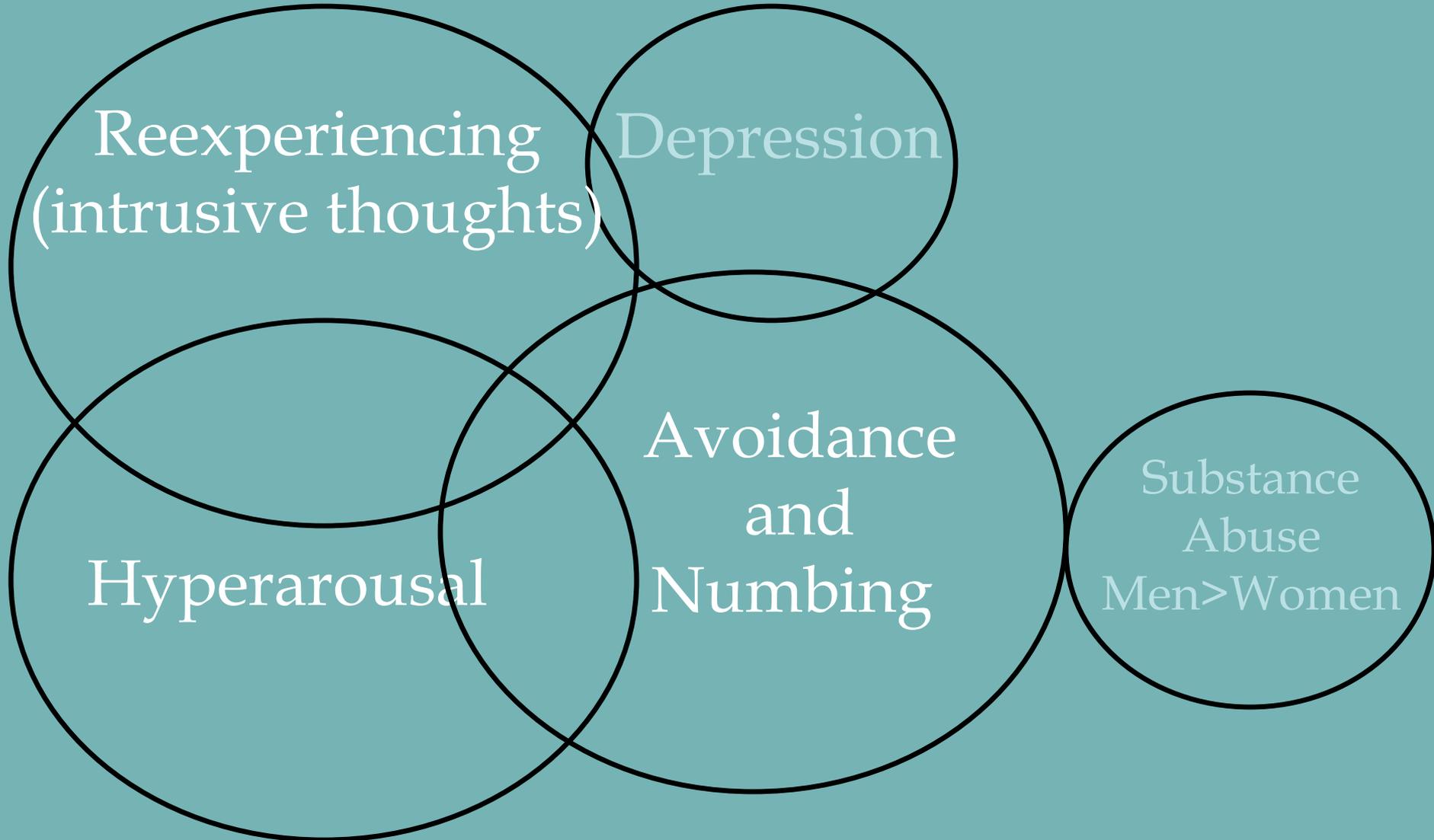
1. Re-experiencing symptoms (nightmares, intrusive thoughts)
2. Numbing/detachment from others
3. Hyperarousal (i.e. increased startle, hypervigilance)

# Post Traumatic Stress Disorder (PTSD)

A Medical Diagnosis



# PTSD: Symptom Clusters





# PTSD: Reexperiencing

1. Intrusive distressing memories
2. Distressing dreams
3. Acting or feeling as if the traumatic event were happening
4. Intense distress about reminders of the event
5. Physiological reactivity to reminders about the event

# PTSD: Arousal

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

# PTSD: Avoidance/ Numbing

1. Avoidance of thoughts, feelings, or conversations associated with the event
2. Efforts to avoid activities, places, or people that bring back memories of the event
3. Inability to remember an important part of the event
4. Diminished interest or participation in activities
5. Feeling of detachment or estrangement from others
6. Numbing (e.g., unable to have loving feelings)
7. Sense of a foreshortened future

# What causes PTSD symptoms?

One Theory: Disruption in the  
Hypothalymic/ Pitituary/ Adrenal Axis

“fight or flight” response disrupts a  
complicated network of hormones and  
neurotransmitters in the brain and body.

# Potential Consequences of PTSD

## Self-Destructive/Dangerous Behaviors:

- Substance use
- Suicidal ideation/ behaviors
- Risky sexual behavior
- Reckless driving
- Domestic Violence
- Legal Problems

# What Providers can do to address symptoms of PTSD?

Assess for PTSD

Interrupt Hyperarousal Symptoms





# PTSD Checklist (PCL)

- The PCL is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD.
- The PCL has a variety of purposes, including:
  - Screening individuals for PTSD
  - Diagnosing PTSD
  - Monitoring symptom change during and after treatment
- <http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp>

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# Hyperarousal/Avoidance Priorities for Early Intervention

- Supportive structures to prevent overdoing/overcontrol: excessive work, substance abuse, isolation
- Help people stay active
- Teach about recovery
- Easy access to support services
- Identify and enhance strengths

# How to Interrupt Hyperarousal

- Improve Sleep
- Education
  - Recognize symptoms
  - Recognize triggers
- Identify strategies to decrease triggers
- Identify strategies to diminish the intensity of the response

# VA/ DoD Clinical Guidelines

- Recommendations for the performance or exclusion of specific procedures or services for specific disease entities
- Derived through a rigorous methodological approach
  - Include systematic review of the evidence to outline recommended practice
- Displayed in the form of a flowchart algorithm



# Pharmacotherapy

- Monotherapy
  - Strongly recommend SSRIs
  - 2nd line: TCAs and MAOIs
  - Consider trial of at least 12 weeks before changing medications
  - Consider 2nd generation (e.g., trazodone, bupropion)
- Augmented therapy for targeted symptoms
  - Consider prazosin for nightmares and other PTSD symptoms
- Recommend medication compliance assessment at each visit
- Recommend against...
  - Benzodiazepines to manage core symptoms of PTSD
  - Typical antipsychotics in management of PTSD



# Pharmacotherapy

**FDA Indication: Sertraline (Zoloft) & Paroxetine (Paxil)**

- Address Core PTSD Symptoms**
  - Reexperiencing**
  - Hyperarousal**
- Also Helpful with comorbid depressive symptoms**
  - Depressed mood**
  - Sleep disturbance**
  - Diminished interests**
  - Feelings of guilt worthlessness**
  - Disturbance in energy**
  - Disturbance in concentration and memory**

# Psychotherapies

- Significant benefit – Strongly recommended
  - Cognitive Therapy
  - Exposure Therapy
  - Stress Inoculation Training
  - Eye Movement Desensitization Reprocessing (EMDR)
- Some benefit –
  - Imagery rehearsal therapy
  - Psychodynamic therapy
  - Patient education (recommended for all patients)



# Recognize, Treat and/or Refer: Comorbid/Coexisting Problems

- Medical Disorders
- Depression and Anxiety
- Substance abuse
- Spectrum of severe mental illnesses
- Aggressive behavior problems
- Sleep Disorders
- Suicidality
- Family Disruption
- Traumatic Brain Injury (TBI)
  - “signature injury” of conflict in Iraq



# Treatment Outcomes

(Lawrence Wahlberg, PhD)

- Affect tolerance
- Ability to observe one's own reactions
- Capacity for planning
- Willingness to research one's problems
- An active approach to life
- Capacity for curiosity
- Ability to conduct experiences in change and take responsible risks
- Tolerance of ambiguity
- Acknowledging failure without hating oneself



# Suicide

- Overview
- Suicide Assessment
- Safety Planning

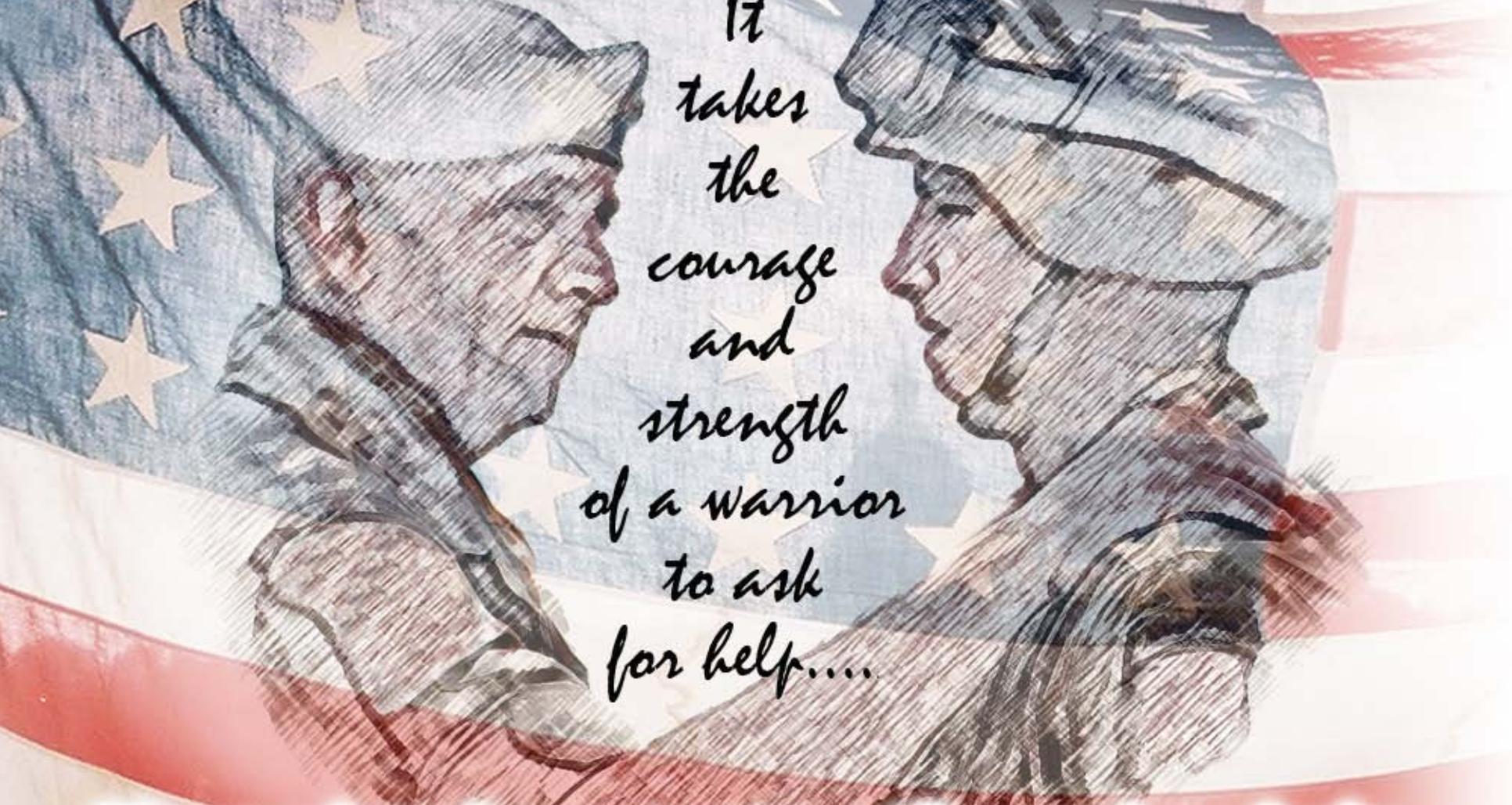
# Risk for Suicide

- Suicide is 11<sup>th</sup> leading cause of death in US
- Suicide is the 3<sup>rd</sup> leading cause of death for 18-34 year olds: Both genders & all races
- Rates are highest in the Mountain States
  - Wyoming: 21.8/100,000
  - Colorado: 19.6/100,000
  - Colorado Springs: 26/100,000
- Male US veterans are twice as non-veterans to die by suicide

# VA Suicide Prevention Program

- Veteran Suicide Hotline
- Suicide Prevention Coordinators
- Community Collaboration/Education
- Employee Education
  - Clinicians
  - Non-Clinical Staff (Operation S.A.V.E)
- MIRECC/ Center of Excellence
- Implementation of Evidence Based Practice
  - (CPT, PE, DBT)





*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](http://www.suicidepreventionlifeline.org)

# The Hotline Has Also Been Used To

- Engage veterans in MH care
- Trigger a more intense level of care
- Facilitate program-solving regarding difficulties in care
- Assist families & friends in accessing resources and resolving crises



# Suicide risk assessment

**A process – not an event...**



# Suicide Assessment Pocket Card

## RESPONDING TO SUICIDE RISK

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

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

**PROVIDE NUMBER OF EMERGENCY CARE CENTER TO PATIENT AND SIGNIFICANT OTHER**

**National Suicide Hotline Resource:**

**1 - 800 - 273 - TALK (8255)**

References:  
American Psychiatric Association. Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. 2nd ed. In: Practice Guidelines for the Treatment of Impulsive Disorders. Compand Unit. Arlington, VA: 2004. 1835-1927.  
Hunt, C. A. Warning signs for suicide ideation, research and clinical applications. Suicide and Life-Threatening Behavior, 2005 June;33:623-62.

 Employee Education System

## SUICIDE RISK ASSESSMENT GUIDE

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

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

### LOOK FOR THE WARNING SIGNS

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

Presence of any of the above warning signs requires immediate attention and referral. Suicide risk stratification for safety and complete assessment may be needed.

### Additional Warning Signs

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

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

 Department of  
Veterans Affairs

## ASSESS FOR SPECIFIC FACTORS THAT MAY INCREASE OR DECREASE RISK FOR SUICIDE

### FACTORS THAT MAY INCREASE RISK

- Current ideation, intent, plan, access to means
- Previous suicide attempt or attempts
- Alcohol/substance abuse
- Previous history of psychiatric diagnosis
- Impulsivity and poor self-control
- Hopelessness – presence, duration, severity
- Recent losses – physical, financial, personal
- Recent discharge from an inpatient unit
- Family history of suicide
- History of abuse (physical, sexual or emotional)
- Comorbid health problems, especially if newly diagnosed problem or worsening symptoms
- Age, gender, race (elderly or young adult, unmarried, white, male, living alone)
- Same-sex sexual orientation

### FACTORS THAT MAY DECREASE RISK

- Positive social support
- Spousality
- Sense of responsibility to family
- Childless in the home, pregnancy
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Positive therapeutic relationship

## ASK THE QUESTIONS

*Are you feeling hopeless about the present/future?*

**If yes ask...**

*Have you had thoughts about taking your life?*

**If yes ask...**

*When did you have these thoughts and do you have a plan to take your life?*

*Have you ever had a suicide attempt?*



# “VA Suicide Risk Assessment Guide”:

## 1. Look for warning signs

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

# Other Warning Signs

- \_\_\_ Evidence of Hopelessness (the despair you feel when you have abandoned hope of comfort or success)
- \_\_\_ Rage, anger, seeking revenge
- \_\_\_ Acting reckless or engaging in risky activities, seemingly without thinking
- \_\_\_ Feeling trapped-like there's no way out
- \_\_\_ Increasing alcohol or drug use
- \_\_\_ Withdrawing from friends, family, or society
- \_\_\_ Anxiety, agitation
- \_\_\_ Inability to sleep or sleeping all the time
- \_\_\_ Dramatic changes in mood
- \_\_\_ No reason for living; no sense of purpose in life
- \_\_\_ Recent changes in mood, medications or inability to follow treatment recommendations



# Definition: Warning Sign

David Rudd defines “warning sign” as:

“the earliest detectable sign that may indicate heightened risk for suicide within the near term, i.e. minutes, hours, days”

# “VA Suicide Risk Assessment Guide”

## 2. Assess for risk and protective factors

(Please refer to brochure for complete list)

### Risk Factors

- Current Ideation
- Previous Attempt
- History Mental Illness
- Hopelessness
- Recent Losses
- Easy access to lethal means

### Protective Factors

- Social Support
- Spirituality
- Responsibility to Family
- Positive Coping Skills
- Children

# DVAMC Suicide/Homicide Assessment Progress Note Template (Risk Factors)

- \_\_\_ History of self-harm behaviors
- \_\_\_ Preparatory self-harm behaviors or preparatory suicidal behaviors
- \_\_\_ Family History of Suicide
- \_\_\_ Psychiatric Disorder/s
- \_\_\_ Substance Use/Abuse
- \_\_\_ Recent loss (job, health, family, friend, pet, income etc)
- \_\_\_ Physical Illness/ Functional Impairment/ Chronic Pain
- \_\_\_ Impulsivity
- \_\_\_ TBI (Traumatic Brain Injury)
- \_\_\_ History of childhood abuse
- \_\_\_ Easy access to weapons or lethal means

# DVAMC Suicide/Homicide Assessment Progress Note Template (Protective Factors)

- \_\_\_ Ability to implement Safety Plan
- \_\_\_ Evidence of an alliance with MH/VA Providers
- \_\_\_ Ability to identify reasons for living
- \_\_\_ Restricted access to lethal means
- \_\_\_ Positive coping skills
- \_\_\_ Sense of competency/resilience
- \_\_\_ Future oriented plans and commitments

# DVAMC Suicide/Homicide Assessment Progress Note Template (Protective Factors)

- Required by JC and VA policy
- Content taken from Comprehensive Textbook of Suicidology and RCA (Root Cause Analysis) Committee members
- No empirical evidence of effectiveness in preventing suicide
- But....helpful in developing a “safety plan”



# “VA Suicide Risk Assessment Guide”

## 3. Ask the Questions

- a. Are you feeling hopeless about the present/future?
- b. Have you had thoughts about taking your life?
- c. When did you have these thoughts and do you have a plan to take your life?
- d. Have you ever had a suicide attempt?

# Bottom Line

- There is no single or cluster group of symptoms that will predict who will become violent
  - Don't do this alone...Consult with your colleagues
  - Engage with patient's family
  - Remove lethal means

# Clinical Assessment and Judgment

- Remember.....legal and medical standards require clinicians to address the issues
- There is recognition that you must make a clinical judgment
- There are multiple, complex and everchanging dynamics involved in suicide
- The point is to document that you know what is going on and what your best judgment is based on that information at that time



# Intervention



# Treatment Interventions for Suicide Prevention

Kate Comtois, PhD, MPH  
University of Washington  
Presentation at Denver  
VA Medical Center

- [http://www.mirecc.va.gov/visn19/docs/presentations/Comtois\\_VA\\_Suicide\\_Prevention\\_Week\\_9-4-10.pdf](http://www.mirecc.va.gov/visn19/docs/presentations/Comtois_VA_Suicide_Prevention_Week_9-4-10.pdf)



# Kate Comtois, PhD, MPH

## Summary

- There are relatively few clinical trials for treatments for suicidality
- Standard of care interventions such as inpatient and anti-depressants do not have strong support
- Psychotherapy-particularly CBT and DBT have support
- Caring letters alone have support
- Psychotherapy emphasizes collaboration and directly treating suicidality

# Safety Planning:

Lisa Brenner, PhD, ABPP(Rp)

[http://vaww.mentalhealth.va.gov/files/suicideprevention/VA\\_Safety\\_planning\\_manual\\_8-19-08revisions.doc](http://vaww.mentalhealth.va.gov/files/suicideprevention/VA_Safety_planning_manual_8-19-08revisions.doc)



### VA Safety Plan: Brief Instructions\*

#### Step 1: Recognizing Warning Signs

- Ask "How will you know when the safety plan should be used?"
- Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

#### Step 2: Using Internal Coping Strategies

- Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
- Ask "How likely do you think you would be able to do this step during a time of crisis?"
- If doubt about using coping strategies is expressed, 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 ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

#### Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
- Ask patients to list several people and social settings, in case the first option is unavailable.
- Ask for safe places they can go to do be around people, e.g. coffee shop.
- Remember, in this step, suicidal thoughts and feelings are not revealed.

#### Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

- Instruct 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?"
- Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
- Ask "How likely would you be willing to contact these individuals?"
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

#### Step 5: Contacting Professionals and Agencies

- Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
- List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255))
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

#### Step 6: Reducing the Potential for Use of Lethal Means

- The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
- For methods with low lethality, clinicians may ask veterans to remove or restrict their access to these methods themselves.
- Restricting the veterans' access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

# 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 to do this?



Brown, Stanley, Karlin, Brenner & Kemp 2008

**Suicide Risk Assessment**



**Mental Health Referral / Treatment**



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Problems with This Approach

- Individuals often do not have a way to manage their crises
- Many of these individuals may not engage in follow-up treatment



Brown, Stanley, Karlin, Brenner & Kemp 2008

# “No Suicide Contract”

- 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

**Suicide Risk Assessment**



**Safety Plan**



**Mental Health Referral / Treatment**

# What is a Safety Plan?

- Prioritized written list of **coping strategies and resources** for use during a suicidal crisis
- Helps provide a sense of control
- Uses a brief, easy-to-read format that uses the patients' own words
- Involves a **commitment to treatment** process (and staying alive)



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Who Develops the Plan?

- Collaboratively developed by the clinician **and** the veteran in any clinical setting
- **Veterans** who have
  - made a suicide attempt
  - have suicide ideation
  - have psychiatric disorders that increase suicide risk
  - otherwise been determined to be at high risk for suicide

# When Is It Appropriate?

- A safety plan may be done at any point during the assessment or treatment process
- Usually follows a suicide risk assessment
- Safety Plan may not be appropriate when patients are at imminent suicide risk or have profound cognitive impairment
- The clinician should adapt the approach to the veteran's needs -- such as involving family members in using the safety plan

# How Do You Do It?

- VA clinician and patient should sit side-by-side, use a problem solving approach, and focus on developing the safety plan
- Safety plan should be completed using a paper form with the veteran



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Overview of Safety Planning

## 6 Steps

1. Recognize warning signs
2. Employing internal coping strategies without contacting another person
3. Socializing with family members or others who may offer support as well as distraction from the crisis



# Overview of Safety Planning

## 6 Steps

1. Contacting family members or friends who may help to resolve a crisis
4. Contacting mental health professionals or agencies
5. Reducing the potential for use of lethal means



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Step 1: Recognizing Warning Signs

- Safety plan is only useful if the patient can recognize the warning signs
- The clinician should obtain an accurate account of the events that transpired before, during and after the most recent suicidal crisis
- Ask “How will you know when the safety plan should be used?”

# Step 1: Recognizing Warning Signs

- Ask, “What do you experience when you start to think about suicide or feel extremely distressed?”
- Write down the warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients’ own words



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Step 1: Recognizing Warning Signs Examples

- Automatic Thoughts
  - “I am a nobody”
  - “I am a failure”
  - “I don’t make a difference”
  - “I am worthless”
  - “I can’t cope with my problems”
  - “Things aren’t going to get better”
  - Images
  - “Flashbacks”

# Step 1: Recognizing Warning Signs: Examples

- Thinking Processes
  - “Having racing thoughts”
  - “Thinking about a whole bunch of problems”
- Mood
  - Feeling depressed
  - Intense worry
  - Intense anger

# Step 1: Recognizing Warning Signs Examples

- Behaviors
  - “Crying”
  - Isolating
  - Using Drugs

## Step 2: Using Internal Coping Strategies

- List activities that patients can do without contacting another person
- Activities function as a way to help patients take their minds off their problems and promote meaning in the patient's life
- Coping strategies prevent suicide ideation from escalating

## Step 2: Using Internal Coping Strategies

- It is useful to have patients try to cope on their own with their suicidal feelings, even if it is for a brief time
- Ask “What can you do on your own if you become suicidal again...to help yourself not act on your thoughts or urges?”

## Step 2: Using Internal Coping Strategies

- Examples
  - Going for a walk
  - Listening to music
  - Taking a hot shower
  - Walking the dog

## Step 2: Using Internal Coping Strategies

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

## Step 3: Socializing with Family Members or Others

- Coach patients to use Step 3 if Step 2 does not resolve the crisis or lower risk
- Family, friends, or acquaintances who may offer support and distraction from the crisis



Brown, Stanley, Karlin, Brenner & Kemp 2008

## Step 3: Socializing with Family Members or Others

- Ask “Who do you enjoy socializing with?”
- Ask “Who helps you take your mind off your problems at least for a little while?”
- Ask patients to list several people, in case they cannot reach the first person on the list



Brown, Stanley, Karlin, Brenner & Kemp 2008

## Step 4: Contacting Family Members or Friends for Help

- Coach patients to use Step 4 if Step 3 does not resolve the crisis or lower risk
- Ask “How likely would you be willing to contact these individuals?”
- Identify potential obstacles and problem solve ways to overcome them



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Step 5: Contacting Professionals and Agencies

- Coach patients to use Step 5 if Step 4 does not resolve the crisis or lower risk
- Ask “Which clinicians should be on your safety plan?”
- Identify potential obstacles and develop ways to overcome them



Brown, Stanley, Karlin, Brenner & Kemp 2008

## Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
  - **Clinicians**
  - **Local urgent care services**
  - **VA Suicide Prevention Coordinator**
  - **VA Suicide Prevention Hotline**  
800-273-TALK(8255), press “1” if veteran



Brown, Stanley, Karlin, Brenner & Kemp 2008

## Step 6: Reducing the Potential for Use of Lethal Means

- Ask patients what means they would consider using during a suicidal crisis
- Regardless, the clinician should always ask whether the veteran has access to a firearm

## Step 6: Reducing the Potential for Use of Lethal Means

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

# Step 6: Reducing the Potential for Use of Lethal Means

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

# Implementation: What is the Likelihood of Use?

1. Ask: “Where will you keep your safety plan?”
2. Ask: “How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?”



Brown, Stanley, Karlin, Brenner & Kemp 2008

## Implementation: What is the Likelihood of Use?

**3. Ask: “What might get in the way or serve as a barrier to your using the safety plan?”**

- **Help the veteran find ways to overcome these barriers**
- **May be adapted for brief crisis cards, cell phones or other portable electronic devices- must be readily accessible and easy to use**



# Implementation: Review the Safety Plan Periodically

- Periodically review, discuss, and possibly revise the safety plan after each time it is used
- The plan is not a static document
- It should be revised as veterans' circumstances and needs change over time



Brown, Stanley, Karlin, Brenner & Kemp 2008

# Thank you!

[Pamela.Staves@va.gov](mailto:Pamela.Staves@va.gov)

**303-399-8020 ext 2557**

**[www.va.mirecc.gov/visn19](http://www.va.mirecc.gov/visn19)**



# Resources





## MIRECC CENTERS

### Useful Links

MIRECC Centers Home

VISN 19 MIRECC

Research

Education

Clinical Care

Personnel

Site Search

## MIRECC of the VA Rocky Mountain Network (VISN 19)



VA ACE Cards - How you can talk to a Vet about suicide information.

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# US Department of Veterans Affairs

[www.va.gov](http://www.va.gov)

- \* Veterans Health Administration  
Includes “Vet Centers”
- \* Veterans Benefits Administration

# Veterans Benefits Administration

- \* Compensation and Pension
- \* Home Loan Guaranty
- \* Insurance
- \* Education
- \* Vocational Rehabilitation and Employment

# VHA: Veterans Health Administration

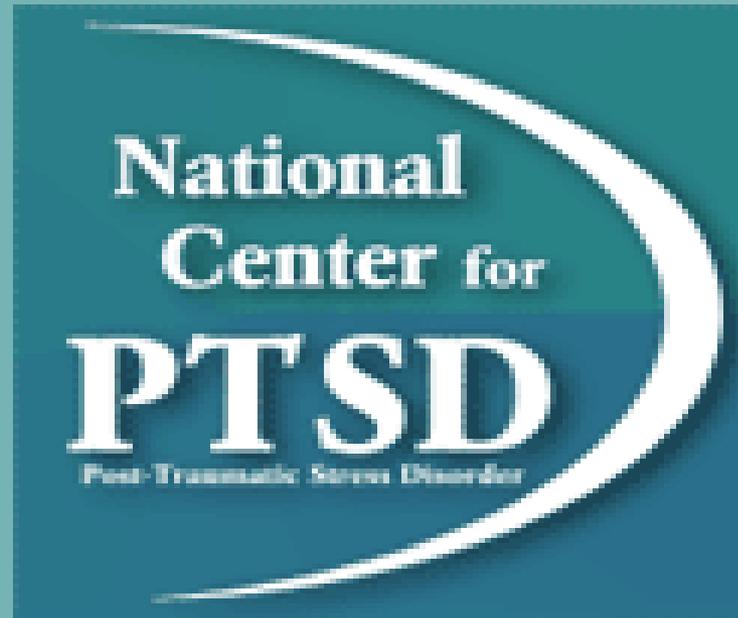
- Five Years (post-deployment) free medical care for combat related illness or injury
- Eligible for all levels of medical care, even if not combat related (may be co-pays)
- Once enrolled, may return at any time (Combat Vet status places you into Priority Group 6 which grandfather future care)

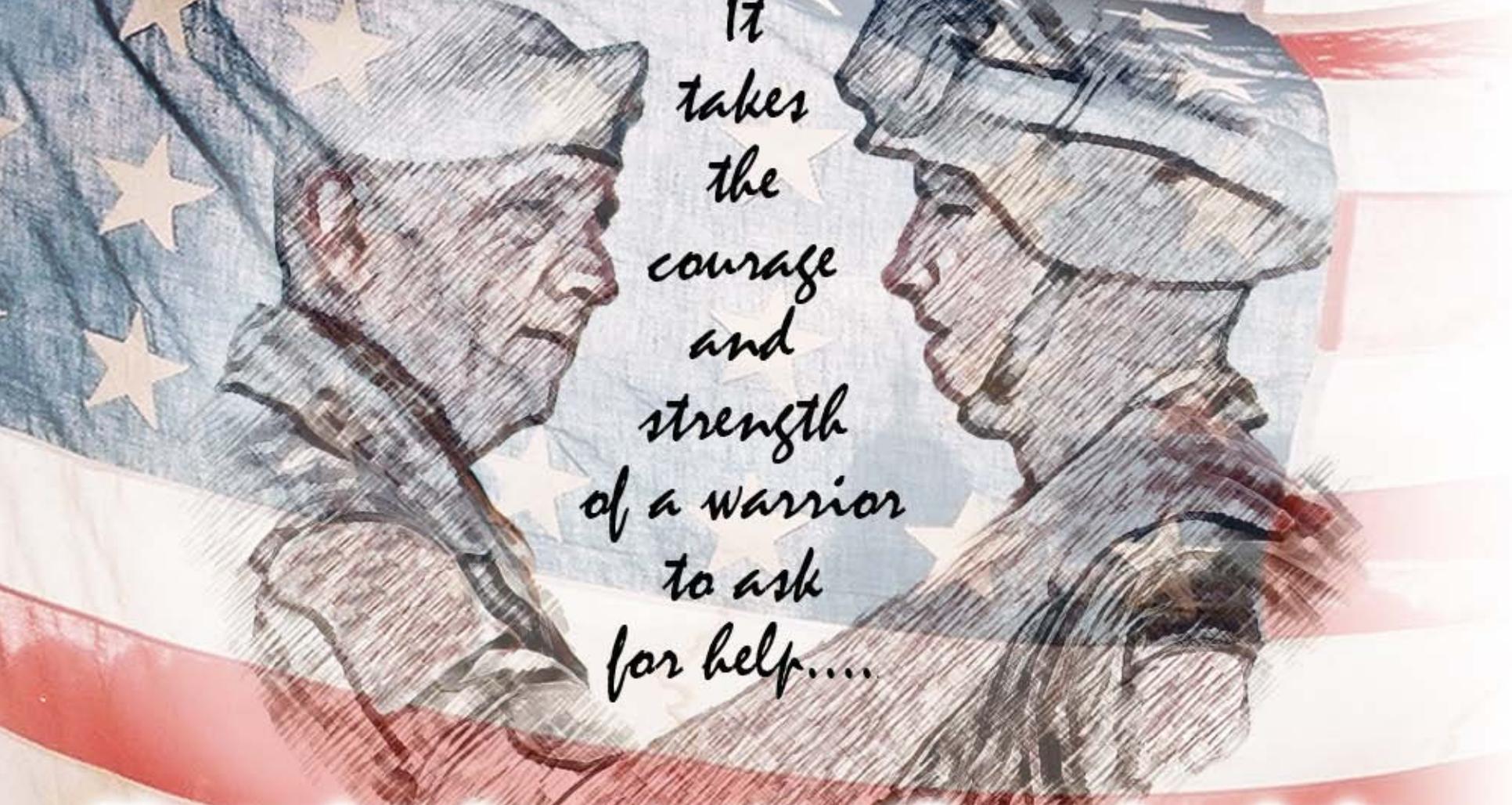
# Vet Centers: Regional Counseling Centers

- Many centers have GWOT (Global War on Terrorism) Counselors
- Provide:
  - \* counseling
  - \* referral for benefits assistance
  - \* community education
  - \* confidential services

# National Center for PTSD

- [www.ncptsd.va.gov](http://www.ncptsd.va.gov)





*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](http://www.suicidepreventionlifeline.org)